A SERIES OF SYSTEMATIC CASE STUDIES ON THE TREATMENT OF RAPE-RELATED PTSD IN THE SOUTH AFRICAN CONTEXT: IMPLICATIONS FOR PRACTICE AND POLICY

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ANITA PADMANABHANUNNI

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ABSTRACT

In 2009, South African police statistics revealed that more than 68 332 women were raped in the country. The evidence from independent researchers has shown that SAPS statistics are highly susceptible to under-reporting and the actual figure is more than double this amount. One pervasive feature of the phenomenology of rape is post-traumatic stress disorder (PTSD). PTSD is a highly debilitating condition with severe individual and societal costs. The condition takes a critical toll on occupational functioning, schooling and personal relationships and is associated with depression, suicide risk, self-harming behaviours and alcohol-abuse problems. The Ehlers and Clark (2000) cognitive model represents the most efficacious treatment for PTSD but the approach is severely under-utilised by South African practitioners working with sexual trauma. The reasons for such under-utilisation relate to a lack of exposure and training surrounding the model and concerns about the transportability of the treatment to a multi-cultural context. One method of addressing these barriers to treatment delivery is through systematic case-based research. Systematic case-based research offers a complementary means of refining theory and developing evidence-based practice in the context of a developing country. The method offers an intensive analysis and description of the particular phenomena under study within its real-life context. It allows the researcher to intensively examine and identify the specific aspects of the therapist's responses and client's reactions that contributed to significant change. Unlike efficacy studies, generalisability in case-study research is based on replication on a case-by-case basis and the creation of case law. This research study uses a systematic-case study approach to investigate the applicability of the Ehlers and Clark (2000) model in the treatment of rape-related PTSD in South Africa. The study aims to demonstrate the transportability of the model and develop a needed evidence base for service providers in the country. Seven women participated in the project and lent their treatment process to the research. The participants varied in terms of age, race, culture, socio-economic status and the nature of their sexual trauma. Through synoptic thematic analysis of their therapy process specific client-related personal aspects, client-related contextual factors and state-level factors were found to impede treatment delivery and implementation. The implications of these aspects for clinical practice and social policy are comprehensively discussed.

Make your own notes. NEVER underline or write in a book.

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INTRODUCTION

This introductory chapter offers an overview of the specific motivations underlying the present study through a synthesis of the chapters that constitute this dissertation.

SETTING THE SCENE

Rape has always been a feature of human society and the physical reality of rape and its centrality to women's lives has not changed over time. Rape, with very few exceptions, remains a crime perpetrated by men against women (Brownmiller, 1975; Freedman, 2006; MacKinnon, 1987). One aspect of rape that has changed is the visibility of this crime. Prior to the feminist movement of the 1960's and 1970's rape was shrouded in secrecy (Chasteen, 2001; Rose, 1977) and in South Africa this pattern continued due to an oppressive political system (Britton, 2006). However, since the advent of democracy in South Africa, rape has become glaringly visible (Abrahams, 2004; Abrahams, Martin, & Vetten, 2004) with statistics providing disconcerting evidence of the pervasive nature of sexual violence in the country. This situation has raised questions about whether there has been a real increase in the incidence of rape post-democracy or whether this form of violence has been a constant feature of South African society and therefore persists simply because it has always been tolerated. Such questions have led researchers to examine South Africa's history and the changing social, cultural and political climate in search of explanations for the prevalence of rape. One prominent explanation involves the country's turbulent history and sustained political violence over three decades which is argued to have contributed to the normalisation of violent practices and the blunting of empathy (Gobodo-Madikizela, 2008; Moffett, 2006; Vetten, 2000). The trans-generational transmission of these attitudes is regarded as central to the persistence of rape (Volkan, 2001, 2006). Another explanation points to the transformation in gender ideologies post 1994 and argues that the increased independence of women has contributed to defensive reactions (Morrell, 2001) from certain groups of men and thereby fuelled the endemic rates of rape. These accounts, however, merely provide theoretical frameworks for understanding the persistence of rape in the country and do not offer justifications for this crime.

With increased awareness of rape, attention has also shifted towards understanding the personal aspects of this injury, that is, the subjective experience or phenomenology of rape. One of the

earliest attempts to capture and understand the effects of rape was undertaken by Burgess and Holmstrom (1974) who, on the basis of their clinical observations of rape victims[1], developed the conceptual model Rape Trauma Syndrome (RTS). These latter researchers identified a pattern of responses shared by most women exposed to rape and one central and pervasive feature of the phenomenology of rape was post-traumatic stress disorder (PTSD).

PTSD is characterised by three sets of symptomatic reactions namely: symptoms of intrusive re-experiencing of the traumatic event; symptoms of increased physiological arousal and; symptoms of cognitive and behavioural avoidance of reminders of the trauma. These symptoms are particularly debilitating and can compromise an individual's ability to perform occupationally or in terms of schooling. PTSD also takes a severe toll on personal relationships particularly within the context of the family (Edwards, 2005b). To underscore the critical individual and societal costs of rape-related PTSD, rape victims with PTSD have been found to be at significant risk for suicide and to have high rates of depression, self-harming behaviours and alcohol-abuse problems (Green, Krupnick, Stockton, & Goodman, 2005; Khan, Leventhal, Khan, & Brown, 2002; Ullman, Filipas, Townsend, & Starzynski, 2007; Tarrier & Gregg, 2004).

In South Africa, PTSD represents a salient aspect of the phenomenology of rape for victimised women (Kaminer, Grimsrud, Myer, Stein, & Williams, 2008; Seedat, Nyamai, Njenga, Vythilingum, & Stein, 2004; Peltzer, 2000) and is also associated with critical negative health outcomes including suicidal ideation, self-harming behaviours, depression and alcohol abuse (Payne & Edwards, 2009; Olley, Abrahams, & Stein, 2006; van der Linde, 2007)

In recognition of the severe implications of PTSD, considerable international research has been undertaken over the past decades to understand the causative factors underlying the disorder and the best treatment approach to address symptoms. From such research, the Ehlers and Clark

[1] The term 'rape victim' is used throughout this project because I believe that the term encompasses the disempowering nature of sexual violence and acknowledges that those exposed to rape are not to blame for the crime. In addition, many women are faced with obstacles that prevent them from recovering from sexual trauma and therefore do not reach a stage where they can be called a 'survivor'. Furthermore, even when a woman achieves psychological recovery she can continue to experience certain challenges related to the rape particularly when it comes to seeking legal recourse. As such, despite being a survivor, a woman can still remain a victim of a larger disempowering system. The term 'victim' is not used to deny the subjectivity or agency of a woman who has been exposed to rape but to acknowledge the wrong that was done to her and the trials she still faces even once she has achieved psychological recovery.

(2000) cognitive model has emerged as having the greatest explanatory power (Brewin & Holmes, 2003; Edwards, 2009). The model integrates and expands on what has been learnt in previous decades about PTSD and offers a treatment approach with the best evidence base. Despite the presence of an effective psychological treatment approach, the Ehlers and Clark (2000) model is severely under-utilised in South Africa for two reasons. The first is related to a lack of knowledge among relevant professionals about the model and its application. The second involves concerns about the transportability (Schoenwald & Hoagwood, 2001) of a model designed in a western clinical setting to a culturally diverse environment such as that found in South Africa (Edwards, 2005c). The current research project aims to address this situation by: demonstrating the application of the model in the South African context; identifying client-related and contextual factors that affect the use of the model and; advising on the implications of these aspects for clinical practice and social policy.

To achieve these goals a systematic case study approach is used based on the mixed methods approach to research. The mixed methods paradigm (Dattilio, Edwards, & Fishman, in press; Teddlie & Tashakorrie, 2009) "embraces the complementarities not only between [qualitative and quantitative] research methods but also between [their] epistemological systems" (Dattilio et al., in press). They offer a means of formally investigating the manner in which clients respond to the same treatment and the most useful way a therapist can respond to client differences. Well written case studies also provide a unique, accessible and meaningful way of communicating knowledge to practitioners in the field and therefore directly informing clinical practice (Goodheart, 2005). In the past, case studies were largely discredited because the methodology underlying this approach was not rigorously developed (Messer, 2007). However, in the past two decades this situation has changed dramatically and criteria (Guba & Lincoln, 1994) have been developed to ensure that case studies have sufficient rigor to offer trustworthy and reliable knowledge (Edwards, Dattilio, & Bromley, 2004; Teddlie & Tashakorrie, 2009). This study lends further legitimacy to the utility of case study based research in developing contextually grounded knowledge. Seven women affected by rape-related PTSD participated in this study and their psychotherapy process was carefully documented and formed the basis for the creation of seven systematic case studies. These case studies informed the research findings and recommendations of this project.

SYNOPSIS

CHAPTER 1

The first chapter is divided into five sections and these are described below.

The extent of rape in South Africa

In the first section, the existing evidence on the extent to which sexual violence is perpetrated in South Africa is presented. Rape statistics released annually by the South African Police Services (SAPS) are argued to merely offer a glimpse of the magnitude of the problem of rape due to high rates of under-reporting. The aspects underlying a victim's reluctance to disclose her trauma to the police are extensively described and rape statistics for the preceding five years are presented.

Causative factors underlying rape in South Africa

Three features of South African society contributing to the prevalence of rape are discussed. The first being the legacy of apartheid and the violent struggle against this oppressive system which is argued to have contributed to the legitimisation and normalisation of violent behaviour and a society characterised by what Mack (1979, as cited in Volkan, 2001) terms egoism of victimisation. This concept describes the inability of specific groups who have suffered repeated traumas in their own national experiences to show empathy for the suffering of other people. The trans-generational transmission of trauma (Volkan, 2001) and the justificatory narratives (Moffett, 2006) for violent behaviour that have contributed to the persistence of rape following democratisation are then described. The second causative aspect involves transforming ideologies surrounding gender and sexuality. The empowerment of women and the related disruption of traditional gender roles as well as changing ideas surrounding masculinity are argued to contribute to sexual violence. Thirdly, the shortcomings in the criminal justice system both at the level of policing and the judicial system are extensively described and the role of these agencies in perpetuating violent practices is examined.

The phenomenology of rape

The phenomenology of rape refers to the subjective experience of sexual trauma and in this chapter it is argued that there are commonalities in the experiences of victims of rape. The major

phenomenological themes that characterise the responses of rape victims are comprehensively described within the framework of Rape Trauma Syndrome (RTS) and with specific reference to the South African context. Thereafter, the diagnostic construct of PTSD is introduced and the symptoms that characterise this disorder are extensively discussed as a central and pervasive component of the phenomenology of rape. The construct of complex PTSD is also introduced and discussed as a reaction characteristic of victims of repeated sexual trauma.

Theoretical models of PTSD

The fourth section looks at the cognitive mechanisms underlying PTSD. In this respect, the major cognitive-behaviour conceptual models of PTSD are presented as these approaches have the best explanatory power. First, the early approaches to understanding PTSD are described and these include: two factor avoidance theory (Mowrer, 1956, 1960); stress response systems (Horowitz, 1976, 1986) and; theory of shattered assumptions (Janoff-Bulman, 1992). These early theoretical perspectives offered important insights into the role of conditioning and cognitive appraisals in generating and maintaining PTSD. However, they were restricted by the limited research available on memory systems. Secondly, the more recent approaches, based on autobiographical memory research, are presented and extensively described including: emotional processing therapy (Foa & Kozak, 1986; Foa & Riggs, 1993; Foa & Rothbaum, 1998); cognitive processing theory (Resick & Schnicke, 1996) and; dual representational theory (Brewin, Dalgleish, & Joseph, 1996). The Ehlers and Clark (2000) model is then introduced and the integration and expansion of the latter theories within this framework is comprehensively described. Efficacy research on both the theoretical and treatment components of the model are also presented and compared with other treatment approaches.

Treatment Approaches used by South African practitioners to target PTSD following rape

The final section investigates the treatment approaches used in South Africa to address the psychological sequelae associated with rape. Recent research findings are presented which demonstrate that practitioners typically use general approaches or the Wits trauma model when working with rape trauma and the shortcomings inherent in using these approaches are discussed. It is subsequently argued that despite the availability of a specialist approach with demonstrated efficacy, the Ehlers and Clark (2000) model is severely under-utilised in South Africa. The two reasons for the limited use of this approach are then discussed. This includes

concerns about the transportability of a model designed in a Western clinical context to a cultural diverse setting and lack of exposure and training surrounding the model. Systematic case study research is then presented as an effective method of addressing these barriers to treatment delivery. The utility of the approach in developing evidence-based practice is then discussed.

CHAPTER 2

Methodology

The research and clinical methodology underlying this research project is presented in Chapter two. The rationale for the use of systematic case studies is discussed and this method is compared with that of multivariate methods such as randomised controlled trials to underscore the relevance of this approach for psychotherapy research in this country. Seven participants were selected for the study. They varied in terms of demographic characteristics, race, culture and ethnicity. Four participants were black women between the ages of sixteen and twenty-three from disadvantaged community backgrounds. Three participants were white women ranging in age from twenty-one to forty-three from upper-middle class environments. These latter three participants were exposed to drug-facilitated sexual assaults (DFSA). The black participants varied in terms of the nature of their sexual trauma. These included isolated assaults and gang rapes as well as multiple victimisations from childhood onwards. The diversity in the sample meant that it was typical of the population and also facilitative of cross-case comparisons. Data collection, analysis and interpretation and the methods used to establish rigor throughout this process are also detailed in this chapter. In addition, the complexities inherent in assuming the dual role of researcher and clinician are discussed. Finally, the role of reflexivity in the project is examined.

RESULTS: THE CASE SERIES

The case series is organised in terms of the nature of the sexual trauma the client experienced and is discussed across chapters' three to five. Each of the seven case studies contains: biographical information about the client and how they came to be part of the research; a synopsis of the assessment, case formulation and treatment plan; a therapy narrative; self-report scales (where available as certain clients could not complete scales due to language barriers) and; an interpretation of the salient aspects of the case in respect of the research questions.

CHAPTER 3

PTSD in response to isolated sexual traumas

Chapter three presents the two case studies involving discrete, isolated sexual traumas and includes the case of Zinhle and Lulama.

CHAPTER 4

PTSD in response to repeated and multiple sexual traumas

This chapter includes the case studies of Khuselwa and Sanele who both suffered repeated and multiple sexual traumas from childhood onwards.

CHAPTER 5

PTSD in response to drug facilitated sexual assaults

Chapter five presents the three cases involving drug-facilitated sexual assaults (DFSA) and includes the case studies of Anna, Emmy and Lori.

DATA INTERPRETATION

The interpretation of the findings of the case series are presented in chapters' six and seven.

CHAPTER 6

Psychological impact of DFSA: Implications for assessment and treatment

This chapter focuses on the interpretation of the DFSA case series. Limited research is available on the treatment of this category of sexual trauma and for this reason this case series is afforded a separate analysis. The section draws out the specific psychological implications of this type of trauma for clinical practice and the findings of the case series are compared with the latest international research on the treatment of DFSA using the Ehlers and Clark (2000) model.

CHAPTER 7

Treating rape-related PTSD in the South African context: Obstacles to treatment delivery and implementation

Three aspects are described as impacting the application of the treatment model and these include: client-related personal features; client-related contextual factors and; state-level factors. The implications of these aspects for the use of the treatment model within the South African

context are then comprehensively discussed. The client-related factors include: the nature of PTSD symptomology (i.e. simple or complex PTSD); the presence of comorbid Axis II personality disorders; client motivation and; language barriers (which are discussed in the context of culture and ethnicity). The client-related contextual factors included dysfunctional home environments and problems with social support. The deficiencies in the responses of state level institutions including the primary health sector, the criminal justice system and the Department of Social Development and their implications for clinical practice are also comprehensively described. The primary health sector, through the provision of sensitive care, HIV testing and PEP, is argued to have a salient role in minimising additional trauma. The criminal justice system is seen as a critical institution in promoting victim safety by apprehending and removing perpetrators from communities. It is argued that in the absence of such felt security, victims are unable to engage with psychological treatment and recover from their trauma. The Department of Social Development is argued to have a critical role in ensuring the safety of rape victims by creating facilities such as women's shelters that can afford victims a temporary sanctuary.

CHAPTER 8

Conclusion and recommendations

In chapter eight, the research questions and results of the study are reviewed and briefly summarised and recommendations are provided for the comprehensive and cost-effective care of rape victims within the context of primary health care.

CHAPTER 1: THE CONTEXT OF THE RESEARCH

1.1. THE EXTENT OF RAPE IN SOUTH AFRICA

"A woman born in South Africa has a greater chance of being raped than learning how to read."
(Dempster, 2002)

Rape statistics released by the South African Police Services (SAPS) represent the mostly readily available information on the incidence of sexual violence in the country (Jewkes & Abrahams, 2002). However, these statistics are severely affected by high rates of under-reporting. Under-reporting is influenced by various inter-related factors (Fisher, Daigle, Cullen, & Turner, 2003; Jewkes & Abrahams, 2002) and these are further described below so as to provide a frame from which the available information on the extent of rape in the country can be viewed.

1.1.1. BARRIERS TO REPORTING

Researchers (Jewkes & Abrahams, 2002; Sable, Danis, Mauzy, & Gallagher, 2006; Wolitzky-Taylor et al., 2010) have identified specific barriers to reporting sexual assault to the police and in South Africa these include: lack of access to police stations; uncertainty as to what constitutes rape; self-blame; nature of the relationship with the perpetrator; negative expectations regarding the outcome of disclosure and; features of the criminal justice system. These obstacles to disclosure are further discussed below.

(i) Lack of access

South Africa has one of the lowest police to population ratios (SAPS employs two hundred and thirty four police officers per one hundred thousand citizens) and police stations are not evenly distributed throughout the country (Artz, Smythe, & Leggett, 2004; Goosen, Bowley, Degiannis, & Plani, 2003). As such, many women, especially those who live in rural areas, have to commute long distances to access services. The unavailability of transport or poverty may inhibit many of these women from reporting to the nearest police station (Artz, 1999). In addition, if they are able to report, a shortage of police vehicles and difficulties in accessing areas where the victim resides can prevent the police from taking any action (Artz et al., 2004). The knowledge that the

police may not be able to intervene to protect them can further serve to deter reporting (Jewkes & Abrahams, 2002).

(ii) Definitions of rape

Legal definitions of rape play a significant role in influencing the interpretation and labelling of specific sexual acts as constitutive of rape and therefore the decision to disclose or report the experience (Chasteen, 2001; Naylor, 2008; Jewkes & Abrahams, 2002). In South Africa, the legal definition of rape has undergone radical transformation. Originally, as observed by Naylor (2008), rape was defined in terms of common law as forced sexual intercourse perpetrated by a man against a woman and for rape to have occurred there must have been sexual penetration. This definition, however, was problematic due to its gender specificity and failure to recognise that sexual violence was not limited to physical invasion of the body (Naylor, 2008). As a result, new sexual offences legislation was drafted and approved by parliament in 2003. In 2007, as observed by Vetten, Kim, Ntlemo and Mokwena (2009), further additions were made with the enactment of the Criminal Law (Sexual Offences and Related Matters) Amendment Act (32) in 2007. In terms of this legislation, rape is defined as a physical invasion of a sexual nature, committed on a person by coercion, force or threat of force. The use of gender neutral terminology and the recognition that rape involves a variety of sexual acts that can be perpetrated through a variety of means represented a critical advancement in the protection of vulnerable populations (Kim, 2000; Naylor, 2008; Reitan, 2001; van der Bijl & Rumney, 2009.).

Despite the inclusive nature of South African sexual offences legislation, societal definitions of rape that markedly differ from those encountered in legislature still prevail (Jewkes & Abrahams, 2002). Social discourses on sexual violence are generally dominated by the idea that rape is a crime of violence, perpetrated by a stranger or a gang. For this reason, victims who are exposed to sexual assaults that fall outside this definition may not report their assault. This is particularly the case for victims who experience sexual coercion (Jewkes & Abrahams, 2002; Naylor, 2008; Wood & Jewkes, 1997). Sexual coercion typically involves the use of verbal or emotional pressure to compel a woman to engage in sexual intercourse against her will (Heise, 1995; Heise, Moore, & Toubia, 1995). Sexually coercive tactics include the use of verbal insistence (e.g. pleading), emotional threats (e.g. threatening to terminate the relationship or spread malicious information), deception (e.g. asserting that participation in sexual intercourse would provide

confirmation of affection) or economic pressure (e.g. withholding money in the event of non-compliance) (Heise et al., 1995; Kaufman & Stavrou, 2004). The consequence for a victim is a lack of choice to pursue other options without severe social, emotional or financial repercussions (Heise et al., 1995). Various researchers (Abrahams, Jewkes, Hoffman, & Laubscher, 2004; Wood, Lambert, & Jewkes, 2007) have found that sexual coercion is a prevalent practice in South African society, particularly among the youth. However, experiences of coerced sex are often not disclosed or reported to the police (Kim, Martin, & Denny, 2003) and this is partially due to incongruence between social and legal definitions of rape. These differences generate significant confusion and uncertainty in the mind of the victim and in most cases, social definitions exert the overriding influence and thereby inhibit victims from reporting (Naylor, 2008; Wood & Jewkes, 1997).

(iii) Self-Blame

Crime victims generally do not feel responsible for having been victimisation. However, when it comes to rape, victims have been found to experience significant self-blame and this serves as a significant obstacle to disclosure (Fisher et al., 2003; Jewkes & Abrahams, 2002; Wolitzky-Taylor et al., 2010). Self-blame arises when the victim believes that she contributed to the rape through her own actions and this appraisal can produce significant feelings of guilt and shame (Janoff-Bulman, 1992). Victims who consumed alcohol prior to the assault are particularly prone to attributing the rape to their own negligence (Clay-Warner & Burt, 2005). In circumstances where the perpetrator was a trusted individual, the victim may assume that the rape occurred due to her gullibility and this can also inhibit reporting (Fisher et al., 2003).

(iv) Victim-Offender relationship

The nature of the relationship between the victim and perpetrator is another feature influencing the decision to report rape (Fisher et al., 2003; Jewkes & Abrahams, 2002). Victims are less likely to report instances of rape perpetrated by boyfriends, husbands or fathers owing to their uncertainty as to whether these acts actually constitute rape (Wood, Mofarah, & Jewkes, 1998) and also due to fears of reprisal (van Niekerk, 2004). In circumstances where the perpetrator is the primary breadwinner, the possibility of losing needed financial support may further deter disclosure (Jewkes, Levin, Mbananga, & Bradshaw, 2002). The victim's significant others may also dissuade her from reporting because of the economic implications for the family (Petersen,

Bhana, & McKay, 2005). Furthermore, perpetrators who are family members may also threaten victims with the possibility of the family breaking up if they disclose the assault and fears of contributing to the potential dissolution of their family can act as a barrier to reporting rape (Jewkes, Watts, Abrahams, Penn-Kekana, & Garcia-Moreno, 2001; Kim, 2000; Kim et al., 2003).

(v) Outcome of disclosure

Negative expectations regarding the outcome of disclosure can also inhibit a victim from reporting their rape. Two salient assumptions in this regard include the fear of not being believed and the expectation that others may blame the victim for the rape (Fisher et al., 2003; Jewkes & Abrahams, 2002; Wolitzky-Taylor et al., 2010). The fear of not being believed is heightened in circumstances where the perpetrator was a significant other or where the victim did not incur severe physical injuries. Victim-blaming attitudes are particularly prevalent in South African society even among service providers (Artz & Smythe, 2007; Kim & Motsei, 2002) and these attitudes are often influenced by the need to maintain a belief in a just world (Lerner, 1980) and by dominant rape myths and stereotypes surrounding rape victims (*see section 1.3.1.(ii)*). Expectations that they will receive insensitive treatment from various sources can severely deter a victim from reporting their trauma (Killian, Suliman, Fakier, & Seedat, 2007).

(vi) Criminal Justice System

In South Africa, the criminal justice system comprises the police and the courts and these institutions have been found to perpetrate secondary victimisation (Smythe, Artz, Combrinck, Doolan, & Martin, 2008; Vetten et al., 2009). For example, police officials in the country have been found to doubt the credibility of rape victims and to dissuade victims from reporting their rapes. Artz and Smythe (2007) in a study of the Johannesburg region found that only six percent of rapes reported to the police were qualified as being a rape case and attended to. The reasons for cases not being investigated included a failure to find the victim, a failure to find the perpetrator and a belief that there was no *prima facie* case. Artz and Smythe (2007) also found that victims who were ambivalent, intoxicated or confused were less likely to receive appropriate police attention or have their cases investigated. Police corruption in dealing with rape cases is also widespread with many perpetrators paying police officials to misplace or lose case dockets (Artz et al., 2004; Stanton, 1993 cited in Jewkes & Abrahams, 2002). Victims also fear that

reporting a rape to the police may result in the perpetrator retaliating (Payne & Edwards, 2009; van Niekerk, 2004) and this expectation further reflects a lack of faith in the SAPS.

Negative expectations of the judicial system also deter victims from reporting their rape. In the South African judicial system lengthy delays before trials, inadequate bail conditions that fail to protect victims from intimidation and adversarial court environments are the norm when it comes to rape cases (Woods et al., 1998; Barday & Combrinck, 2002; Combrinck & Skepu, 2003). These factors contribute to a lack of public confidence that rape will be taken seriously and that the victim will receive justice.

CONCLUSION

The barriers in reporting to the police have been described and these aspects severely affect the degree to which conclusions can be drawn about existing statistics on the incidence of sexual violence in the country. In the following section, police statistics on reported rapes for the preceding five years are presented.

1.1.2. SOUTH AFRICAN POLICE STATISTICS ON RAPE

SAPS releases crime statistics detailing the levels of reported crime in the country on an annual basis (i.e. from April to March the subsequent year in accordance with the financial year) and these statistics are compiled through the use of case dockets (Breetzke, 2007). Generally, once a crime is reported, information about the type of crime committed, the location of the crime, a few details regarding the offender and victim, the *modus operandi* of the perpetrator and the time the crime occurred is recorded in a case docket (Breetzke, 2007). The docket is then registered on SAPS Crime Administration System (CAS) and analysed by the Crime Information Analysis Centre (CIAC) (Breetzke, 2007). As such, these statistics are essentially dependent on a victim reporting a crime and the crime being appropriately documented by police officials (Vetten et al., 2009).

A summary of rape statistics for the period 2005 to 2010 is provided below.

Table 1: SAPS Rape Statistics 2005-2010

2005/2006	2006/2007	2007/2008	2008/2009	2009/2010
68, 078	65, 201	63, 818	70, 514	68, 332

From these statistics it is evident that more than sixty thousand rapes are perpetrated in the country each year. The marginal differences in the number of rapes documented by SAPS are not indicative of there being changes in the commission of this crime. Instead, these variations are generally influenced by reporting rates (Jewkes, Sikweyiya, Morrell, & Dunkle, 2009; Vetten et al., 2009). There are few recent studies by independent researchers investigating the incidence of rape in the country that can be used for comparative purposes. However, certain early surveys provide evidence of the degree to which SAPS statistics are affected by under-reporting and these are discussed below.

(i) Evidence of the effects of under-reporting on SAPS statistics

In 1998, two large scale national victimisation surveys namely, the South African Demographic and Health Survey (SADHS) (Department of Health, 1999) and the National Victims of Crime Survey (NVCS) (Burton et al., 2003) investigated the experience of rape among South African women. The SADHS was an initiative of the Medical Research Council and the Department of Health and one of its aims was to investigate the prevalence of rape. The survey therefore did not include questions about the time period in which a given rape occurred (i.e. incidence rates). In the study, women (the sample comprised 11 753 women) were asked about their experience of sexual victimisation and whether they had reported their rape to the police. Four percent of women in the study reported having been raped. Thirty six percent of these women also indicated that they had never disclosed their rape to the SAPS. The SADHS survey was repeated in 2003 but it did not include questions about rape as this was deemed inappropriate for a household survey.

The National Victims of Crime Survey (NVCS), as observed by Hirschowitz, Worku and Orkin (2000), was commissioned by the Department of Safety and Security and conducted by Statistics South Africa (Stats SA). The survey used a national probability sample of four-thousand people

(approximately 2000 women) above sixteen years of age and focused on crimes committed between March 1993 and March 1998. As such, the study provided information about the incidence of rape. Women in the NVCS were also asked about disclosure to the police. Approximately two percent (i.e. 2.1%) of women in the study had been raped and forty-four percent of these victims indicated that they had not reported their rape to SAPS. Also, some of these women (8, 9 %) indicated that they had been raped on more than one occasion. The most common reasons cited for not reporting included fear of reprisals, concerns that the police would not be able to help or would not take them seriously, fear of being blamed and feelings of shame.

SAPS rape statistics are directly comparable with the NVCS as they both focus on incidence rates that is, the number of incidents per 100 000 of the population within a given time period. For the period 1997/1998 police statistics showed an incidence rate of 70 per 100 000 of the population for women aged eighteen years and above. The total volume of rapes encountered in the NVCS for 1997/1998 was 134 per 100 000 women aged 16 and above. Furthermore, if the number of women indicating that they had been raped on more than one occasion during this time period is taken into account the rates become 143 per 100 000 of the population. This is essentially double the rates encountered in SAPS statistics. Furthermore, the NVCS itself was also afflicted by significant rates of under-reporting. This is evident when the rates of rape captured in the NVCS are compared with a small scale survey, namely the Three Provinces Survey. The Three Provinces Survey (Jewkes, Penn-Kekana, Levin, Ratsaka, & Schreiber, 1999) was undertaken by the Medical Research Council in 1998 and represents the first community based prevalence survey undertaken in South Africa. Approximately 1039 questionnaires were completed by participants as part of the study. The Three Provinces Survey managed to ascertain that approximately 1% of the women interviewed in the study had been raped in 1997. This proportion was over twice as high as that found country wide in the NVCS (0.4%).

The findings of independent researchers essentially reveal that more rapes are occurring in the country than are captured by police statistics. Although these surveys are dated, the barriers in reporting sexual violence to the police are still present (Artz & Smythe, 2008; Vetten et al., 2009).

CONCLUSION

In this chapter, through statistical and other sources of information, rape has been shown to be a highly pervasive and persistent practice in the country. This crime therefore represents a significant public health concern. The high rates of rape and the persistence of this crime in South Africa have fuelled much theorising about the causal factors underlying the perpetration of rape. In the subsequent chapter, some of the most prominent arguments and perspectives are presented and discussed.

1.2. CAUSAL FACTORS UNDERLYING RAPE IN SOUTH AFRICA

There is no single causal factor underlying the perpetration of rape in South Africa but various theorists (Britton, 2006; du Toit, 2001; Jewkes & Abrahams, 2002; Louw, 2004; Moffett, 2006; Volkan, 2006) have argued that three features of South African society contribute to the pervasive nature of sexual violence. The first is the legacy of apartheid and the violent struggle against this oppressive system which is argued to have contributed to the normalisation of violent practices. A second aspect involves the presence of gender-based ideologies and specific constructions of masculinity that glorify the use of violence in interpersonal relationships. The third involves the shortcomings of the criminal justice system. Each of these aspects is further discussed below. However, it needs to be emphasised that the intention here is not to provide a justification for rape but to offer frameworks for understanding the facets of South African society that contribute to the perpetration and persistence of this crime.

1.2.1. APARTHEID, THE LIBERATION STRUGGLE AND THE NORMALISATION OF VIOLENT PRACTICES

"The past is never dead. It's not even past" (Faulkner, 1951)

South African society is described as having a "culture of violence" (du Toit, 2001, p. 81). The term culture of violence refers to the existence of a social climate in which violence, including sexual violence, is viewed as an acceptable and legitimate means of acquiring resources, achieving goals, asserting authority and retaining control (du Toit, 2001). The creation of such a culture is attributed to the country's turbulent history specifically, apartheid and the struggle against this oppressive system (Boonzaier, 2005; Britton, 2006; du Toit, 2001). In this section,

these historical influences are described and their role in contributing to the normalisation and persistence of violent practices is elaborated.

(i) Apartheid, the struggle for democracy and the creation of a traumatised society

The apartheid system of governance in South Africa grew from a history of colonial rule and segregation and was largely aimed at securing rights and privileges for white people at the expense of other race groups (Adonis, 2008; Beinart & Dubow, 1995). Under the apartheid government, 'non-whites' (i.e. blacks, coloureds, Indians and Asians) were deprived of their basic human rights through the systematic implementation of a series of restrictive legislation with black South Africans being the most affected (Britton, 2006). The Population registration act of 1950, for example, required all South Africans to be classified into specific racial categories (i.e. white, black, coloured and Indian). The Group Areas Act was subsequently used to force three million black people (68% of the population) into ten artificially created homelands that comprised fifteen percent of the country's land (Worden, 2000). The creation of pass laws further restricted their freedom of movement outside these areas (Beinart & Dubow, 1995). Overcrowding, lack of housing and unemployment meant that those forced to live in such areas were faced with tremendous hardship and poverty (Worden, 2000).

Black South Africans were also exploited economically through the migrant labour system (Spiegel, 1995). Young black men were recruited from homelands and township settlements to work in industrial, mining and agricultural sectors for meagre incomes. The families of these labourers were not accommodated at these workplaces and black workers were only able to see their families for one month a year (Britton, 2006). The poverty and deprivation associated with living in the group areas led many black women to seek work as domestic workers or farm labourers and many women also established drinking houses or shebeens to earn an income (Wood, 2005). One of the salient effects of these latter influx control policies was the fragmentation of traditional families and ways of life in which men had traditionally assumed the role of revered and powerful patriarch, source of community wisdom and sole family provider. Men raised in traditional patriarchal families often returned home to find their positions severely challenged (Appolis, 1996; Sharp, 1994; Wood, 2005). This sense of threat was compounded by the marginalisation and discrimination they experienced as a result of the larger political environment. In an attempt to reclaim positions of authority and privilege some men resorted to

violence (Morrell, 2001; Britton, 2006). As a consequence, the family became a site of tension, fear and conflict for many black South Africans (Clark & Worger, 2004).

The enforcement of apartheid laws was officially the mandate of the security police and so rather than protecting the citizenry of the country, the police focused on ensuring the preservation of an apartheid state (Adonis, 2008; Britton, 2006). As a result, police surveillance and harassment were highly prevalent practices in black communities. The defence forces often detained and tortured those suspected of contravening apartheid laws and as a result many black people endured solitary confinement, beatings, electric shock and interrogation at gunpoint (Barber, 1999; McGovern & Manby, 1993). In addition, the South African Defence Force (SADF) also raped many black women (Britton, 2006). The absence of civil policing in black communities led to the proliferation of criminal activities in these areas including rape, murder and robbery. There was also in-fighting between specific groups involved in the liberation struggle including, the African National Congress (ANC) and the Inkhatha Freedom Party (IFP) and these conflicts were often fuelled by the security police. As a result, people living in homeland areas and townships lived in a constant state of fear and anxiety. In white communities, civil policing was present but rape, in particular, was silenced due to the need to preserve the impression of white civility. In addition, there were laws aimed at preventing miscegenation and any white person found to be involved in intimate relationships with people belonging to other race groups were severely punished (Barber, 1999; Britton, 2006; Dissel, 1997; McGovern & Manby, 1993).

From the outset, there was significant resistance to the apartheid system (Adonis, 2008) and initially these resistance campaigns were non-violent. However, in the wake of the Sharpeville massacre in which hundreds of students protesting against pass laws were shot or wounded by the security police, the ANC declared an armed struggle and subsequently established a military wing named Umkhonto we Sizwe meaning Spear of the Nation (Adonis, 2008; Ellis & Secheba, 1992). The military wing of the liberation movement was comprised mostly of youth who carried out violent attacks including bombings of government installations and police stations. These youth also instigated boycotts, civil disobedience campaigns and guerrilla attacks (Robins, 2005). One of the effects of youth involvement in the political struggle was significant inter-generational conflict (Mokwena, 1991; van Kessel, 2001). The older generation at the time perceived the youth as being insolent and destructive and their involvement in the liberation movement was

seen as undermining the supremacy of traditional leaders. This fuelled anger and led to vigilante attacks against the youth which the state often colluded in for the purposes of destabilising resistance movements. The youth, resentful of the older generation for their presumed complicity with the apartheid system, retaliated by punishing any individuals deemed to be collaborating with the apartheid government including black police men, community leaders, parents and teachers. These conflicts further fragmented the traditional social order in which the older generation was accorded a certain degree of reverence, deferred to in decision making and generally respected and obeyed. Consequently, one of the basic internal mechanisms of social control, namely the authority of parents or adults over children, began to erode (Mokwena, 1991; van Kessel, 2001).

The activities of the liberation forces severely threatened the apartheid regime which subsequently embarked on the forced recruitment and training of young white men as soldiers. These white youth were raised in environments that not only condoned racial prejudice but also demanded unquestioning adherence to the apartheid state. They were encouraged to use violence and wage a war against their fellow citizens. Those who refused were proclaimed traitors and faced imprisonment and brutal torture (Conway, 2005). By 1964 the state succeeded in suppressing the liberation movement and their leaders were either arrested or forced into exile. As a result, the struggle for liberation was left to the black youth of the country who then constituted fifty five percent of South Africa's population. These youth became the foot soldiers of the liberation struggle and continued to orchestrate insurrections against the apartheid state. In response, the state launched a campaign of intensified repression by expanding the powers of the security police who were granted unlimited authority to arrest and detain anyone without trial, declare curfews, control public spaces and silence the media. Approximately eighty thousand people (48 000 of which were youth) were arrested and detained by the police and brutally tortured. Many youth were killed by the police while in detention and this left many communities severely traumatised (Barber, 1999; Louw, 2004; van Kessel, 2001).

The combination of state sanctioned brutality and the violent resistance of the liberation struggle created a highly fragmented and traumatised society. The frequency with which killings, rape and torture were perpetrated for more than three decades desensitised many South Africans to violence (Gobodo-Madikizela, 2008). It also contributed to a sense of indifference towards the

pain and agony caused through the ill treatment of others. Mack (1979, cited in Volkan, 2006) uses the term egoism of victimisation to describe the inability of specific groups who have suffered repeated traumas in their own national experiences to show empathy for the suffering of other people. One salient effect of South Africa's history was the creation of such egoism of victimisation where many people became largely indifferent to the suffering inflicted through interpersonal violence including rape. The persistence of such an attitude almost two decades after the removal of the apartheid system is partly ascribed to the trans-generational transmission of this chosen trauma (Volkan, 1991).

(ii) Trans-generational transmission of trauma

Volkan (1991, 2001) has argued that when a trauma is deliberately inflicted on a particular group of people by a repressive political system, the victimised group suffers: a shared sense of loss, shame and humiliation and; a shared inability to be assertive because such action could threaten their lives or livelihood. Such helpless anger or helpless rage subsequently interferes with mourning over losses once the oppressive system has been removed and this includes losses to personal dignity as well as the loss of loved ones. According to Volkan (2001), these shared unresolved psychological tasks are then transmitted from one generation to the next. Such transmission occurs through a variety of mechanisms including attachment relationships, parental communication styles, child rearing practices and family interactions and in this way contributes to the creation of a chosen trauma. The term chosen trauma (Volkan, 1991) refers to the shared memory of a traumatic event that causes a large group to feel helpless, victimised and humiliated by another group. Volkan (1991, 2001) argues that while the group does not choose to feel victimised or humiliated, they do choose to mythologize losses and in doing so create powerful cultural narratives that form part of their social identity and are therefore pervasive in society.

In South Africa, there are specific cultural narratives that have emerged from the legacy of apartheid (i.e. the chosen trauma) and contribute to the persistence of sexual violence (Moffett, 2006; Wood, 2005). On such narrative involves the assumption that women need to be raped to ensure that they know their place. This particular narrative is not only found in South Africa but also universally and is tied in with patriarchal expectations and assumptions of appropriate gender role behaviour (*see section 1.2.2.(i)*). However, Moffett (2006) argues that in South Africa

this particular narrative was also fuelled by the legacy of apartheid. She points out that there are parallels between the manner in which these discourses are currently used to justify the rape of women and the way in which they were used to justify violence against black people. For example, in the apartheid era violence against black people was justified as a means of "showing the 'darkies' their place" and ensuring that they were sufficiently humbled (Moffett, 2006, p. 11). Similar sentiments are currently echoed in the discourses of young men who perpetrate rape. Petersen et al. (2005), for example, conducted interviews with adolescent boys and girls in a semi-rural area in Kwa-Zulu Natal and revealed that the narratives of the boys contained themes involving the belief that women need to be "put in their place" (p. 1238) if they showed signs of being assertive or independent. One preferred method of putting women "in their place" was through rape.

Volkan (1996, 2001) and (Scott, 2000) also argue that cultural narratives can be used to evoke the chosen trauma for the purpose of deflecting from current crises. In South Africa, as observed by Moffett (2006), this was clearly evident in former president Thabo Mbeki's public verbal attack on Charlene Smith (a rape victim and activist) "on the grounds that her attempts to educate people about rape were racist" (p. 5) and cast black men as animalistic and unable to control their sexual impulses. Such rekindling of memories of the chosen trauma (i.e. apartheid and the racism inherent in this system) has been argued (Volkan, 2001) to be a means of deflecting from the current crisis in order to consolidate the victimised group emotionally and ideologically. However, in doing so, these narratives fail to address the current crisis and therefore contribute to the persistence of the problem (Volkan, 2001).

Apart from creating problematic cultural narratives, another salient effect of the chosen trauma is that it can lead to the creation of an entitlement ideology (Volkan, 2001). Such an ideology involves the belief that a previously victimised group has a right to own what they wish. This assumption is essentially aimed at reversing helplessness and shame and regaining past losses. Ideologies of entitlement further contribute to the maintenance of a culture of violence by legitimising the use of force in acquiring status and material goods. These entitlement ideologies have been shown to be highly pervasive in South African society, particularly among the youth. For example, several studies (Jewkes et al., 2006; Petersen et al., 2005; Wood et al., 1998) involving different communities in South Africa have found that a great many young men assume

that they have a right to women's bodies and are justified in forcing unwilling women into having sex. These entitlement ideologies are reflected in the discourses of these men and include assumptions such as "...we need to be given what we want...when we ask" (Petersen et al., 2005, p. 1238) and contribute to the prevalence and persistence of sexual violence in the country.

1.2.2. GENDER-BASED IDEOLOGIES AND VIOLENT MASCULINITIES

"These women, they force us to rape them" (Moffet, 2006)

Gender refers to the socio-culturally constructed roles, responsibilities and obligations associated with being a woman or a man and gender identities are actively constructed through experiences and interactions in one's social and cultural environment (Dunphy, 2000). There is no single shared understanding of either masculinity or femininity but there are dominant ideas, in all patriarchal societies, about what it means to be masculine or feminine and therefore a man or a woman. For example, the traits associated with masculinity or with being a man include aggression, virility, dominance, strength and power. In contrast, to be feminine or to be a woman is associated with possessing traits characterised by weakness, chastity and submissiveness (Butler, 2004; Dunphy, 2000; Green, 1999).

Feminist theorists (Brownmiller, 1975; MacKinnon, 1987; Gavey, 2005) have argued that these ideologically defined gender stereotypes serve as the basis for the hierarchical structuring of relationships between men and women and a patriarchal social organisation in which men derive the most benefits. The informal benefits that men receive are referred to as patriarchal dividends and include: receiving domestic service and care from women; being afforded better opportunities for educational and occupational advancement; higher wages and; control over political, social and economic arenas. However, not all men receive the same share of the patriarchal dividend and this is due to the hierarchical system of patriarchy itself. Patriarchy not only involves the hierarchical ranking of men in relation to women but also involves massive hierarchical rankings among men themselves (Schacht & Ewing, 2004). These rankings are often on the basis of age, race, ethnicity, economic position and educational level. For example, in apartheid South Africa, white Afrikaner men were the greatest beneficiaries of the patriarchal system simply owing to their race and culture. Similarly, older men in traditional African societies were afforded greater status and regarded as repositories of wisdom and knowledge while

younger men were often viewed as immature and irresponsible. As such, specific political, historical and cultural contexts can also shape the degree to which men benefit from patriarchy (Moffett, 2001).

Despite these differences, one constant in patriarchy is that being a man is always constructed as better than being a woman and men are united in their shared dominance of women. As such, irrespective of a man's hierarchical ranking among men in general, he can still derive certain patriarchal dividends (e.g. control over women, receipt of domestic care from women, etc). This patriarchal structure of social organisation has been argued to contribute to the perpetration of sexual violence. Rape is seen as a means through which men perpetuate these dominant ideologies and thereby preserve patriarchy and the dividends associated with this system (Boonzaier & de lay Rey, 2003, 2004; Boonzaier, 2005; Leclerc-Madladla, 2000; Chasteen, 2001).

(i) Gender-based ideologies in South Africa

In South Africa, specific constructions of masculinity have been argued to contribute to the prevalence of gender-based violence such as rape and these constructions originally arose within the context of apartheid (Morrell, 1998). In apartheid South Africa, in both black and white communities, masculine traits characterised by aggressiveness, strength and toughness were glorified and used to "galvanise men in the protection of privilege on the one hand, and in the pursuit of freedom on the other" (Elliot, 2003, p.5). Similarly, feminine traits that were idealised were predominantly domestically focused (e.g. caring for the family, safeguarding chastity, etc). However, with the advent of democracy, gender equality became a critical focus of attention and women were offered opportunities for employment and advancement in all sectors of society. Women therefore no longer had to rely exclusively on men for the provision of basic resources and were able to assume a more independent and assertive stance and be more sexually expressive than before. In addition, previous notions of masculinity, specifically those that were highly militaristic, were also frowned upon and men were encouraged to embrace the equal rights embedded in the new constitution (Moffett, 2006; Elliot, 2003).

Morrell (1998) has argued that in circumstances where gender identities are transformed, those who previously held privileged positions respond in one of three ways namely through, accommodation, responsiveness or defensiveness. Accommodating attitudes involve the re-

evaluation of gender identities while still holding on to traditional masculine identities. Responsive attitudes are supportive of changes in gender relationships (Morrell, 2001; Seidler, 2006). In contrast, defensive attitudes are highly resistant to any changes in traditional gender relations and often lead to the use of violence to preserve patriarchal relationships (Morrell, 2001). Men who respond defensively are argued to constitute the group who received little of the patriarchal dividend following the transition to democracy. Rape is argued to be used by these men as a means of retaliating against women and punishing them for their role in contributing to this situation (Moffett, 2006).

Evidence for the use of rape as a mechanism for retaliating against and punishing women for stepping out of their traditionally defined gender roles is clearly evident in South Africa. It can be seen in the practice of jackrolling (Vetten, 2000) and streamlining (Wood, 2005) and also in the rape of lesbian identified women. The word "jackroll" was originally used to describe the forceful abduction and violent rape of young women by a prominent gang in Soweto called the Jackrollers in the late 1980's (Mokwena, 1991). Jackrolling subsequently became a common initiation ritual used by South African gangs with the practice being characterised by the excessive use of force, sadistic violence and the debasement of the victim (Vogelman & Lewis, 1993). The women that are targeted by the gang are those perceived to be haughty, unattainable or uppity because of their social or economic position. The gang rape usually occurs in a setting that is as public as possible and the perpetrators do not make any attempt to hide their identity. It is constructed as a means through which gang members can confirm that they possess specific masculine traits (e.g. strength, aggression, toughness, etc) and gain status and also punish women for stepping outside of traditional gender role behaviours (Mokwena, 1991; Vogelman & Lewis, 1993; Wood, 2005).

Streamlining is essentially a form of jackrolling perpetrated by "loose groupings of friends" (Wood, 2005, p. 307) that are not necessarily affiliated with a gang like, for example, the Jackrollers. It is therefore commensurate with the concept of gang rape as it is used in the colloquial sense. According to Wood (2005), streamlining generally involves one of four scenarios. The first scenario is characterised by an opportunistic attack against a woman (e.g. a women who is walking alone in an isolated area). The second scenario involves the rape of a woman who had consumed too much alcohol and therefore was not in a position to resist. The

third scenario involves the rape of a woman as punishment for her refusing the advances of a particular member of the group. The rape is usually perpetrated by the man who had propositioned the woman and his friends. The fourth scenario involves a man organising the rape of his girlfriend by his friends as a means of ending the relationship or punishing her for any behaviour on her part that undermined his masculinity. Streamlining is also not constructed as rape by the perpetrators. Instead, it is seen as an appropriate and necessary means of punishing women for their behaviour and ensuring their conformity and compliance (Wood, 2005).

In South Africa, the practice of 'corrective rape' of lesbian identified women has also become increasingly prevalent (Arndt & Hewat, 2009; Mufweba, 2003; Reid & Dirsuweit, 2002). 'Corrective rape' is based on the prejudiced idea that it is possible to change (i.e. "correct") a lesbian woman's sexuality through rape (Nel & Judge, 2008). The practice of 'corrective rape' is intricately linked to patriarchal gender ideologies surrounding appropriate female behaviour. Lesbian women are seen as disrupting traditional gender roles and behaviours and 'corrective rape' is used as a means of justifying sexual violence against these particular groups and ensuring their conformity with prescribed gender roles and behaviours (Nel & Judge, 2008; Mufweba, 2003).

In addition to the above mentioned practices, the operation of gender ideologies are also illustrated in the sexual molestation of women wearing mini-skirts by taxi-drivers in the Gauteng province ("Outrage over attack on miniskirt-wearing woman", 2008) and the assault of women wearing trousers in the Kwa-Zulu Natal province ("T section: No pants zone for ladies", 2007). In these cases, women are also punished for stepping out of traditional gender moulds and responsibility for such assault is placed squarely with the women concerned.

The fear of rape and the attendant humiliation and shame associated with being a rape victim is essentially used by certain men to immobilise women, restrict their participation in various social spheres and ensure that they defer to men for protection. In this manner, the traditional gender order is defended and maintained (Chasteen, 2001; Jewkes & Abrahams, 2002; Wood, 2005).

1.2.3. DEFICIENCIES IN THE CRIMINAL JUSTICE SYSTEM

"When the president does it, that means that it is not illegal" (Richard Nixon)

Deficiencies in the criminal justice system have also been argued to be a critical contributing factor in the endemic rates of sexual violence in the country (Artz & Smythe, 2008; Vetten et al., 2009) and these shortcomings are further described below

(i) South African Police Services (SAPS)

Various researchers (Artz & Smythe, 2008; Jewkes & Abrahams, 2002; Jewkes et al., 2009; Vetten et al., 2008) have identified shortcomings in the responses of the SAPS to rape victims that compromise the effectiveness of the police as an agent of social control. These deficiencies include a lack of sensitivity in dealing with rape victims as well as a lack of commitment in investigating and managing rape cases and protecting victims.

a) Lack of sensitivity in the treatment of rape victims

The rape victim's first point of contact with the criminal justice system is through the police services and legislative provisions have stipulated that the police must respond with sensitivity when dealing with vulnerable populations (Vetten et al., 2008). However, in practice this is not often the case. Male police officers in particular have been found to endorse rape myths (Stephanus, 2006) and as a result respond to rape victims with scepticism, insensitivity and indifference. Police officials have also been found to turn rape victims away and to actively dissuade them from laying a charge. As a result of police insensitivity and indifference, perpetrators are not arrested or removed from communities and this lends a tacit legitimacy to rape (Artz & Smythe, 2008; Jewkes & Abrahams, 2002; van Niekerk, 2004).

b) Shortcomings in investigating and managing rape cases and protecting victims

Police officials in the country have been found to have extremely high case loads and this compromises their ability to respond adequately to the needs of victims. Ideally, twenty dockets is the maximum number a detective should be investigating at any one time (Artz et al., 2004) but in practice this is often not the case. For example, in a study by Artz et al. (2004) the most rape cases being investigated by any one investigator was one hundred and seventy eight. In these circumstances, detectives have been found to respond mostly to women who regularly visit

the station and demand their cases be attended to and so only a certain number of victims receive any police attention (Artz et al., 2004; van Niekerk, 2004). This means that the majority of perpetrators are not apprehended or charged for their crime. The failure to make perpetrators accountable for their behaviour contributes to the persistence of the problem of rape (Vetten et al., 2009).

Police corruption in the management of rape cases is another salient problem in South Africa (Jewkes & Abrahams, 2002). Corrupt police practices include accepting bribes from perpetrators to ensure that a docket disappears and also demanding monetary compensation from victims for a case to be investigated. Jewkes and Abrahams (2002), for example, cite a study in which it was reported that, one in twenty case dockets involving rape cases in Southern Johannesburg were lost in a fraudulent manner. These corrupt practices convey the message that rape is a crime that is not taken seriously by the SAPS and therefore can be perpetrated with impunity (Artz & Smythe, 2008; Vetten et al., 2009).

(ii) The Judicial system

In South Africa specialist Sexual Offences Courts (SOC) have been established to meet the needs of rape victims and reduce the perpetration of rape. These specialist courts are increasing in number but they are still not available in many parts of the country. As a result, the significant majority of rape cases are seen in normal courts such as a lower court and shortcomings in the responses of these institutions also contribute to the endemic rates of rape in the country (Vetten et al., 2010; Walker & Louw, 2003). Three of these shortcomings include biased attitudes; leniency in the granting of bail and low conviction rates (Woods et al., 1998; Barday & Combrinck, 2002; Combrinck & Skepu, 2003).

a) Bias

In South Africa, as a result of educational, social and other privileges, the majority of judges are male and their sexist and stereotypical beliefs have been shown to influence their decisions in rape trials with the result that perpetrators are not held accountable for rape. For example, in a rape trial (State v Berhard Abrahams) held in 2001 (Treatment Action Campaign, 2007) involving the rape of a fourteen year old adolescent by her father, the sentence imposed was seven years imprisonment. The minimum sentence in rape cases is generally ten years. The justification for

the sentence related to the judge's views that this particular sexual offence was not "one of the worst cases of rape" (Treatment Action Campaign, 2007) and that the complainant had not suffered any long lasting effects from the assault. The judge's views impart the assumption that only certain categories of rape are worthy of legal attention (e.g. rape involving extreme violence perpetrator by a stranger) and that rape committed by familiars or intimates do not result in any significant psychological harm. In another highly publicised rape trial (State v Sikipha) in 2005 (Treatment Action Campaign, 2007) a judge justified a minimum sentence for an accused rapist by stating that men ought to be forgiven for committing rape particularly if the woman concerned dressed or acted in a seductive manner. This perspective supports rape myths that hold women accountable for rape in the event that their behaviour does not correspond to traditional gender role behaviour (e.g. modesty, chastity, etc). In addition, it constructs male sexuality as an uncontrollable drive thereby absolving perpetrators of responsibility. The ideologies advocated by such senior representatives of the law and the judgements arising from their sexist beliefs have the effect of lending institutional legitimacy to rape and victim-blaming attitudes (Reitan, 2001).

b) Bail

The purpose of bail is "to strike a balance between the liberty of the accused and the interests of society" (Combrinck & Skepu, 2003, p.9). Initially, in terms of legislation the onus was on the accused to show that they were entitled to be released on bail. However, due to significant deficits in this system, amendments to the law were implemented and currently the onus is on the prosecution to ensure that offenders who pose a risk to society do not receive bail (Artz & Smythe, 2007). Legislative changes have also provided for investigating officers to be afforded the opportunity to investigate the case and provide evidence to prosecutors that could influence the bail application. Investigating officers can also testify in court so as to influence the bail status of the perpetrator (Barday & Combrinck, 2002; van Niekerk, 2004). However, in practice, there is limited collaboration between investigating officers and prosecutors and police officials are often unaware of these legal provisions or the necessity of their testifying in court (Barday & Combrinck, 2002). As a result, bail is regularly granted to perpetrators and this was evident in a study by Vetten et al. (2008). These researchers investigated the progression of rape cases in the criminal justice system in the Gauteng province and found that one in three perpetrators was

released on bail and that these individuals subsequently returned to their communities. They therefore had the opportunity to re-offend and also harass the victim.

c) Low conviction rates

To decrease the perpetration of a given crime, the penalties associated with committing such an offence need to be of a certain severity and consistently applied (Artz & Smythe, 2008). In South Africa, less than seven percent of perpetrators of sexual offences are convicted (Jewkes & Abrahams, 2002). Vetten et al. (2008), for example, found that rape trials commenced in one in five cases and that conviction only occurred in four percent of cases. Such low conviction rates represent another factor contributing to the persistence of sexual violence in South Africa.

CONCLUSION

In analysing sexual violence against women in South Africa, one of the primary challenges is addressing the multiple levels of influence that lead to the perpetration and persistence of this crime. In this section, three inter-related features of South African society that contribute to the persistence of rape have been described. These aspects provide frameworks for understanding the endemic rates of rape in the country but they do not offer a justification for rape. In the following section, the psychological and health-related implications of being subjected to rape are discussed.

1.3. THE PHENOMENOLOGY OF RAPE

According to Lebowitz and Wigren (2005), the phenomenology of rape refers to the subjective experience of sexual violence. These authors emphasize that despite differences in the victim's experience of rape, there are certain broad categories or themes that are salient across victims' stories and that capture the core features of the phenomenology of rape. Over the years, various researchers have attempted to encapsulate these features in conceptual models. Sutherland and Scherl (1970) were among the first to investigate the responses of rape victims. They subsequently developed a three phase conceptual model to capture the experiences of women who had experienced sexual trauma and the process involved in recovery. Burgess and Holmstrom (1974) subsequently synthesized this latter model into two stages namely, the acute

phase and the long term re-organisation phase and termed their conceptual framework Rape Trauma Syndrome (RTS).

The RTS model was instrumental in the recognition of rape as a trauma capable of inflicting severe psychological distress and disrupting a victim's life. For this reason, the model is described below and the phenomenological aspects of rape outlined in this framework are comprehensively discussed with specific reference to the South African context. Thereafter, the diagnostic construct of post-traumatic stress disorder is introduced as it forms a central feature of the phenomenology of rape.

1.3.1. RAPE TRAUMA SYNDROME (RTS)

According to Burgess and Holmstrom (1974), the acute phase, occurs immediately after the attack and can continue for days, weeks or months. Reactions in the acute phase include feelings of helplessness and powerlessness, anger, disgust, shame, guilt and self-blame as well as emotional outbursts, irritability and pronounced anxiety. These reactions are termed expressive reactions and differ from the controlled reactions that can manifest in certain victims. Controlled reactions are characterised by flattened affect where the victim appears calm, unemotional, contained and not in need of assistance.

The second phase is termed the long term re-organisation phase and occurs in the weeks or months following the trauma. In this phase, feelings of degradation, helplessness, powerlessness, guilt, anger, self-blame and shame either manifest (i.e. for those who initially experienced controlled reactions) or are heightened. Social functioning is also impaired due to fears of encountering strangers or situations that elicit memories of the trauma. Difficulties resuming pre-rape sexual relations may also manifest and are characterised by fears of sex and diminished arousal or interest in sexual activity. During the latter stages of the Re-organisation phase the victim involves herself in daily activities and avoids focusing on the rape. As such, high levels of denial of the rape and suppression of thoughts and feelings related to the incident are evident. However, such attempts at suppression often result in the manifestation of intrusive thoughts and memories of the trauma. In addition, the emotional reactions characterising the initial stage of the re-organisation phase are often unresolved. The resolution of this phase can take months

to years and involves the victim integrating the traumatic event into existing meaning structures in such a way that the destructive impact of the trauma decreases.

The phenomenological features of sexual trauma as outlined by Burgess and Holmstrom (1974) in the RTS model are discussed below in relation to the South African context.

(i) Helplessness and powerlessness

One of the reactions to rape, identified by Burgess and Holmstrom (1974) is feelings of helplessness and powerlessness. In contrast to other types of traumatic events such as motor vehicle accidents or physical assaults, intrinsic to the act of rape is the physical incapacitation of the victim. For this reason, rape in particular is more likely to lead to significant feelings of helplessness and powerlessness (Lebowitz & Wigren, 2005; Roth & Lebowitz, 1988; Wyatt, 1990; Welch & Mason, 2007). Specific forms of sexual trauma are also associated with a heightened sense of helplessness and powerlessness and these include childhood sexual abuse and drug facilitated sexual assault.

Browne and Finkelhor (1986) theorised that a "basic kind of powerlessness occurs in sexual abuse when a child's territory and body space [are violated] against the child's will" (p. 532) and repeated abuses of this nature can lead to a pervasive sense of helplessness (Gold, Sinclair, & Balge, 1999). This can result in the child growing up to believe that they have no personal control over their lives and can do little to change their circumstances. These attitudes can lead to revictimisation in adulthood (Berliner & Elliot, 2002; Gold et al., 1999; Filipas & Ullman, 2006; Messman-Moore, Long, & Siegfried, 2000). Ehlers and Clark (2000) use the term mental defeat to capture this sense of absolute helplessness experienced by certain victims of trauma, including victims of sexual assault (Dunmore, Clark, & Ehlers 2001). Mental defeat refers to the victim's perception that they have lost all autonomy and this experience is often reflected in the statements of victims who describe themselves as being destroyed or damaged by the trauma or ceasing to care whether they lived or died. The experience of mental defeat has been found to be more likely to lead to negative outcomes including the formation of symptoms of PTSD and depression and the experience of a diminished sense of self (Ebert & Dyck, 2004; Ehlers & Clark, 2000).

Drug facilitated sexual assaults (DFSA) represent another form of sexual trauma that can enhance feelings of helplessness and powerlessness. DFSA involves the covert administration of an illicit drug for the purposes of procuring sexual contact (Hall & Moore, 2008). Victims of DFSA are rendered either partially or completely unconscious during the rape. In addition, the drugs used to perpetrate DFSA can lead to the victim experiencing a sense of physical paralysis in the event that they regain consciousness during the trauma. The nature of this type of assault essentially heightens the victim's sense of being unable to protect and defend their bodies (Gauntlett-Gilbert, Keegan, & Petrak, 2004; Hall & Moore, 2008; Hurley, Parker, & Wells, 2006).

For rape victims, feelings of helplessness and powerlessness are not only related to the trauma itself but can also arise as a result of negative social responses and adverse experiences within the criminal justice system. According to Punamaki et al. (2005, cited in Charuvastra and Cloitre, 2008) rape is more likely to lead to negative social reactions when compared to other traumatic events because sexual traumas are generally "unseen and unshared, ambiguous in their acceptability, and associated with stigma and shame" (p. 7). As such, a victims significant others can respond with disbelief or hostility or encourage the victim to keep the trauma a secret. In South Africa, rape has also acquired a certain normalcy due to the culture of violence which can lead to significant others responding to the victim with indifference (Jewkes & Abrahams, 2002; Moffett, 2006; Woods, 2005). These factors can further enhance feelings of powerlessness and helplessness. In addition, in South Africa, rape victims also have to contend with negative responses from the criminal justice system which can further enhance their sense of helplessness and powerlessness (*see section 1.2.3.*).

(ii) Self-Blame and feelings of guilt and shame

In terms of the RTS model, self-blame is another common reaction experienced by rape victims. Janoff-Bulman (1979) in one of the first studies investigation rape victims attributions of responsibility distinguished between characterological self-blame and behavioural self-blame. Characterological self-blame is associated with feelings of shame and involves the victim attributing the rape to her character or certain personality traits. Behavioural self-blame is associated with feelings of guilt and involves the victim blaming herself for having engaged in a particular behaviour or failing to have engaged in a particular activity. According to Janoff-Bulman (1979) and other researchers (Frazier, 2003), self-blame serves the function of defending

against feelings of personal vulnerability and offers a means of reasserting a sense of personal control. By blaming herself, the rape victim essentially believes that by changing a certain aspect of herself or her behaviour, she can avoid being hurt again in the future. Both behavioural and characterological self-blame are associated with negative outcomes including greater psychological distress and post-traumatic symptomology (Arata, 2000; Frazier, 2003; Ullman et al., 2007).

In certain circumstances, self-blame arises as a result of negative social responses. For example, significant others might accuse the victim of having provoked the assault by drinking alcohol excessively or by staying out late into the night or for wearing certain types of clothing. Such negative reactions are influenced by the need to maintain a belief in a just world (Lerner, 1980). Just world beliefs involve, for example, believing that bad things do not happen to good people and that people deserve what they get. By believing that the rape victim did something concrete to deserve the assault, the observer creates a false sense of safety and security. Rape myths are symbolic of this need to maintain a belief in a just world and in personal control by blaming the victim (Lerner, 1980).

Rape myths also reflect the operation of gender based ideologies which can contribute to significant others blaming the victim for the rape because they stepped outside of certain prescribed roles (Petersen et al., 2005). In South Africa, the operation of these ideologies is evident in, for example, the attack of lesbian identified women *(see section 1.2.2. (i))*

(iii) Betrayal and loss of trust

The majority of rapes are perpetrated by known assailants including friends, family members and acquaintances and for this reason the victim can experience a profound sense of betrayal and loss of trust (Jewkes et al., 2001). In addition, the sense of incomprehension as to why a trusted other would want to harm them can lead to the victim believing that they had done something wrong for the assault to have occurred. This is particularly the case for children who are sexually abused by a trusted caregiver. To cope with the magnitude of the betrayal, the child may come to view themselves as bad or inadequate rather than seeing the needed other as dangerous, ruthless and self-serving (Gobin & Freyd, 2009). Zurbriggen and Freyd (2004) and other researchers (Davis & Petretic-Jackson, 2000) have also argued that traumas such as childhood

sexual abuse perpetrated by a trusted caregiver tends to damage cognitive mechanisms that would normally help an individual to make appropriate relationship and sexual decisions and judgements regarding the trustworthiness of other people. This has been argued to lead to revictimisation (Cloitre & Rosenberg, 2006). A sense of betrayal and loss of trust can also arise when significant others fail to respond in ways that are supportive and protective of the victim. Negative social responses can be particularly harmful and exacerbate existing feelings of self-blame, shame and isolation (Lebowitz & Wigren, 2005).

(iv) Loss of meaning

For many victims, the experience of trauma shatters positive assumptions or schemas about the self, world and other people. Roth and Newman (1991) identified four major schemas that are affected by exposure to trauma. The first three are those originally identified by Janoff-Bulman (1979) and include the belief that: the self is invulnerable; the world is just and meaningful and; that other people are benevolent. The fourth assumption added by Roth and Newman (1991) is the belief that other people are trustworthy and worth relating to. The belief in invulnerability is argued to serve a protective function that helps us operate in the world. The shattering of this assumption can lead to feelings of helplessness, insecurity and anxiety. For rape victims the new perception of vulnerability can lead to a preoccupation with the possibility of the trauma recurring and result in increased concerns about personal safety and security. This in turn can lead to the victim taking more precautions to guard against the possibility of being harmed.

Victims can also come to view themselves as vulnerable, tainted, bad or unworthy due the rape (Fairbrother & Rachman, 2004). In addition, the meaning of the perpetrator's actions (i.e. that the victim is an object and that her needs are immaterial and that she exists solely for his gratification) can become a critical aspect of how the victim organises her view of self, especially if the perpetrator is a family member. Furthermore, sexual trauma can lead to the victim expecting that other people are dangerous, untrustworthy and exploiting and these assumptions can negatively impact the ability to form relationships (Herman, 1992a).

Rape challenges notions about order and meaning in the world and can lead to the belief that the world is unjust, unpredictability and uncontrollable. According to Roth and Newman (1991) and other authors (Herman, 1992a, b) the invalidation of the individual's positive schemata compels

the search for a compensatory system of meaning that can accommodate the traumatic event. This belief system can be either adaptive or maladaptive. For example, an adaptive resolution to shattered assumptions about the world can involve the recognition of danger and vulnerability but within limits. Similarly, rather than seeing all people as untrustworthy a more adaptive solution would be to realise that some, but not all, people are untrustworthy and exploitative. Pre-existing schemas about the world, self and other people are not always positive. Instead, individuals exposed to adverse developmental experiences can develop maladaptive beliefs including that the self is unworthy and inadequate, that others are malevolent and untrustworthy and that the world is a dangerous place. The subsequent experience of rape then reinforces these negative assumptions and compounds feelings of distress (Foa & Rothbaum, 1998).

(v) Feelings of anger

Rape victims often do not experience feelings of anger towards the perpetrator in the immediate aftermath of the trauma. Instead, they can experience anger towards themselves for not acting in ways that could have prevented the rape from occurring. Only once the victim realises that a change in behaviour would not have prevented the trauma and that the perpetrator was solely responsible for the assault are they able to experience feelings of anger towards the rapist (Lebowitz & Wigren, 2005). This emotion can then either be channelled in adaptive ways by, for example, taking action against the perpetrator or it can be internalised or displaced. Internalising feelings of anger can lead to the victim feeling despondent which can enhance self-blame and lead to self-destructive behaviour such as self-mutilation or risk taking behaviours. Victims may direct their anger towards those closest to them and this represents displaced anger which can lead to the victim being misunderstood and alienated. Victims may also experience feelings of anger in relation to society for not punishing the crime of rape more severely. In addition, anger can be directed at significant others for not adequately caring for and supporting the victim (Dalbert, 2002; Kuppens, Van Mechelen, Smits, De Boeck, & Ceulemans, 2007; Resick & Schnicke, 1996; Riggs, Dancu, Gershuny, Greenberg, & Foa, 1992).

(vi) Disgust and contamination

Rape victims often experience feelings of disgust and a sense of having been contaminated by the assault (Wormesley & Maw, 2009). In terms of the literature (Fairbrother & Rachman, 2004; Olatunji & Sawchuk, 2005; Olatunji, Elwood, Williams, & Lohr, 2008), disgust and contamination

are regarded as separate but inter-related concepts. Disgust is seen as a basic emotion accompanied by characteristic facial expressions, physiological reactions (e.g. nausea) and a corresponding behaviour (i.e. avoidance of the offensive stimuli) while contamination is viewed as the "evaluative/interpretive process that occurs upon the experience of disgust or anticipated exposure to potential disgust elicitors" (Olatunji, Lohr, Sawchuk, & Tolin, 2007, p.264). The concept of mental pollution (Rachman, 1994) has been used in the literature to refer to the individual's sense of having been contaminated and their associated feelings of disgust. Mental pollution is defined as an internal or psychological sense of uncleanliness or contamination which arises and persists regardless of the presence or absence of an observable contaminant (Rachman, 1994). Mental pollution is also associated with a moral component in that those affected often equate the sense of uncleanliness with being a bad person or being immoral (Rachman, 1994).

Studies investigating the presence of mental pollution following exposure to sexual assault (Fairbrother & Rachman, 2004; Gershuny, Baer, Randomsky, Wilson, & Jenike, 2003) have found that women frequently experience a sense of contamination. This experience is generally associated with the victim's belief that they have been tainted or sullied in some way by the assault. Preliminary findings also indicate that the experience of mental pollution following sexual assault predicts subsequent PTSD (Fairbrother, Newth, & Rachman, 2004). This is believed to be due to the impact of the experience of mental pollution on the individual's appraisal of the trauma. Individuals can interpret the experience of uncleanliness as indicating that they have been permanently tainted or changed in some way. Furthermore, certain victims may experience unwanted sexual arousal during rape which can lead to a sense of disgust and self-blame. These negative attributions can serve to heighten their distress thereby generating or exacerbating symptoms (Fairbrother et al., 2004).

(vii) Disconnection from others: Isolation and alienation

Rape victims often experience a sense of alienation or a feeling of being set apart from other people due to the trauma. This experience can arise due to negative social reactions. Significant others, for example, may encourage the victim to keep the rape a secret in order to preserve the family structure or their own perceptions of the world. These responses can lead to the victim feeling alienated from others. A sense of disconnection can also arise when the victim assumes

that other people do not understand or cannot relate to their victimisation and expects to be ostracised for having been raped. These assumptions can lead to the victim isolating themselves and spending more and more time alone (Herman, 1992a; Lebowitz & Wingren, 2005).

(viii) Impact on subsequent sexual health and functioning

Various researchers (Becker, Skinner, Abel, & Treacy, 1982; Cloitre, Scarvalone, & Difede, 1997) have documented the adverse effects of sexual assault on the sexual health and functioning of women. Rape victims frequently experience chronic gynaecological problems including vaginal and perineal tears and menstrual irregularity. In addition, rape can also lead to the victim contracting sexually transmitted diseases which can adversely affect their reproductive health and their general wellbeing. South Africa has one of highest HIV/AIDS infection rates in the world (Kim et al., 2003; Pettifor et al., 2004) and given the prevalence of rape in the country, the likelihood of a victim contracting the HI-virus following sexual assault is extremely high. This situation is even further compounded by the myth of the virgin cure involving the assumption that HIV/AIDS can be cured through sexual intercourse with a virgin. This myth has been argued to motivate men infected with HIV/AIDS to rape young girls and infants (Dunkle et al., 2004; Jewkes et al., 2009; Kim et al., 2003)

Rape also significantly impacts on the victims sexual functioning in intimate relationships. The most frequently experienced difficulties in sexual relationships following rape include reduced interest in engaging in sexual intimacy, difficulties with becoming subjectively and/or genitally aroused as well as orgasm disorder and sexual pain (Cloitre et al., 1997). Some of these difficulties (e.g. lack of sexual desire) are due to the negative associations between the rape and sexual intimacy. Being sexually intimate may also trigger memories or flashbacks of being raped and lead to the victim experiencing feelings of shame, disgust, anxiety or fear. This can lead to avoidance of sexual intimacy. A portion of sexual assault victims have been found to engage in high risk sexual behaviours including reduced contraceptive use, increased sexual activity with strangers and also prostitution. The motivations underlying such behaviours differ and include the victim's need to regain control over their life and body. However, these actions can exacerbate feelings of shame and self-blame and lead to a diminished sense of self (Campbell, Sefl, & Ahrens, 2004; Faravelli, Giugni, Salvatori, & Ricca, 2004).

CONCLUSION

The RTS model provides key insights about the sequelae of sexual trauma and the process involved in recovery. The phenomenological aspects of the experience of being sexually victimised, outlined in the model, have been comprehensively described in relation to the South African context. In South Africa, the sense of helplessness and powerlessness experienced by rape victims was shown to also be related to severe deficits in the criminal justice system with regard to the treatment of victims and the apprehension and prosecution of perpetrators. The culture of violence in the country was described as an influential factor in determining the responses of significant others to the victim and enhancing the sense of self-blame and feelings of guilt and shame. Gender-based ideologies were also discussed as a salient aspect enhancing feelings of self-blame as women are often deemed responsible for being raped due to their non-conformity to gender-based expectations. This is particularly evident in the practice of 'corrective rape'. The high prevalence of HIV/AIDS in the country was described as a significant health risk for victims of sexual assault and the myth of the virgin cure was shown to be one motivating factor underlying the rape of children and girls. In the subsequent section, the construct of PTSD is introduced and described as a central feature of the phenomenology of rape.

1.3.2. POST-TRAUMATIC STRESS DISORDER (PTSD)

The diagnostic construct of Post-Traumatic Stress Disorder was introduced in the third edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders in 1980 following activism on the part of Vietnam veterans and feminist organisations to have the diagnosis officially recognised (Jones & Wessely, 2007). It was therefore the first diagnostic category to incorporate the findings in the feminist literature on violence against women (Root, 1996; Edwards, 2005a) and, as with RTS, it offered a means of validating the psychological distress experienced by female victims of sexual trauma. Since its inception considerable research has been undertaken on PTSD and one of the findings to consistently emerge is that rape victims are the most vulnerable population group when it comes to developing symptoms of this disorder (Breslau et al., 1998; Creamer, Burgess, & McFarlane, 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Norris, 1992; Perkonigg, Kessler, Storz, & Wittchen, 2000; Perkonigg et al., 2005). Research studies in South Africa have also provided support for this finding and these are discussed below.

Kaminer et al. (2008), for example, examined the risk for PTSD associated with various forms of interpersonal violence in South Africa and concluded that rape had the strongest association with PTSD among women. In a comparative study, Seedat et al. (2004) investigated the effects of exposure to violence among youth. These authors found that sexual assault, when compared to all other traumas, was associated with the greatest risk of PTSD. Dinan, McCall and Gibson (2004) in research investigating community violence and PTSD in selected South African townships also provided additional support for these findings. These authors found high rates of PTSD among women exposed to specific forms of interpersonal violence, particularly rape. Peltzer (2000) investigated the psychological sequelae associated with exposure to violent crime in a community setting and also found rape to be associated with negative psychological outcomes, including PTSD. Peltzer (1998) also examined the presence of PTSD symptoms among South African university students and found that one of the traumas most highly correlated with PTSD among female students was rape. In addition to the above mentioned findings, case-based research studies (Davidow & Edwards, 2005; Labe, 2005; Payne & Edwards, 2009; Swartz, 2007; van der Linde, 2007) have also attested to the prevalence of PTSD among women exposed to rape. This makes PTSD an extremely salient aspect of the phenomenology of rape in South Africa and the symptom picture of the disorder is comprehensively described below. In the subsequent section, the cognitive mechanisms underlying this disorder are explained.

(i) PTSD: Symptom picture

The latest edition of the DSM, that is DSM-IV-TR (APA, 2000), defines PTSD as a syndrome initiated by a precipitating traumatic event and manifesting in a constellation of symptoms grouped into three broad categories: symptoms of intrusive re-experiencing, symptoms of cognitive and behavioural avoidance and symptoms of increased physiological arousal.

a) Intrusive re-experiencing

The first symptom cluster involves involuntary re-experiencing and is regarded as the hallmark characteristic of the disorder (Halligan, Clark, & Ehlers, 2002). Involuntary re-experiencing is triggered by a range of perceptual cues that resemble aspects of the traumatic event. These cues represent stimuli that were present shortly before or during the trauma and that have, through temporal association with the trauma, acquired the ability to trigger involuntary re-experiencing of the traumatic event (Ehlers & Steil, 1995; Ehlers, Hackmann, & Michael, 2004; Michael, Ehlers,

Halligan, & Clark, 2005). Symptoms of involuntary re-experiencing largely manifest as intrusive memories of the trauma and are experienced in the form of intrusive images, flashbacks, nightmares and unpleasant emotional or physiological reactions to reminders of the traumatic event (Ehlers et al., 2004). A number of defining features of intrusive memories have been revealed (Hackmann, Ehlers, Speckens, & Clark, 2004). Firstly, intrusive memories have been identified as constituting fragments of the traumatic event rather than a complete memory of the event. These fragments have been found to represent stimuli that either signalled the onset of the trauma or the moments with the largest emotional impact. Examples of such stimuli include visual images, sounds, smells, tastes or specific bodily sensations. Secondly, these memories appear to lack spatial and temporal context in that, during an episode of re-experiencing, the sensory impressions constitutive of the intrusive memory are experienced as occurring in the immediate present rather than as a past experience. This is confusing and contributes to substantial distress. Thirdly, the emotions accompanying such intrusive recollections correspond to the primary emotions experienced at the time of the trauma thereby exacerbating the distress experienced (APA, 2000; Hackmann et al., 2004; van der Kolk, Hopper, & Osterman, 2001).

b) Avoidance

In an attempt to avoid or escape states of high anxiety triggered by involuntary re-experiencing upon exposure to relevant trauma related stimuli, PTSD patients adopt a variety of cognitive and behavioural strategies (Ehlers & Clark, 2000). These strategies are constitutive of the second cluster of symptoms that characterise PTSD and are regarded as distinguishing features of the disorder. These symptoms include avoidance of situations, places or people that serve as reminders of the trauma, thought suppression, distraction and emotional numbing. Emotional numbing is conceived of as a form of emotional avoidance and includes loss of interest in activities, detachment from others and a restricted range of affect. Although they are termed strategies, these dysfunctional behaviours and cognitive processes are not necessarily intentional. Instead, they are often reflexive or habitual in nature (APA, 2000; Hughes, 2006).

c) Hyper-arousal

The third symptom cluster in PTSD involves symptoms of increased autonomic and physiological arousal manifested in sleep disturbances, hyper-vigilance, irritability and anger, increased startle

responses and difficulties concentrating. Autonomic and physiological arousal generally serves the function of alerting the organism to potential danger. However, in PTSD, these functions have become excessive and inappropriate owing to conditioned autonomic arousal to trauma related stimuli (Ehlers & Clark, 2000). Patients with PTSD develop an enduring vigilance for and sensitivity to perceptual cues that serve as reminders of the trauma. However, the trauma related stimuli no longer constitute a threat. Nevertheless, they continue to be perceived as a warning of impending danger and consequently activate the stress response system resulting in increased autonomic and physiological arousal (APA, 2000; Hughes, 2006).

1.3.3. COMPLEX PTSD

The construct of PTSD as defined by the DSM-IV-TR (APA, 2000) has been described by various theorists (Herman, 1992a, b; Taylor, Asmundson, & Carleton, 2006) as reflecting the reactions of victims of discrete, single episode traumatic events (e.g. a single incident of rape). For this reason, it has been termed simple PTSD (Herman, 1992a, b). In contrast, the concept of complex PTSD was introduced (Herman, 1992b) to capture and conceptualise the responses of victims of chronic and repeated relational trauma beginning at an early age (e.g. repeated exposure to childhood sexual abuse) (Ford & Courtois, 2009; Pelcovitz et al., 1997; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Women exposed to repeated sexual trauma, beginning in childhood, have been consistently found to display symptoms characteristic of complex PTSD (Cloitre, Cohen, & Koenen, 2006; Dorahy et al., 2009; Zlotnick et al., 1996). This makes the condition a central feature of the phenomenology of exposure to repeated sexual abuse. Multiple sexual traumas are a common feature of the clinical picture in South Africa as was evident in the National Victims of Crime Survey (*see section 1.1.2. (i)*). As such, it is highly probable that South African women exposed to multiple sexual traumas will develop symptoms of complex PTSD.

(i) Symptom picture

Complex PTSD not only includes the symptoms that comprise simple PTSD but is also characterised by the presence of the following features: alterations in the regulation of affect (e.g. alexythymia, suicidal ideation, difficulty modulating anger and dysfunctional self-soothing behaviour such as alcohol abuse, self-mutilation and binge-eating); alterations in attention and consciousness (e.g. amnesia and dissociative episodes); alterations in self-perception (e.g. sense

of being ineffective or permanently damaged or misunderstood by others, chronic feelings of guilt and shame, and a sense of being unworthy of positive attention); alterations in perceptions of the perpetrator (e.g. adopting the perpetrators opinions and feeling a sympathetic closeness or bond with the abuser); alterations in relationships to others (e.g. inability to trust and increased risk of revictimisation); alterations in systems of meaning (e.g. feelings of hopelessness and despair) and; somatisation such as chronic pain or sexual symptoms (Briere & Spinazzola, 2005; Ford & Courtois , 2009; Pelcovitz et al., 1997; van der Kolk et al., 2005). These features of complex PTSD, as emphasised by Taylor et al. (2006), are currently described with the associated features and disorders of PTSD in the DSM-IV-TR (APA, 2000) and provide additional insights into the victimisation experience that is critical for treating the problem.

(ii) Aetiology of Complex PTSD: Disorganised attachment

Disorganised attachment relationships (Main & Hesse, 1990) in infancy have been proposed to be the first stage in the developmental trajectories (provided these include exposure to subsequent repeated trauma in childhood or adolescence) of individuals who subsequently develop complex trauma reactions (Liotti, 1999; Ford, 2009; Ford & Courtois, 2009). As such, the characteristics of these early relationships require further consideration and are extensively described below.

Under normal developmental circumstances, in attachment relationships, the caregiver is able to remain available, attuned and responsive to the needs of the child. This generates a felt sense of safety and stability and contributes to the development of a secure attachment relationship. Such a relationship enables the child to recognise and identify their needs and feelings, regulate threatening affective states and engage in learning and exploratory behaviour (Bowlby, 1980). Attuned and responsive parenting also shapes the formation of internal working models (IWM) or mental representations of self and others in which the self is viewed as worthy, competent and valued and others are regarded as trustworthy and reliable. These internal working models or schemas are carried forward into subsequent interpersonal relationships and allow the child to form effective relationships with others and use the social environment for emotional coping (Bowlby, 1980; Kagan, 2004; Liotti, 1999).

According to attachment and developmental theorists (Liotti, 1999; Lyons-Ruth, Yellin, Melnick, & Atwood, 2005; Main & Hesse, 1990), when the caregiver is a source of distress, the child is placed

in a paradoxical situation because they are impelled to seek comfort and nurturance from their caregiver but this figure of safety and reassurance is also a source of threat. Repeated experiences of this nature result in the disorganisation of the attachment behaviour system (i.e. the child is not able to establish a behavioural response pattern towards their caregiver that will result in the cessation of their distress). This leads to the child using a chaotic mix of approach-avoidant behaviours towards the caregiver when distressed (Main & Hesse, 1990). The failure to develop an organised strategy for coping with emotional distress leads to affective dysregulation or "alternative experiences of emotional flooding and numbing" (Cloitre & Rosenberg, 2006, p. 325). This inhibits the learning of skills necessary to identify and reflect on emotions (i.e. self-awareness) and modulate affective states and contributes to alexythymia. Alexythymia refers to difficulties identifying and labelling emotional experiences (Cloitre et al., 1997). Affect dysregulation also leads to reliance on maladaptive methods of regulating emotions such as denial of emotional experiences, active avoidance of internal states, intentional self-injury, alcohol or drug abuse and dissociation (Kagan, 2004). Dissociation refers to a failure to integrate experiences and involves a variety of psychological mechanisms (e.g. amnesia, depersonalisation and derealization) that are designed to decrease conscious awareness of threatening and unmanageable information (Kennedy et al., 2004). Dissociative tendencies have been said (Liotti, 1992, 1999) to specifically arise from the incompatible meaning structures that the child draws from the disorganised attachment relationship and these are further discussed below.

Liotti (1999) has argued that under normal conditions, the infant is able to integrate explicit and implicit memories of their interactions with their primary caregivers into coherent meaning structures. However, in disorganised attachment relationships, the infant is unable to synthesis their experiences because they are extremely incongruent. According to Liotti (1999), despite the child's ambivalence about approaching the caregiver, she will eventually do so due to her attachment needs. Since contact with young children is soothing for most adults (Solomon & George, 1996) the caregiver will ultimately respond to the child with a degree of reassurance and care. As a result of this interaction, the child extracts certain problematic and conflicting meanings, namely that: they are somehow responsible for the disturbing behaviour of the caregiver; the caregiver is the source of their extreme distress; the caregiver is able to comfort and reassure them and; they are able to soothe the caregiver. These meanings coalesce into three reciprocally incompatible representations of the self and the attachment figure namely that

of the self and attachment figure as 'victim', 'persecutor' and 'rescuer' and this hampers the integration of a unitary sense of self. It needs to be noted that there is a great deal of complementary between Liotti's (1999) ideas and the concept of early maladaptive schemas as defined by Young, Klosko and Weishaar (2003) (*see section 2.2.2. (iii)*).

In the course of development, the child learns interpersonal strategies to regulate the behaviour of the caregiver. The strategy chosen corresponds to the original representation of self as the persecutor or rescuer of the caregiver and involves the child's use of either punitive or solicitous behaviour to control the caregiver. The choice of strategy (i.e. 'persecutor' or 'rescuer') necessitates the displacement of the other representations of the self and attachment figure in the organisation of conscious experience (Liotti, 1999). This ultimately allows the child to achieve a certain degree of mental and behavioural coherence. However, this coherence is ultimately shattered when the child is later exposed to interpersonally traumatic events because the experience of trauma strongly activates the attachment system and gives rise to the incompatible set of meaning structures. The traumatic event is subsequently interpreted in terms of the roles inherent in these meaning structures namely that the self: is deserving of the trauma (self as 'persecutor'); is the innocent, helpless and vulnerable target (self as 'victim') and; has to understand and protect the abuser (self as 'rescuer'). These reciprocally incompatible and dramatic meanings induce a failure in the integrative functions of conscious (i.e. they hamper mental synthesis) leading to dissociation (Bowlby, 1980; Liotti, 1999; Pasquini, Liotti, Mazzotti, Fassone, & Picard, 2002).

Cloitre and Rosenberg (2006) have argued that alexythymia and dissociative tendencies pose a risk for victimisation through certain pathways (*see section 4.1.7.*).

Apart from deficits in affect regulation, disorganised attachment in infancy confers vulnerability to negative working models of self and others. This can affect the child's capacity to form meaningful relationships and use the social environment for emotional coping. In the preschool years, disorganised children have been found to display a sense of confusion in response to the emotional displays of others and have difficulty identifying their own emotional responses or discriminating the emotional reactions of others. They also have problems interacting with peers and tend be socially withdrawn and isolated. In addition, when faced with even minor stressors

they display a sense of hopeless and are unable to respond effectively to situational demands. In childhood and adolescence, these disorganised children continue to experience problems with social adaptation in that they are likely to be withdrawn, aggressive, disruptive, uncooperative and unpopular with their peers. As a result, they have few reciprocated relationships (Cloitre et al., 1997; Hesse & Main, 2000; Hildyard & Wolfe, 2002; Lyons-Ruth & Spielman, 2004; Muller, Sicoli, & Lemieux, 2000).

CONCLUSION

PTSD symptoms are a central feature of the phenomenology of rape, be it a single episode of sexual trauma or repeated instances of sexual victimisation. The symptoms that characterise the disorder are severely debilitating in that they not only cause significant psychological distress but also lead to impairments in interpersonal relationships and occupational functioning. For this reason, the disorder represents a serious public health concern (Edwards, 2005b) and significant research efforts have been devoted to understanding the causal mechanisms underlying the disorder and developing effective treatments to address the condition. The theories with the greatest explanatory power are cognitive-behavioural models and these are comprehensively described below.

1.4. THEORETICAL MODELS OF POST-TRAUMATIC STRESS DISORDER

Currently, the conceptual model with the greatest explanatory power and also treatment efficacy for PTSD is the Ehlers and Clark (2000) cognitive model. In explaining PTSD, Ehlers and Clark (2000) have integrated and expanded on the ideas of earlier theorists and provided a more comprehensive theoretical perspective that fully accounts for each of the symptoms of the disorder and their persistence without treatment. The earlier theories drawn upon by the model include: two factor avoidance theory (Mowrer, 1956, 1960); stress response systems (Horowitz, 1976, 1986); theory of shattered assumptions (Janoff-Bulman, 1992); emotional processing theory (Foa & Kozak, 1986; Foa & Riggs, 1993; Foa & Rothbaum, 1998); cognitive processing theory (Resick & Schnicke, 1996) and; dual representational theory (Brewin et al., 1996). Each of these perspectives will be briefly considered below with the aim of demonstrating the manner in which these models have evolved and subsequently been integrated and expanded upon by Ehlers and Clark (2000).

1.4.1. EARLY APPROACHES

The early theories of PTSD described below include two factor avoidance theory (Mowrer, 1956, 1960); stress response systems (Horowitz, 1976, 1986) and; theory of shattered assumptions (Janoff-Bulman, 1992). The strengths and limitations of each of these approaches are also briefly described.

(i) Two Factor Avoidance Theory

Mowrer (1956, 1960) incorporated the principals of classical and operant condition to explain how avoidance maintains anxiety disorders such as PTSD. He proposed that a traumatic event represents an unconditional stimulus that elicits an unconditional response (e.g. fear, helplessness, horror, etc) and that the internal and external stimuli present at the time of the trauma (e.g. particular objects, sounds, smells or physiological reactions) become paired with the traumatic event. Consequently, whenever the individual encounters such stimuli in future, they are likely to experience an aversive emotional response and to reduce or eliminate this unpleasant reaction they are likely to engage in avoidance behaviours. Such avoidance provides temporary relief (i.e. negative reinforcement) and is therefore likely to be repeated (i.e. operant conditioning). However, this inhibits the extinction of the fear response by preventing the individual from learning that the traumatic event no longer poses a threat and thereby contributes to the persistence of anxiety disorders. Mowrer's (1956, 1960) two factor theory provides a very salient explanation of certain features of PTSD, specifically the range of cues that trigger intrusions and the critical role of avoidance in maintaining symptoms. However, as emphasised by Brewin and Holmes (2003), it is less well suited to explain certain aspects of the disorder such as the role of cognitive appraisals and the impact of emotions apart from fear. For this reason it needs to be supplemented by other theoretical perspectives such as those provided by Horowitz (1976, 1986) for it to adequately account for PTSD.

(ii) Stress Response Theory

Horowitz (1976, 1986), expanded on Mowrer's (1956, 1960) theory by proposing that in addition to conditioned stimulus-response associations, aspects of the meaning of the traumatic event were also involved in learning. In terms of Horowitz's (1976, 1986) stress response theory, individuals interpret events on the basis of their pre-existing schemas or beliefs which are built

up from past experiences. When a traumatic event occurs they are forced to reconcile this new unfamiliar and painful experience with existing structures. This can lead to significant internal disequilibrium and distress and the individual "may oscillate between letting the information in and feeling overwhelming emotions, and blocking the information and feeling numb" (Edwards, 2005c, p. 210). Horowitz termed this process the completion tendency and argued that until the traumatic event can be integrated into existing meaning structures, the psychological aspects of the event will remain in active memory storage and cause symptomatic reactions. Horowitz's (1976, 1986) theory therefore considered the impact of traumatic events on the individual's conceptual world and emphasised that recovery involved significant cognitive change. For this reason it remains highly influential. However, certain areas are not adequately addressed by the theory including, for example, individual differences in trauma response, delayed onset PTSD and how to distinguish remission due to adequate processing from remission due to successful avoidance (Brewin & Holmes, 2003; Wilson, Friedman, & Lindy, 2001).

(iii) Theory of shattered assumptions

Janoff-Bulman (1992) significantly expanded on Horowitz's (1976, 1986) model by proposing that the majority of people in the world operate on the basis of three illusory assumptions namely, that: the self is worthy; other people are trustworthy and well-meaning and; the world is a meaningful and benevolent place. When a traumatic event occurs, the individual is forced to reconcile the traumatic experience with these pre-existing cognitive schemas. This process of integration can either occur through the re-experiencing and avoidance cycle proposed by Horowitz (1976) or through deliberate reflection on the traumatic event.

In terms of Janoff-Bulman's (1992) theory, people with the most positive pre-existing assumptions are likely to be the most affected by traumatic events but are also able to recover quickly because of their existing internal capacities and resources. In contrast, people with negative schemas are likely to be further disadvantaged by trauma because for them victimisation merely confirms existing maladaptive assumptions and therefore enhances problematic behaviours.

The theory of shattered assumptions was influential in providing insights on the nature of the beliefs that are affected by trauma and the implications this has for long term adjustment. It also

emphasizes the role of the social environment in either facilitating or hindering recovery. However, the approach also has limitations in that it does not describe the impact of trauma in the short term or the manner in which information is represented in memory (Brewin & Holmes, 2003). Furthermore, apart from the three assumptions identified by Janoff-Bulman (1992), other beliefs have also been found to be equally influential. These include the belief that the world is predictable, the self is competent to act and that the world provides adequate satisfaction of one's needs (Bolton & Hill, 1996). They also include beliefs related to safety, trust, intimacy, power and/or control, and esteem (McCann & Pearlman, 1990).

SUMMARY

As emphasised by Brewin and Holmes (2003) and other researchers (Edwards, 2005c; Feldner, Monson, & Friedman, 2007), these early theories provided important insights into the mechanisms underlying and maintaining PTSD symptoms. Mowrer's (1956, 1960) conditioning theory drew attention to the role of trauma-related cues in triggering memories and the manner in which conditioned avoidance maintains symptoms. Horowitz's (1976, 1986) and Janoff-Bulman's (1992) theories emphasised the impact of trauma on cognitive meaning structures and explained PTSD as resulting from deficits in integrating traumatic material with pre-existing internal schemas. However, these early approaches were hindered by the limited research available on memory and the impact of traumatic events on memory structures (Brewin & Holmes, 2003). For this reason, they could not provide a comprehensive account of the disorder.

1.4.2. AUTOBIOGRAPHICAL MEMORY DEFICITS IMPLICATED IN PTSD

More recent theoretical accounts of PTSD (Foa & Kozak, 1986; Resick & Schnicke, 1996; Brewin et al., 1996) including the Ehlers and Clark (2000) model have focused on how traumatic information is represented in memory and emphasised that deficits in the processing of information in autobiographical memory structures underlie the disorder. As such, prior to a discussion of these recent models, the nature of autobiographical memory and the encoding and retrieval of memories within this structure is described.

Autobiographical memory forms part of declarative memory which contains factual information about the world. Declarative memory takes two forms namely, episodic and semantic memory.

Episodic memory consists of "knowledge of a previously experienced event along with an awareness that the event occurred in the past" (Klein, German, Cosmides, & Gabriel, 2004, p. 462) while semantic memory refers to "memory experienced as knowledge without regard to where and when that knowledge was obtained" (Klein et al, 2004, p. 462). Semantic memory is therefore not contextualised within the context of past experience. According to Conway and Rubin (1993), there are three "levels of structure that contribute to the creation of memories" (p. 104) in the autobiographical memory base and these include life time periods, general events and event specific knowledge and are explained below.

Life time periods represent thematic knowledge about: specific periods in one's life (e.g. primary school, high school, college); the actors, activities and locations related to these specific periods (e.g. one's knowledge of primary school can include information about class mates, teachers and the location of one's school); evaluations of the behaviour of self (e.g. being good at Maths) and others which can be more or less detailed (e.g. high school was a good/bad time for me) and; the feelings associated with a specific period (e.g. confused during adolescence). Life time periods are used to access representations of general events as well as more specific knowledge (Conway & Rubin, 1993; Conway & Pleydell-Pearce, 2000; Tulving, 1993).

General events, like life time periods, also represent thematic knowledge but these are related to specific experiences including repeated events (e.g. walks in the park), extended events (e.g. holiday in Greece) or more specific experiences (e.g. the job interview). General events can also be organised to create mini-histories (e.g. learning to drive) which can have a direct connection to an associated life time period (e.g. while in high school, I learnt to drive and got my licence). As such, general events can also serve as cues to access life time periods (Conway, 2001; Tulving, 1993).

Event specific knowledge retains highly specific perceptual and sensory details of an individual's recent experiences (i.e. experiences that have occurred over preceding minutes or hours) and therefore it essentially corresponds to episodic memory. A central feature of episodic memory is that it is involved in recollective experience which refers to the feeling of remembering. Recollective experience signals to the individual that a currently remembered experience is in fact a memory of an actual experience that occurred in the individual's past and not some other

type of mental representation such as a day dream or fantasy (Conway, 2001; Conway & Pleydell-Pearce, 2000).

(i) Encoding of autobiographical memories

Conway and Rubin (1993) and Conway and Pleydell-Pearce (2000) have proposed that the encoding and retrieval of information within the autobiographical memory base is determined by the working self which is seen as a complex hierarchy of personal goals. These latter researchers draw on Higgins (1987) theory to conceptualise the operation of the working self. According to Higgins (1987) the self comprises three domains namely: the actual self (i.e. a relatively accurate approximation of one's self); the ideal self (i.e. the self one aspires to be) and; the ought self (i.e. the self that one should be on the basis of the expectations of significant others including parents, siblings, partners and society in general). Inconsistencies between these three domains are said to produce negative emotional reactions and these self-discrepancies first originate in childhood. The memories of these childhood experiences are retained and highly accessible when cued by relevant stimuli.

In terms of Higgins (1987) theory self-discrepancies provide the psychological tension necessary to drive this system and one of the primary goals of the working self is to reduce discrepancies between these three domains. This idea also resembles Horowitz's (1976, 1986) completion tendency in that he regards the oscillation between re-experiencing and avoidance as aimed at reducing the incongruence between existing and new information. According to Conway and Pleydell-Pearce (2000), because of the operation of this rule-based system, memories of experiences that are either disjointed or highly integrated will be vividly remembered by the individual. When applied to traumatic material, these events are recalled vividly because they are either highly incompatible with an individual's existing working self goals or because they confirm the individual's existing assumptions. The ideas of Conway and Pleydell-Pearce's (2000) also correspond to that of earlier theorists (Barsalou, 1988) who have proposed that autobiographical memories are essentially records of success or failure in goal attainment.

(ii) Retrieval of autobiographical memories

According to Conway and Pleydell-Pearce (2000) and Conway (2001) autobiographical memories are accessed through two types of cue driven retrieval processes, namely direct retrieval and

generative retrieval. Direct retrieval is said to entail an automatic form of retrieval in response to cues. Information retrieved in this way "is experienced by the remembering person as spontaneously coming to mind" (Conway 2001, p. 495). Conway and Pleydell-Pearce (2000) also indicate that direct retrieval involves highly specific cues that are predominantly perceptual in nature. The cues most associated with direct retrieval are being in the same place as the original event or being in the same place and engaging in the same activity as when the original event occurred. In generative retrieval, the search for events is executed in a strategic form in that retrieval cues are compared to stored information. If a cue matches information in memory, the experience is recalled. However, if a cue does not correspond to stored information, then the search process continues. Generative retrieval, in contrast to direct retrieval, is associated with more verbal cues. These latter authors also emphasise that the recall of autobiographical memories can be highly disruptive because it requires the individual to turn conscious attention inwards. Conscious experience then becomes dominated by the internal representations that are retrieved. For this reason, the retrieval of autobiographical information is inhibited by the working self (unless a task or goal can be facilitated by remembering or remembering is intentional).

1.4.3. RECENT THEORIES OF PTSD

Recent theories of PTSD have implicated deficits in the encoding, organisation and retrieval of information in autobiographical memory as a central factor underlying PTSD. These theories are further discussed below.

(i) Emotional Processing Theory (EPT)

Foa and Kozak (1986), like Horowitz (1976, 1986) and Janoff-Bulman (1992) emphasised that for PTSD symptoms to resolve the traumatic experience needed to be incorporated or integrated within the context of the individual's pre-existing memory structures (i.e. autobiographical memory base). However, in contrast to these latter theorists, they attributed the difficulties in integrating this new information to the characteristics of the trauma memory itself and not so much to the conflict with pre-existing belief systems. Foa and Kozak (1986) proposed that a traumatic event generates a specific type of memory representation which they called a pathological fear structure. They subsequently drew on conditioning theory (e.g. Mowrer's two factor theory) and argued that these pathological structures contained unrealistic stimulus

associations or associations that do not accurately correspond to reality; incorrect stimulus-meaning associations and; erroneous associations between harmless stimuli and escape or avoidance responses. In PTSD specifically, Foa and Kozak (1986) argued, there was an excessive number of stimulus-response elements that were highly resistant to modification and so a wide variety of stimuli in the environment were capable of activating the fear structure. According to these researchers, for information contained in the fear network to be integrated within the context of existing meaning structures (i.e. autobiographical memory) these problematic associations or links needed to be broken. Foa and Rothbaum (1998) later developed prolonged exposure therapy (PET) to achieve this goal and correct the information contained in the pathological fear structure. Their treatment approach has received considerable empirical support (Brewin & Holmes, 2003; Foa & Hembree, 2003; Foa et al., 2005; Taylor, 2006) and is described in the subsequent section (*see section 1.5.1.*)

Foa and Kozak's (1986) EPT is comprehensive and provides significant insights about the nature of information processing during trauma and the type of cognitive mechanisms involved in maintaining symptoms. The theory is also associated with an extremely effective treatment (*see section1.5.1.*). However, concerns have been raised that EPT, particularly the concept of a single fear network, is not flexible enough to account for complex clinical phenomena such as memory gaps or fragmented recall. In terms of the model exposure to trauma-related stimuli should result in the retrieval of the entire memory for the traumatic event. However, individuals with PTSD often have difficulty remembering certain aspects of their trauma and this is not sufficiently explained by EPT. In addition, it has been argued (Teasdale & Barnard, 1993) that a single level of representation does not adequately distinguish between phenomena such as recalling a specific event in an emotionally-laden way from recalling it in a detached way. These aspects constitute the major shortcomings of the approach.

(ii) Cognitive Processing Theory (CPT)

CPT (Resick & Schnicke, 1996) was heavily influenced by EPT but also expanded on the model by arguing that fear was not the only emotion capable of activating the cognitive structure. Instead, the fear network could also be activated by other strong emotions including guilt, shame and disgust. Resick and Schnicke (1996) proposed the concepts of assimilation, accommodation and overaccomodation to explain the process through which conflicting information is integrated into

existing schemas in autobiographical memory. Assimilation refers to the alteration of information related to the experience of the trauma to ensure that it matches the schema. For example, when a woman with a defectiveness/shame schema is exposed to a physical assault she may view the trauma as evidence of her inadequacy rather than as an injustice perpetrated by another. In contrast, accommodation occurs when a schema is altered to accommodate new incompatible information. For example, an individual holding a strong stereotype may change their beliefs following exposure to information that disconfirms the stereotype. Overaccomodation refers to the process by which victims of trauma radically alter their world views in an attempt to prevent future trauma. For example, after being raped at night, a woman may start to believe that it is dangerous to go out at night and subsequently never leave her home after dark. Beliefs arising from the process of overaccomodation interfere with the emotional processing of the traumatic event due to their tendency to enhance avoidant behaviour. Resick and Schnicke (1996) developed a treatment manual for rape victims based on their model. The goal of therapy is essentially to facilitate accommodation of trauma related information while helping the client to achieve an adaptive perspective regarding self, others and the world. In this respect, these latter authors use the techniques involved in PET. They also incorporate a focus on the areas identified by McCann and Pearlman (1990) that are disrupted by exposure to trauma. These areas include safety, trust, control/power, intimacy and esteem. CPT has been evaluated in a number of studies (*see section 1.5.3.*) and has achieved promising results but the conceptual model suffers from the same deficits as emotional processing theory in that it does not offer a comprehensive account of the symptoms of PTSD or the mechanisms underlying the development and maintenance of the disorder.

(iii) Dual Representational Theory (DRT)

Brewin et al. (1996) expanded on Foa and Kozak's (1986) ideas by proposing that two memory structures, instead of a single structure, were involved in the processing of material in autobiographical memory and that PTSD results from insufficient processing in one of these systems. The first of these memory systems is termed verbally accessible memory (VAM) and its functioning is essentially similar to what Conway and Pleydell-Pearce (2001) describe as generative retrieval. The VAM system is said to contain verbal information related to the individual's conscious processing of the traumatic event. As such, it can contain information pertaining to the sensory aspects of the event, the emotional and physiological reactions

experienced at the time of the event and the perceived meaning of the event. The amount of information that can be contained in the VAM system is, however, severely limited because input is through "limited-capacity serial processes such as attention" (Taylor, 2006, p. 46). Since the VAM system is capable of interacting with the rest of the autobiographical memory knowledge base, traumatic material can be represented in the context of time and place as well as past, present and future information. This allows for the deliberate retrieval and also editing of information in memory.

The second system is called situationally accessible memory (SAM) and is activated involuntarily and the functioning of this system corresponds to Conway and Pleydell-Pearce's (2000) concept of direct retrieval. SAM is a perceptual memory system that contains information that has received too little conscious attention during the traumatic event (e.g. sights, sounds, smells) to be recorded in the VAM system. SAM does not interact with the autobiographical memory base and for this reason information contained in the system lacks temporal and spatial context. The emotions that accompany SAM memories are restricted to the primary emotions experienced at the time of the original trauma. Furthermore, the SAM system is perceptual and therefore does not contain a verbal code and so memories contained in the system are difficult to communicate. Information in this system is predominantly accessed automatically as a result of exposure to cues resembling features of the traumatic event. This information is typically experienced in the form of flashbacks and affective responses that correspond to the specific moments of intense arousal that occurred during the traumatic event. The automatic activation of SAM memories is primarily attributed to the systems lack of interaction with other autobiographical memory systems that could serve to update and appropriately integrate the information.

Resolution of PTSD symptoms, according to Brewin et al. (1996) requires emotional processing or integration of the traumatic event in both memories systems and involves two stages. Firstly, individuals need to consciously integrate the information contained in the VAM system with their pre-existing beliefs regarding the self, world and others. This entails making appropriate adjustments to these expectations and beliefs in light of the trauma. These latter ideas are essentially a restatement of Foa and Kozak's (1986), Horowitz's (1976) and Janoff-Bulman's (1992) theoretical perspectives. The second stage involves preventing the activation of SAM and the accompanying flashbacks and intrusions by creating new SAM's that can either inhibit or

block the original SAM representation. This process entails pairing original images of the trauma with "states of reduced cognitive arousal and reduced negative affect" (Brewin & Holmes, 2003, p. 19). This process is achieved through the elicitation of intrusive memories and a subsequent deliberate focus on their content which serves to facilitate habituation. These proposals for addressing PTSD symptoms are similar to those found in earlier models (Foa & Kozak, 1986; Foa & Rothbaum, 1998; Resick & Schnicke, 1996).

Brewin et al. (1996) expanded on earlier theories by providing a coherent account of the mechanisms underlying PTSD. Their ideas have received considerable empirical support (Brewin & Saunders, 2001; Hellawell & Brewin, 2002; Holmes, Brewin, & Hennessy, 2004). The model has, however, received some criticism for excessively focusing on flashbacks while neglecting other symptoms of PTSD (Dalgleish, 2004; Taylor, 2006) but it still remains a highly influential perspective. One significant limitation of the theory is that it does not provide guidelines for psychological treatment planning and intervention.

(iv) Ehlers and Clark's (2000) cognitive model of PTSD

Ehlers and Clark (2000) draw heavily from the work of prior theorists (Brewin et al., 1996; Foa & Kozak, 1986; Foa & Rothbaum, 1998; Resick & Schnicke, 1996) in their cognitive model of PTSD. However, their model significantly differs from earlier cognitive formulations in that it: specifies more fully the mechanisms underlying PTSD; accounts for all the symptoms that characterise the disorder and; addresses the idiosyncratic nature of appraisals made by individuals. Ehlers and Clark (2000) view PTSD as a paradoxical disorder in that unlike other anxiety disorders which involve a fear of a threat in the future, PTSD involves a fear of a threat that has already occurred. They agree with Foa and Kozak (1986) that PTSD arises from deficits in the processing of the traumatic event that lead to an over-generalised sense of current threat but they significantly expand on these early ideas by proposing that two mechanisms are involved in producing this sense of current threat.

a) Idiosyncratic cognitive appraisals

The first involves negative appraisals of the trauma and/or its sequelae. These idiosyncratic negative appraisals can be internal and include, for example, negative evaluations of the way one felt or behaved during the trauma or they can be external and include, for example, believing

that the world is no longer a safe place. These appraisals result in situational fear and avoidant behaviour which, as observed by earlier theorists such as Mowrer (1960) and Foa and Kozak (1986), maintain over-generalised fear and contribute to the maintenance of the disorder. The negative appraisals of trauma sequelae can further contribute to the persistence of PTSD. These appraisals can include perceiving symptomatic reactions, such as intrusions, as an indication that one is going crazy or is permanently and irrevocably damaged. It can also include problematic interpretations of the reactions of others following the trauma (e.g. no one understands me) and negative interpretations of the impact of the trauma on other domains of life (e.g. I'll never be able to trust anyone again).

These negative appraisals contribute to the persistence of the disorder because they not only enhance distress but also lead to the individual adopting problematic behavioural and cognitive strategies so as to control their symptoms. For example, a rape victim may assume that she contributed to her victimisation by going out late at night and expect that others will share this belief. As a result, she may keep the trauma a secret and avoid other people as a means of coping. However, such avoidance directly enhances and maintains symptoms by depriving her of the opportunity to correct problematic appraisals (Clark & Ehlers, 2005; Ehlers & Clark, 2000). According to Ehlers and Clark (2000), negative appraisals of the trauma and its sequelae generate problematic emotions which in turn contribute to the persistence of the disorder by prompting avoidant behaviour (Edwards, 2005c). The nature of these negative emotional responses is said to be dependent on the specific types of appraisals activated. For example, a rape victim who perceives the traumatic event as having compromised her identity as a virgin may experience feelings of shame, guilt or disgust. Due to the painful nature of these emotional reactions, she may try and avoid thinking about the trauma and such avoidance maintains PTSD symptoms.

b) Deficits in autobiographical memory

The second mechanism implicated in the sense of current threat involves a disturbance of autobiographical memory characterised by poor elaboration and contextualisation, strong associative memory and strong perceptual priming. This disturbance in memory is attributed to the nature of encoding during the traumatic event which subsequently impacts on the nature and retrieval of the trauma memory. In explaining the encoding of trauma memories, Ehlers and Clark (2000) draw on the distinction between conceptual processing and data-driven processing.

These two concepts are essentially identical to VAM and SAM as described by Brewin et al. (1996) in that they are used to differentiate between broadly verbal and imagery based information in memory. According to Ehlers and Clark (2000), conceptual processing involves the encoding of the event in spatial and temporal order and its organisation and integration within the context of previous and subsequent information and other autobiographical memories. Data-driven processing, in contrast, involves the encoding of sensory impressions. Ehlers and Clark (2000) argue that the degree of conceptual processing during the traumatic event affects the nature of the trauma memory and the resultant ability to intentionally retrieve information from this memory store.

Retrieval of information from memory is hypothesised to involve two routes. The first being higher-order meaning based retrieval strategies which access autobiographical memory. This corresponds to Conway's (2001) generative retrieval. The second route involves direct triggering by stimuli that were associated with the past event and this resembles Conway's (2001) concept of direct retrieval. The normal encoding of autobiographical memories through conceptual processing is believed to enhance retrieval via the first route (generative retrieval) and inhibit the ease with which memories are unintentionally retrieved (direct retrieval). If data-driven processing (or the SAM system) predominates during a traumatic event, the resulting trauma memory would be poorly elaborated and insufficiently integrated into its context in time, place and previous and subsequent information and other autobiographical memories. This enhances retrieval via the second route (direct retrieval) contributing to difficulties in intentionally retrieving memories of the trauma and involuntary recollections of trauma-related information that are often experienced as possessing a 'here and now' quality.

According to Ehlers and Clark (2000), data-driven processing results in strong associative memory and enhanced perceptual priming and thereby augments intrusive re-experiencing. These ideas correspond to Mowrer's (1956, 1960) and Foa and Kozak's (1986) conceptualisations but Ehlers and Clark (2000) significantly elaborate and expand on these early perspectives. They propose that associative memory in the form of stimulus-stimulus (S-S) and stimulus-response (S-R) associations are integrally involved in helping people predict future outcomes. Consequently, strong associative memory arising from data-driven processing results in stimuli present shortly before or during the trauma being associated with the prediction of danger. Strong associative

memory also results in perceptual priming, which is defined by Ehlers and Clark (2000) as a reduced perceptual threshold for trauma related stimuli. As a result of perceptual priming, cues associated with the trauma and that are capable of directly eliciting re-experiencing are more readily noticed. These cues often possess only a vague resemblance to the original stimuli encountered before and during the traumatic encounter making it difficult for PTSD patients to identify the exact source of triggering. This also contributes to the sense of current threat.

c) Sense of current threat: Adoption of problematic cognitive and behavioural coping strategies

As indicated earlier, Ehlers and Clark (2000) have argued that the perception of current threat leads to the adoption of behavioural and cognitive strategies directed at reducing distress. These strategies provide temporary relief from distress but in the long term they contribute to the persistence of the disorder because they inhibit processing of the traumatic event. Maladaptive cognitive strategies can include avoiding thinking about the trauma while problematic behavioural strategies can involve avoiding people, places or situations that act as reminders of the event. Such strategies also entail the use of alcohol or medication to control feelings of anxiety.

Ehlers and Clark (2000) have identified certain cognitive responses that maintain PTSD including rumination, thought suppression and selective attention. Trauma victims frequently ruminate on the traumatic event and their ruminations are predominantly focused on why the trauma happened or how it could have been prevented or alleviated (Ehlers, Mayou, & Bryant, 1998; Michael, Halligan, Clark, & Ehlers, 2007). Such ruminations are problematic because they: increase negative emotional reactions; prevent the individual from accepting that the trauma has occurred and; enhance negative appraisals of the trauma and its sequelae. This contributes to maintenance of the disorder by inhibiting the formation of an integrated trauma memory (Ehlers & Clark, 2000). Thought suppression is a highly prevalent coping strategy following exposure to trauma because of its temporary positive effect on mood. However, thought suppression actually tends to increase rather than decrease the frequency of trauma-related thoughts thus exacerbating distress (Shepherd & Beck, 1999). It also compromises the quality of cognitive processing by preventing the individual from evaluating their experience and drawing new meanings from it and this further contributes to the persistence of PTSD symptoms (Beever & Scott, 2001; Geraerts & McNally, 2008; Geraerts, McNally, Jelicic, Merckelbach, & Raymaekers,

2008; Shepherd & Beck, 1999). Selective attention to cues that represent threat or to aspects that serve as reminders of the trauma directly produces or increases the frequently of intrusive memories and therefore also contributes to the persistence of PTSD (Clark & Ehlers, 2005).

d) Support for Ehlers and Clark's (2000) theory of PTSD

The theoretical tenets of the Ehlers and Clark (2000) model, in contrast to the majority of other approaches described earlier, have been extensively tested and received significant support. Some of the aspects that have been evaluated include the influence of: data-driven compared to conceptual processing (Halligan, Clark, & Ehlers, 2002; Murray, Ehlers, & Mayou, 2002); negative appraisals of the trauma (Dunmore et al., 1999, 2001); problematic interpretations of initial PTSD symptoms (Mayou, Bryant, & Ehlers, 2001; Steil & Ehlers, 2000); negative interpretations of the responses of others (Dunmore et al., 1999); perceptions of permanent change (Ehlers, Maercker, & Boos, 2000) rumination (Clohessy & Ehlers, 1999; Murray et al., 2002); thought suppression (Mayou et al., 2001; Steil & Ehlers, 2000) and; avoidant behaviour (Dunmore et al., 1999).

SUMMARY

Ehlers and Clark (2000) have unified and expanded on the ideas of earlier researchers (Brewin et al., 1996; Foa & Kozak, 1986; Horowitz, 1976, 1986; Mowrer, 1956, 1960; Resick & Schnicke, 1996) and provided the most current account of the persistence and maintenance of PTSD. They have specified the role of a range of negative appraisals and the influence of cognitive and behavioural coping strategies in maintaining symptoms. In addition, they have implicated deficits in autobiographical memory as central to PTSD and have comprehensively described the memory dysfunction contributing to the persistence of the disorder. Furthermore, their theoretical perspective has been consistently supported by research findings. In the next section, the prominent cognitive-behavioural treatment (CBT) models used to treat PTSD are presented and compared with the Ehlers and Clark (2000) model to demonstrate the strength of this treatment approach.

1.5. TREATING PTSD: COGNITIVE-BEHAVIOURAL TREATMENT (CBT) PROGRAMMES

There are typically three phases in treating PTSD irrespective of the treatment modality used (Pearlman & Courtois, 2005; Edwards, 2009). The first stage focuses on safety and stabilisation. This involves crises intervention, building social support and ensuring safety both within the therapeutic context and in the client's external environment. The second stage focuses on the client's readiness and motivation for treatment. It involves: assessing and enhancing the client's understanding of the treatment model; strengthening the therapeutic alliance and; promoting their active engagement with treatment. As Edwards (2009) emphasises, this is the territory of Prochaska's and DiClemente's (1982) classic stages of change model (*see section 3.1.7.*). The therapist needs to be aware of the client's stage of change and respond accordingly to promote their movement to the action stage (*see section 3.1.7*). Client motivation encompasses six inter-related factors (Drieschner, Lammers, & van der Staak, 2004) (*see section 7.1.1. (iii)*) that need to be considered in enhancing engagement. The third stage involves: addressing re-experiencing; working with triggers; addressing maladaptive assumptions and trauma-related appraisals and; repairing and enlarging social connections by encouraging the client to re-engage with avoided activities and helping them to rebuild their lives (Edwards, 2009). Social support is particularly influential in promoting recovery from PTSD (*see section 7.1.2. (iii)*) and, for this reason, it is critical that client's access supportive others.

CBT treatment models are the most extensively researched and widely used approaches for targeting PTSD symptoms. Apart from the Ehlers and Clark (2000) model, the other widely used treatments include: Prolonged Exposure Therapy (PET); Eye-Movement Desensitization and Reprocessing (EMDR) and; Cognitive Processing Therapy (CPT). These cognitive-behavioural approaches are extensively described below. The efficacy research on these treatments is provided and subsequently compared with the Ehlers and Clark (2000) model. With respect to effect sizes: 0.2 represents a small effect size; 0.5 a medium effect size and; 0.8 or greater a large effect size (Cohen 1977). 'Intent-to-treat' refers to the analysis obtained from all the participants who enrolled for the treatment while 'completer analysis' refers to analysis obtained from only those participants who actually remained in the study and completed the treatment protocol.

1.5.1. PROLONGED EXPOSURE THERAPY (PET/PE)

PET (more typically referred to as PE) (Foa & Rothbaum, 1998), as described earlier is based on Foa and Kozak's (1986) emotional processing theory. The treatment incorporates four procedures: psycho-education about PTSD and frequently experienced reactions to trauma; training in controlled breathing to manage anxiety; in vivo exposure to feared situations and; imaginal exposure that involves repeated reliving of the memories of the traumatic event. After imaginal exposure the therapist and client review the problematic thoughts and feelings that emerged and the client is assisted in working through these aspects. Each session typically ends with the client being provided with a homework assignment that involves in vivo exposure exercises and listening to tape recordings of the reliving that occurred in the session (Riggs, Cahill, & Foa, 2006).

Prolonged exposure has been investigated in eight randomised controlled trials (*see* Foa, Keane, Friedman, & Cohen, 2009 *for a more complete description of these studies*). Five of the RCT's met 'gold standard' (Foa and Meadows, 1997) requirements for clinical research (i.e. waitlist controls were used to control most threats to internal validity). In these trials the PE protocol was typically applied over nine sessions with two of these sessions devoted to psycho-education and treatment planning and the remaining seven sessions devoted to imaginal reliving. These studies provided evidence that PE was associated with significant reductions in PTSD symptom severity and was superior to waitlist controls. Three of these studies are discussed below.

Resick, Nishith, Weaver, Astin and Feuer (2002) compared cognitive processing therapy, prolonged exposure and a waitlist control in the treatment of chronic PTSD experienced by female rape victims. The intention-to-treat sample included one hundred and seventy one women (thirteen did not arrive for the first session) and thirty seven subsequently dropped out of treatment. Dropout rates for the active treatments were similar (27.3% for PE). One hundred and twenty one women completed treatment. The intent-to-treat group obtained an effect size of 0.74 for PE while the completer group obtained an effect size of 2.05. Similar findings for PE have been reported in other studies. Ironson, Freud, Strauss and Williams (2002) compared EMDR with PE in the treatment of PTSD among twenty-two patients affected by trauma (predominantly rape) in a university-based clinic. Three of the ten patients allocated to PE dropped out. The intent-to-treat group obtained an effect size of 1.54 for PE while the completer

group effect size was 2.18. Foa et al. (2005) compared prolonged exposure for PTSD with and without cognitive restructuring for the treatment of PTSD among female victims of sexual assault or other forms of assault. The intent-to-treat sample consisted of one hundred and seventy nine women (74 assigned to PE/CR; 79 to PE). Treatment completers comprised one hundred and twenty one women. The dropout rate for PE/CR was 40.5% while the PE dropout rate was 34.2%. The effect sizes for PE/CR intent-to-treat group was 0.86 and PE was 0.96 for PTSD symptom reduction. Effect sizes in the completer sample For PE/CR were 2.39 and PE was 3.31.

These studies reveal that PE is an efficacious treatment for PTSD with medium to large effect sizes obtained in clinical trials. However, it also evident that dropout from PE is a significant problem impacting on the overall efficacy of this treatment protocol. These difficulties with client retention are the result of the intensive focus on reliving the trauma memory. Reliving typically occurs across seven sessions and many patients find this process painful and harrowing. As a result, they fail to complete treatment and continue to be affected by PTSD symptoms.

1.5.2. EYE-MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

EMDR (Shapiro, 2001) entails inducing a series of rapid and rhythmic eye movements for the purpose of facilitating cognitive change and reducing anxiety. The patient is required to move their eyes horizontally or vertically back and forth for a period of twenty seconds following the therapist's finger. While this is taking place, the patient is invited to bring negative emotions, cognitions and memories related to the trauma to the fore. With the assistance of the therapist, the patient is guided in processing negative emotions, challenging problematic cognitions and restructuring the trauma memory. Apart from the rhythmic eye movements, EMDR essentially shares many of the same features as PET and also Ehlers and Clark's (2000) model. EMDR has been evaluated in at least seven studies with a high methodological quality (Foa et al., 2009). Four of these studies are described below.

In the previously mentioned study by Ironson et al. (2002) comparing PE with EMDR, both the EMDR completers and intent-to-treat group obtained an effect size of 1.53. There were no dropouts for the EMDR treatment and this is probably related to the limited focus in EMDR on reliving. Rothbaum, Astin and Marsteller (2005), in another study, compared PE with EMDR and a waitlist group among women exposed to rape. Seventy-four women agreed to participate in the

study and twelve dropped out during treatment (13% from the PE group; 20% from EMDR and; 16.7% from the waitlist control). EMDR obtained an effect size of 1.42 for the completer group while PE obtained an effect size of 2.00 and no information was provided for the intent-to-treat group. In another study, Lee, Gavriel, Drummond, Richards and Greenwald (2002) compared a combination of imaginal and in vivo exposure plus SIT (stress inoculation training) with EMDR. In the study EMDR obtained an effect size of 1.97 for treatment completers (no information was available on the intent-to-treat group) but these authors pointed out that this large effect size was due to the study using seven treatment sessions compared to the average 4.6 generally used in other studies. Power et al. (2002) conducted a controlled comparison of EMDR with exposure plus cognitive restructuring and a waitlist control. There were one hundred and five participants in the study with thirty nine in the EMDR group and twelve (31%) of these individuals dropped out either after assessment (5 participants dropped out) or during treatment (7 participants dropped out). The effect size for treatment completers was 1.66 with little information available on the intent-to treat effect size. In a more recent study Van der Kolk et al. (2007) compared EMDR with fluoxetine and a placebo group among eighty eight men and women affected by a range of traumatic events. Of the twenty nine participants in the EMDR group, five dropped out of treatment. EMDR obtained an effect size of 0.48 for the intent-to-treat group and 0.59 for the completer group.

From these studies it is apparent that EMDR has obtained mostly mixed results. In addition, there has been some controversy about the effect sizes that have been obtained by the approach. Since EMDR does not adequately account for the role of the eye movement component in addressing PTSD symptoms (Seidler & Wagner, 2006) certain researchers have speculated that it is the cognitive behavioural components of the model, particularly those related to exposure, that are the primary contributors to the efficacy results obtained (Renfrey & Spates, 1994; Wilson, Silver, Covi, & Foster, 1996). This assumption has received support from dismantling studies. Cahill, Carrigan and Freuh (1999), for example, in a critical review of dismantling studies on EMDR concluded that there was no convincing evidence that the eye movement component contributed to treatment outcome. In light of the information on EMDR, it is apparent that this treatment approach is not as efficacious as, for example, PE (and CPT which is discussed below) and there are also concerns about the actual mechanisms of change.

1.5.3. COGNITIVE PROCESSING THERAPY (CPT)

The theory underlying CPT has been described earlier (*see section 1.4.3 (ii)*). The CPT treatment manual (Resick & Schnicke, 1996) for rape victims' comprises twelve therapy sessions that include: psycho-education about post-traumatic reactions; the provision of an explanation of the treatment approach; a rationale for the use of this approach; cognitive restructuring and; an exposure element. The exposure element in CPT varies from those used by other treatment approaches (e.g. PET) in that it involves the writing of a detailed narrative of the trauma which is subsequently read aloud by the client rather than imaginal reliving. Five studies have evaluated the efficacy of CPT and offered considerable support for the approach (Foa et al., 2009). However, one salient problem with CPT as with PET is the significant drop out rate from treatment. CPT has been evaluated in six studies with four of these being RCT's that have all met the 'gold standard' criteria (*see* Foa et al., 2009). Effect sizes in these trials have generally ranged between 0.62 (Resick & Schnicke, 1993) and 2.70 (Resick et al., 2002) for CPT treatment completers (Foa et al., 2009). Two of the studies meeting high methodological rigor are discussed below.

As stated earlier, Resick et al. (2002) compared CPT with PE and a waitlist control. There were no statistically significant differences between the active treatments for PTSD. Of the fifty six patients in the CPT group, sixteen dropped out (i.e. almost 29%). CPT obtained an effect size of 1.22 for the intent-to-treat group (PE was 0.74) and 2.70 for treatment completers (PE was 2.05). In a more recent study Resick et al. (2008) dismantled the components of CPT and compared the full treatment protocol with its constituent components (i.e. cognitive therapy only and written accounts) among a group of female victims of interpersonal violence. In the cognitive therapy only condition (CPT-C), the two sessions reserved for exposure work were removed and there was a greater focus on Socratic questioning to address problematic assumptions about the trauma. In the written accounts only condition (WA), participants wrote their narratives during part of a session while the remainder of the session was used to read out the account to the therapist. The intent-to-treat sample comprised one hundred and fifty women that were randomly assigned to one of the three treatments. Each treatment consisted of two hours of therapy per week over a six week period. Twenty four of the participants never returned for the first therapy session following assessment and the study had an overall dropout rate of 15% with 34% women from the CPT group, 22% from the CPT-C group and 26% from the WA group

dropping out. Participants in all three groups showed significant improvements in PTSD symptoms following treatment. In the CPT condition, the intent-to-treat group had an effect size of 1.1 while the treatment completers showed an effect size of 0.9. The CPT-C group had an identical effect size of 1.1 for the intent-to-treat group and 0.9 for treatment completers. In contrast, those in the intent-to-treat group and completer group in the WA condition obtained an effect size of 0.7.

CPT shows mixed results in efficacy studies but unlike EMDR the treatment has a much sounder theoretical basis. When compared to PE, treatment outcomes appear to be similar. In addition, like PE, CPT has significant dropout rates and the intensive focus on reliving has been cited (Rizvi, Vogt, & Resick, 2009) as one of the reasons for this but, as observed by certain theorists (Hembree et al., 2003; Rizvi et al., 2009), there is still a lack of clarity surrounding this issue.

1.5.4. THE EHLERS AND CLARK (2000) COGNITIVE TREATMENT MODEL

The Ehlers and Clark (2000) cognitive model incorporates elements of other cognitive-behavioural models including PE and CPT and involves three specific goals. The first goal is to modify excessive negative appraisals of the trauma and its sequelae while the second goal is to reduce re-experiencing through the elaboration of the trauma narrative and discrimination of triggers. The third goal is to help the client to drop dysfunctional behaviours and cognitive strategies. Their treatment approach is described below (Ehlers & Clark, 2000; Ehlers et al., 2004; Ehlers, Clark, Hackmann, McManus, & Fennel, 2005). Ehlers and Clark (2000) provide guidelines for both the assessment and treatment phases.

(i) The assessment phase

The assessment phase forms the foundation from which the case formulation, treatment goals and treatment plan are devised. The key aims of this phase involve: identifying the main cognitive themes to be addressed during the course of therapy (i.e. problematic appraisals of the traumatic event and/or its sequelae); identifying the problematic cognitive and behavioural strategies used by the client to cope with distress and; characterising the nature of the trauma memory. To identify the dominant cognitive themes, a variety of strategies have been proposed in the model (Ehlers & Clark, 2000; Ehlers et al., 2005) including the use of the Post-Traumatic Cognitions Inventory (PTCI) which covers a range of cognitive themes experienced following a traumatic

event. The client can also be asked to reflect on the trauma and consider what the worst or most painful aspects of the trauma were. This allows the clinician to identify 'hotspots' or moments that elicited significant distress and explore the meanings ascribed to such moments. In addition, the nature of intrusive images and instances where the client dissociates or withdraws can be assessed to identify themes (Ehlers et al., 2004). Furthermore, the nature of the predominant emotions experienced (e.g. sadness, anger, guilt, disgust, etc) by the client can provide an indication of the cognitive themes that need to be addressed.

In identifying problematic appraisals of the traumatic event and/or its sequelae, certain areas can be probed through close questioning and these include the client's: beliefs about the difficulties she has experienced since the trauma; assumptions about her symptomatic reactions; appraisals of her future and; perceptions surrounding the reactions of others. Problematic appraisals of the traumatic event can include negative appraisals of emotions experienced during the trauma (e.g. If I felt arousal, it means I am a disgusting person) and negative appraisals of actions during the trauma (e.g. If I didn't drink alcohol, the rape would not have happened and so I am to blame). Problematic appraisals of the trauma sequelae include negative appraisals of initial PTSD symptoms (e.g. my reactions since the trauma mean that I am going crazy); negative appraisals of the reactions of other people (e.g. other people are disgusted with me because of what happened) and negative perceptions of permanent change since the trauma (e.g. I have been permanently damaged because of the trauma). Problematic cognitive and behavioural coping strategies can be identified by closely questioning the client about the manner in which they have been attempting to put the trauma behind them, the types of things they tend to avoid since the trauma and how they cope with intrusions (Ehlers & Clark, 2000; Ehlers et al., 2004)

Another critical aim of the assessment phase is to investigate the nature of the trauma memory and involuntary intrusions. This involves ascertaining whether "there are gaps in the memory of the trauma, whether the sequence of events seems muddled or confused and the extent to which the memory/intrusions have a here-and-now quality and strong sensory and motor components" (Ehlers & Clark, 2000, p. 336).

(ii) Treatment contract

Once the assessment phase is complete, the clinician provides the client with psycho-educational material about PTSD, the mechanisms underlying this disorder, the rationale for treatment and the nature of the treatment model. Ehlers and Clark (2000) offer various analogies to explain the concept of trauma memory including the cupboard analogy. In using the cupboard analogy, the trauma memory is compared to a crowded cupboard in which various items (i.e. information related to the traumatic event) have simply be thrown in making the cupboard difficult to close and causing items to fall out (i.e. intrusive memories). For the cupboard to be closed, it needs to be reopened (i.e. the client has to review the traumatic event) and reorganised (i.e. trauma processing) so that it can be closed for good. During this phase the client is also invited to raise questions or concerns that they have regarding the treatment process. This facilitates the establishment of a collaborative relationship and provides the client with a sense of ownership of their recovery process (Ehlers & Clark, 2000).

(iii) Treatment phase

a) Goal 1: Modifying negative appraisals

Ehlers and Clark (2000) offer a number of techniques to identify peri-traumatic appraisals (i.e. appraisals occurring at the time of the trauma) or secondary appraisals (i.e. appraisals occurring after the trauma). In identifying peri-traumatic appraisals the client can be guided to relive the intrusive memory. Reliving involves guiding the client to provide a detailed verbal narrative of the trauma, in the present tense, including visual, auditory, emotional, physical and cognitive information. During the reliving the client can be asked to rate their level of distress and moments associated with high levels of distress are typically reflective of 'hotspots'. Hotspots can also be identified by noticing changes that occur during the reliving exercise, for example, if the client becomes visibly emotional, changes from the present tense to the past tense or changes from the first person to the third person. After reliving, the clinician discusses the various hotspots and their cognitive content with the client so as to address problematic appraisals and identify more adaptive appraisals. In this respect, traditional cognitive restructuring is useful (e.g. What is it about this situation that makes you incompetent? How is it that you are responsible for this?). Once alternative appraisals have been identified, the client practices these appraisals and during a subsequent reliving exercise the client is guided to insert these appraisals at the appropriate points in the trauma memory. This process is termed cognitive restructuring within

reliving. The identification and modification of problematic appraisals reduces the sense of current threat posed by the trauma memory. Secondary appraisals can be identified by having the client complete the PTCI or asking the client which aspects of the traumatic event was the worst or most painful. These negative appraisals can be modified using traditional verbal cognitive restructuring, such as, asking the client to review the evidence supporting/not supporting the appraisal or reality testing the validity of the appraisal (Ehlers et al., 2004; Grey, Young, & Holmes, 2002).

b) Goal 2: Reducing re-experiencing

To reduce re-experiencing, a coherent narrative of the trauma needs to be generated and triggers that elicit re-experiencing need to be identified and addressed. In generating a coherent narrative of the trauma, the client is encouraged to tell the story of the trauma starting before the event occurred and concluding when the client is in a safe place. This allows the trauma to be placed in temporal and spatial context and updates the autobiographical memory which then serves to reduce involuntary re-experiencing. In creating a coherent narrative of the trauma, imaginal reliving can be used or the client can be asked to write an account of the trauma and subsequently verbalise it (Ehlers & Clark, 2000; Hackmann et al., 2004).

Triggers can be identified by carefully reviewing or monitoring when and in which context intrusions occur. Once triggers are identified, the link between the trauma memory and the trigger must be intentionally broken. This is achieved by engaging the client in a detailed discussion regarding the differences and similarities between the triggering stimuli in its present context and the same stimuli in the trauma-related context (i.e. 'then versus now' differentiation). This process facilitates stimulus discrimination and allows the client to learn that the same cue has different meanings in both contexts and no longer poses a threat (Ehlers et al., 2004).

c) Goal 3: Changing dysfunctional cognitive and behavioural coping strategies

The cognitive and behavioural strategies used to control PTSD are strongly related to an individual's previous experiences and beliefs. For example, an individual who was told in childhood that showing emotions is a sign of weakness would be more likely to numb such emotions and avoid talking about the traumatic event lest it evoke an emotional reaction which

would lead to feelings of inferiority. Similarly, a person who believes that one can only tolerate a certain amount of distress before going mad would be more likely to use thought suppression to avoid the distress generated by thinking about the trauma. Discussing these strategies with the client and helping them to find alternative ways of conceptualising their experience is one method of facilitating change. In addition, psycho-education regarding the consequences of maladaptive coping strategies, behavioural experimentation, in vivo exposure and cognitive restructuring can be used to target dysfunctional coping strategies. In vivo exposure is particularly useful for clients who avoid certain places or situations that remind them of the trauma. In using the approach, the client is asked to specify what they think is the worst that could happen and how likely it is to happen if they entered the avoided situation or engaged in the avoided activity. They are then guided to confront the avoided situation to test if their assumptions come true. In vivo exposure essentially facilitates disconfirmation of the client's beliefs and helps them to realise that the avoided activity or situation no longer poses a threat (Dunmore et al., 2001; Ehlers & Clark, 2000).

(iv) Efficacy of the Ehlers and Clark (2000) cognitive treatment model

The Ehlers and Clark (2000) treatment model has been evaluated in two randomized controlled trials and in a consecutive case series. Ehlers et al. (2003), in a randomized controlled trial, compared cognitive therapy (CT), a self-help booklet (SH) based on principles of cognitive behavioural therapy and repeated assessments in preventing chronic PTSD. Of the eighty-five patients randomly selected to each intervention, fewer cognitive therapy patients (3) had PTSD compared with those receiving the self help booklet (17) or repeated assessments (16). There were no dropouts from the CT group and the effect size was 2.0. Ehlers et al. (2005) also investigated the efficacy of cognitive therapy in a consecutive case series involving twenty patients. Only one patient dropout out of treatment and this was for reasons completely unrelated to the treatment. The effect size for the intent-to-treat group was 2.70 and 2.81 for completers. These effect sizes are double that obtained in other studies. The results of the consecutive case series were subsequently replicated in a randomised control trial involving twenty-eight patients. The Ehlers and Clarks (2000) cognitive therapy model was compared to a three month waitlist condition. There were no dropouts from treatment. The effect size for pre- and post-treatment changes in PTSD symptoms using CT was 2.82. Again, this is double that obtained in other studies. Gillespie, Duffy, Hackmann and Clark (2002) also tested the Ehlers and

Clark model with a consecutive series of ninety-one patients affected by a terrorist bomb attack in a community setting in Northern Ireland. They found a similarly high effect size (2.47) for pre- and post-treatment changes in PTSD symptoms and no dropouts were reported.

The Ehlers and Clark (2000) model has consistently been shown to be highly efficacious in the treatment of PTSD. The effect size obtained in all their studies exceeds (by almost double) the effect sizes of intent-to-treat analysis reported in other studies. Furthermore, this approach has been shown to be favourable to clients as is evident in the minimal to no dropout rate. Client retention is partially attributed to the limited emphasis placed on the painful process of reliving which occurs in a mean of three sessions (mean of 98 minutes over the entire therapy). When compared to others treatments, the Ehlers and Clark's (2000) CT has essentially been shown to have the best efficacy.

CONCLUSION

In the context of other cognitive behavioural approaches to PTSD, the Ehlers and Clark (2000) model emerges not only as the most comprehensive treatment approach but also as the approach most strongly and consistently supported by empirical evidence (Brewin & Holmes, 2003; Dunmore et al., 2001; Gillespie et al., 2002; Taylor, 2006). The model provides: a psychologically plausible explanation for each of the symptoms of PTSD; a comprehensive understanding of the persistence of the disorder without treatment and; a rationale for treatment which follows from established treatment protocols for other anxiety disorders, yet is specific to the disorder. The treatment approach has consistently yielded greater effect sizes than all other treatments for PTSD. In addition, few to no dropouts have been reported in efficacy studies of the treatment approach. Furthermore, unlike other manualised treatments, a critical strength of the Ehlers and Clark (2000) model is that it is formulation driven and therefore highly flexibly allowing the individual practitioner to customise the treatment and session content to suit the needs of the individual client. This serves to promote collaboration between therapist and client and also promotes treatment adherence.

1.6. TREATMENT APPROACHES USED BY SOUTH AFRICAN PRACTITIONERS TO TARGET PTSD FOLLOWING SEXUAL ASSAULT

"Our age of Anxiety is, in part, the result of trying to do today's job with yesterday's tools"
-Marshall McLuhan

Very few studies (Hajiyiannis & Roberson, 1999; Higson-Smith, Thacker, & Sikhakhane, 2003; Leibowitz-Levy, 2005; Renes, 1999) have provided insights into the psychological modalities used in South Africa to treat individuals affected by trauma. Higson-Smith et al. (2003) conducted one of the most recent studies involving a needs assessment for traumatic stress services in Mpumalanga province. Data for the study was obtained from two-hundred and fourteen service providers who indicated that they offered psychological care to victims of trauma. This included non-governmental organisations, non-profit organisations, government institutions and private sector service providers. One of the major problems encountered in the study was confusion regarding the meaning of terms used to describe particular forms of psychological care. Different practitioners, agencies and institutions used different terms including 'debriefing', 'trauma counselling' and 'trauma therapy' to refer to either the use of specific techniques/approaches or the provision of a general form of counselling or both. As such, in many instances the exact nature of the psychological services offered remained unclear. Nevertheless, the study provided insights into the quality of trauma services typically found in the country.

The majority of service providers in the province were NGO's and non-profit making organisations (NPO's) with the private sector accounting for 11% and government services accounting for 12%. Seventy four organisations in the study indicated that they provided "trauma counselling" (Higson-Smith et al., 2003, pg. 32) but the specific approach used was not specified. The most common presenting problem for trauma counselling was rape followed by intimate partner violence and child abuse. Service providers were mostly nurses, doctors and social workers and a major problem experienced by these individuals was a lack of basic training in the provision of specialised care for trauma victims. The majority of clients approaching these organisations received three or fewer sessions. Higson-Smith et al. (2003) subsequently argued that such short term intervention was insufficient when working with complex cases especially when service providers were not using a specialised treatment approach.

Fifteen service providers (12 of which were government organisations) in the study described themselves as providing "trauma therapy" (Higson-Smith et al., 2003, pg. 33) which entailed the provision of psychotherapy by professional psychologists. Rape also headed the list of presenting problems encountered by this group of service providers. The psychologists in the study were found to use general models of psychotherapy (e.g. psychodynamic, CBT) rather than a specialist approach and this was primarily related to a lack of training and knowledge surrounding specialised treatments. When dealing with complex reactions to trauma specialist treatment approaches are essential for targeting symptoms effectively. In the absence of such measures it is highly likely that patients will continued to be affected by the disorder and this was a point emphasised by Higson-Smith et al. (2003) in their study.

Earlier researcher findings (Hajiyiannis & Roberson, 1999; Leibowitz-Levy, 2005; Renes, 1999) indicated that a frequently used treatment approach in South Africa among professional psychologists, social workers and other categories of service providers (e.g. primary health care nurses) was the Wits trauma model. This approach is described below.

1.6.1. THE WITS TRAUMA MODEL

The Wits Trauma Model was developed in South Africa at the University of the Witwatersrand using an empirical multiple case study approach and it integrates both psychodynamic principles and cognitive-behavioural interventions. The model was primarily designed as a brief term intervention following exposure to trauma and not as a comprehensive treatment approach for PTSD and it is not based on an extensive theory. It comprises five components, namely: telling/re-telling the story, normalising symptoms, addressing survivor guilt or self-blame, encouraging mastery and facilitating the creation of meaning (Eagle, 2005; Straker, 1994).

The model's utility has been demonstrated by Straker (1994) and Eagle (2005). Straker (1994) treated three adolescent sisters displaying symptoms of PTSD following the brutal murder of their father during the civil war in the late 1970's. Straker (1994) used the framework provided by the Wits trauma model and incorporated a variety of cognitive techniques to treat symptoms of PTSD and other attendant difficulties (e.g. feelings of guilt). Following two days of intensive psychotherapy, the sisters reported substantial decreases in symptomatic reactions. Eagle (2005) similarly used an extended version of the model to treat a young black South African woman who

had survived an attempted rape. The woman's close friend had been murdered during the incident while she had managed to escape. She learned that during the funeral, her friend's family had laid a curse on anyone who had knowledge of the rape and failed to disclose the information. Years later the woman experienced an attempted rape and interpreted the ensuing symptoms of PTSD as punishment for her wrongdoing. In treating the victim, Eagle (2005) encouraged the client to provide a coherent account of the trauma and also to evaluate her behavioural options during the incident in which her friend was murdered. Psycho-educative material was also provided to assist the woman in understanding responses to trauma. These interventions helped to alleviate PTSD symptoms and addressed feelings of responsibility, guilt and self-blame.

The Wits trauma model has been found to be highly accessible to many categories of professionals (Leibowitz-Levy, 2005; Renes, 1999). However, a study (Hajiyiannis & Robertson, 1999) investigating counsellors' appraisals of the Wits trauma model found that many service providers were concerned that the model did not sufficiently target specific symptoms. This includes reliving of the trauma memory and high levels of anxiety. Another concern was that the model did not adequately address the variety of emotional reactions associated with exposure to traumas such as rape. These emotions included shame, disgust and anger. These shortcomings are, however, expected given that the approach was only intended to be a brief term intervention and not a comprehensive treatment package. For this reason, specialist practitioners (Eagle, 2005; Straker, 1994) have incorporated other techniques when working within the framework of the Wits trauma model to address complex reactions. However, given that there are very few specialist practitioners in the country, the majority of service providers are unaware of these interventions and do not have training in the use of such procedures (Higson-Smith et al., 2003). This limits the degree to which they can effectively treat the psychological sequelae associated with a trauma such as rape even when working within frameworks such as the Wits trauma model.

1.6.2. NEED FOR A CONTEXTUALLY GROUNDED SPECIALIST APPROACH: THE WAY FORWARD

On the basis of their study Higson-Smith et al. (2003) argued that in South Africa, service providers offering care to trauma victims need access to and training in a specialist treatment approach. They emphasised that such an approach must have demonstrated efficacy and should be contextually appropriate. These sentiments have also been echoed by other South African researchers (Edwards, 2005c).

Currently, the Ehlers and Clark (2000) cognitive model represents the treatment package with the best evidence base (Brewin & Holmes, 2003; Edwards, 2009). However, the model is severely under-utilised in South Africa and there are two main reasons for this. The first reason as was apparent in the study by Higson et al. (2003) relates to a lack of awareness among practitioners of specialist treatment approaches (Edwards, 2005c). This lack of knowledge is partially related to the limited interest shown by practitioners not only in South Africa but also internationally about the findings of efficacy studies. Many researchers (Dattilio et al., in press; Goodheart, 2005; Schultz, Resick, Huber, & Griffin, 2006) have emphasised that treatment efficacy studies are largely ignored by clinicians in the field because these outcome studies omit the types of information that are of clinical utility. This includes information about: the specific obstacles encountered in working with a client, such as, a personality disturbance or issues with safety; how the therapist applies a specific technique like, for example, imaginal reliving and; the rationale behind the choice and timing of a particular intervention. This type of information directly informs clinical practice but cannot be obtained from efficacy research involving RCT's. For this reason, many practitioners simply ignore the results of treatment outcome studies and therefore remain unaware of the best treatment approaches available. In addition, even if practitioners keep abreast of outcome research, they are often not able to apply the approach with the best evidence base in their own clinical practice because they lack exposure to the treatment and do not know how best to use it. The second reason the model is under-utilised in the country involves concerns about whether a treatment developed in a Western clinical context can be transported to a multi-lingual and culturally diverse context such as South Africa (Edwards, 2005c).

Dattilio et al. (in press) and other researchers (Casper, 2007; Eells, 2007; Goodheart, 2005) have argued that one means of addressing these barriers to treatment provision is through the use of systematic case-based research. This approach is comprehensively described in the next chapter (*See Section 2.2.1. (i)*). Briefly, systematic case study research offers a complementary means of developing evidence-based practice (EBP) for a particular treatment in a way that is more meaningful and useful for clinicians in the field (Edwards et al., 2004; Salkovskis, 2002). Currently, in South Africa, a case series is underway that aims to contribute to the development of such an evidence base for the Ehlers and Clark (2000) model. Three case studies that form part of the series have involved the treatment of rape victims and are summarised below.

Davidow and Edwards (2007) discussed the treatment of a black South African rape victim (Oratilwe) using the Ehlers and Clark (2000) model in a case study based research project. Oratilwe aged 23 had been raped by her boyfriend and did not disclose her trauma for two years until she responded to a notice posted by the clinician (Davidow) in the study requesting research participants. The case study (Davidow, 2006) described the workings of the model with a local client and encompassed themes including HIV/AIDS, anger, shame, guilt, negative core beliefs and social support. Oratilwe's treatment was not complete at the time of her termination due to the clinician's internship coming to an end. Nevertheless, at the time of termination there were significant reductions in her depression and anxiety symptoms and she no longer met criteria for PTSD. In another local study, Payne and Edwards (2009) discussed the treatment of a fifteen year old isiXhosa-speaking adolescent rape victim (Zanele) who experienced chronic PTSD. Zanele had been raped on two occasions while visiting her disabled father who lived in a township. The case study (Payne, 2006) described the treatment of the client across twenty-three sessions. Salient themes in the study included HIV/AIDS and problems with social support and physical safety. Contextual aspects also impacted on treatment delivery and these included shortcomings in the provision of HIV test results at the level of primary health care and deficiencies in the SAPS management of the rape case. Despite these challenges, treatment was highly effective in reducing PTSD symptoms. After twenty-three sessions Zanele no longer met criteria for PTSD and there were significant reductions in her depression and anxiety symptoms. In a third local study, van der Linde (2007) described the treatment of a twenty-three year old Swazi woman (Bongi) who had been raped on three occasions, at the age of nine, nineteen and twenty. She entered therapy three years after her revictimisation at the age of twenty and was treated over a period

of five months. The study emphasised the challenges in working with a client who experienced comorbid depression and had limited social support. It also described the influence of the client-therapist relationship and early maladaptive schemas in influencing treatment engagement. Treatment in this study was not complete due to the client having to return home. However, at the time of termination there was significant reduction in PTSD symptoms. The author also indicated that it was highly likely that PTSD symptoms would have completely resolved if the client had been able to complete treatment.

These latter three cases, in conjunction with the other case studies (Boulind & Edwards, 2008; Karpelowsky & Edwards, 2005; Laas, 2009; Smith, 2006) that comprise the database, have provided substantial evidence that the assessment, formulation and treatment aspects that comprise the Ehlers and Clark (2000) model are not culturally biased but can be applied in contexts that differ from those in which the model was developed. The studies that comprise the case series are gradually being published and thereby aim to contribute to a needed evidence base. This form of EPB corresponds to the definition provided by Olsson (2007, cited in Midgley, 2009) who describes evidence-based practice as "a set of structures created with the purpose of fostering systematic knowledge development and effective information dissemination so that public social service interventions could, to a great extent be evidence-based" (p.30).

CONCLUSION

Despite the availability of an effective treatment approach to target rape-related PTSD, the Ehlers and Clark (2000) model is severely under-utilised in South Africa. Instead, a variety of other approaches that are not specifically designed to address post-traumatic symptoms are used and this is related to a lack of training and exposure among service providers. This research project aims to remedy this situation through systematic case study research and the creation of case law *(see section 2.1.1. (i))*

CHAPTER 2: METHODOLOGY

2.1. RESEARCH OBJECTIVES

Presently, in South Africa, the first and usually only contact that the majority of rape victims have with the mental health profession is at the level of primary health care or through NGO's and non-profit organisations. A lack of training and exposure surrounding efficacious treatment models and concerns about the transportability of international approaches to the South African context serve to impede the effective treatment of those affected by sexual trauma within these settings (Higson-Smith et al., 2003). This study aimed to address these barriers to treatment provision to rape victims by investigating the applicability of the Ehlers and Clark (2000) model in South Africa. The process in achieving this goal involved the following:

1. Documenting the assessment and treatment of seven rape victims within the South African context;
2. Identifying client-related personal or contextual aspects that affect the application of the treatment model;
3. Discussing the implications of these client-related and contextual aspects for treatment practice and social policy;
4. Contributing to the creation of an evidence base of case studies, already underway, that can serve as an "explicit public reference point" (Edwards et al., 2004, p. 593) for mental health and other professionals treating vulnerable population groups in the country.

2.2. RESEARCH METHODOLOGY AND CLINICAL METHODOLOGY

In the context of this study, the term research methodology is used to refer to the scientific principles underlying the process of data collection, data reduction and data interpretation (Edwards, 2007). The clinical methodology refers to "the set of procedures for assessment, treatment planning and ongoing decision making in the implementation of an intervention" (Edwards, 2007, p. 21). These two aspects of the research process are further described below.

2.2.1. RESEARCH METHODOLOGY

This research project used the systematic case study method (Fishman, 2005) which is based on a mixed methods approach to research. The mixed methods approach embraces the methods and epistemological systems of both the positivist and interpretative traditions (Dattilio et al., in press).

Positivism was the dominant research paradigm in the social and behavioural sciences for many decades (Barker, Pistrang, & Elliot, 2002). Its fundamental tenets included the belief in an objective reality that is independent of the human mind and therefore the methods of the physical sciences (i.e. quantification, experimentation) are regarded as the only valid means of inquiry as they can be used to collect objective data. Data in positivist research is usually convertible to numbers and findings are generally expressed through mathematical means (e.g. descriptive or inferential statistics) (Barker et al., 2002). Quantitative research grounded in the positivist paradigm has considerable advantages (Kazdin, 1998) and has generally been accorded substantial scientific legitimacy. This has had a profound impact on psychotherapy research with RCT's being regarded as the 'gold standard' for determining treatment efficacy in the mental health field (Leichsenring, 2004). However, as observed by Dattilio et al. (in press) the positive paradigm "is epistemologically incomplete because it fails to provide for context-based knowledge". The limitations of RCT's have been noted and discussed by various researchers (Eells, 2007; Hollon, 2006; Sackett & Oxman, 2003; Westen, Novotny, & Thompson-Brenner, 2004). In summary, RCT's are limited in that they: do not provide information about the mechanisms through which treatments work; are not readily transportable to contexts, such as those found in developing countries, where resources are limited and there are few skilled professionals available to provide treatment and ongoing supervision; do not provide information about the phenomenological aspects of the client's and therapist's experiences and are therefore not accessible to practitioners in the field; cannot account for context-specific and client-related aspects encountered in clinical settings that have a bearing on treatment application. For these reasons, research in the positivist paradigm needs to be balanced or complemented by more qualitative approaches (Edwards, 2008; Noor, 2008; Persons & Silberschatz, 1998; Salkovskis, 2002).

In contrast to the positivist approach, researchers in the interpretative paradigm promote a pragmatic approach and use a variety of methods to capture and describe human experiences. This study uses hermeneutic-phenomenology which refers to the systematic study of the individual's lived experience and their constructions of the world (Rennie, 2007). Language is seen as the primary medium through which the individual's inner world can be understood. As such, this method focuses on analysing text (i.e. written or spoken language) to understand the manner in which people construct their experiences and the influence of their socio-cultural and historical background on their meaning making process. Researchers using this approach are required to be reflexive. This entails carefully considering their experiences, biases and assumptions and the manner in which their own frame of reference relates to the issues under investigation (Terre Blanche & Durrheim, 1999). When it comes to evaluating a psychological treatment approach, the interpretative qualitative framework can complement RCT's by providing: a more nuanced understanding of the processes involved in change; the phenomenological experiences of the client and therapist and; the various contextual and client-related factors that influence treatment outcome (Edwards et al., 2004; Dattilio et al., in press; Fishman, 2007, 2009). The systematic case study method represents one means of obtaining such contextually-grounded knowledge.

(i) Systematic case study method

Case study research is defined as "an empirical enquiry that investigates a contemporary phenomenon in its real life context, particularly when the boundaries between the phenomenon and context are not clearly evident" (Yin, 1994, p. 13). The case study method involves the systematic collection and presentation of detailed information regarding a particular client and/or treatment process. It is differentiated from other research methods in that it offers an intensive analysis and description of the particular phenomena under study within its real-life context (Yin, 1994). In the realm of psychotherapy research, case based research offers a complementary method of testing and developing clinical knowledge. Hilliard (1993, cited in Edwards et al., 2004) identified two aspects of case-based research that "anchor the logic of case-based knowledge building" (p. 502). The first aspect involves inter-subjective variation in that case studies, because of their longitudinal nature, allow the researcher to intensively examine and identify the specific aspects of the therapist's responses and client's reactions that contributed to significant change. The second aspect is that, unlike efficacy studies,

generalisability in case-study research is based on replication on a case-by-case basis. That is, findings from an existing case or number of cases are contrasted with that of a new case to determine if they differ in important respects or share certain similarities. This process also allows for the theory on which the treatment is based to be tested and refined and, in this way, contributes to the creation of what Bromley (1988, cited in Edwards et al., 2004) call "case law" (p. 502). The theory or case law that is subsequently created through this process is grounded in the data itself and it can be tested against new cases that emerge and "its generalizations are lawful relationships between operationalized phenomena that have been observed and replicated" (Edwards et al., 2004, p. 502).

Case studies have clinical utility for practitioners in the field for three reasons. Firstly, case studies are able to account for the contextual realities of therapeutic practice. Client's seen in practice tend to differ in terms of their race, nationality, personality and socio-cultural and historical background. In addition, clients tend to suffer from multiple disorders and often have to contend with complex life circumstances. Furthermore, practitioners tend to differ in terms of their: socio-cultural and historical background; their experience in working with particular categories of clients; their expertise in the use of specific therapeutic modalities and techniques and; their general approach to therapy. These contextual variables impact on the nature of the therapy process not only as it pertains to the implementation of a treatment model but also to aspects such as the development of a therapeutic alliance, treatment contracting and client compliance with treatment. As such, they are highly pertinent to practicing therapists who require information as to how best to respond to the unique characteristics of specific clients and their presenting problems (Eells, 2007; Fishman, 2005, 2007; Flyvbjerg, 2006). Research that focuses on outcome measures is often unable to provide this type of information. However, case studies are able to illuminate these aspects by offering differentiated knowledge regarding the client's background and presentation as well as the therapist's background and expertise and the extent to which these features are likely to impact on the client's engagement with treatment. Therapists can then integrate this knowledge into their own practice to ensure that they are able to offer psychotherapy that is best suited to the individual client (Edwards et al., 2004).

Secondly, case studies are able to offer information regarding therapist responsiveness. Therapist responsiveness is regarded as the central factor in the delivery of psychotherapy and is

conceptualised as the manner in which the "therapist monitors the client's understanding or engagement with the treatment or intervention and adjusts their responses accordingly" (Edwards, 2009, p.4). Therapists are constantly required to adapt their responses to suit the needs of the client and the circumstances of individual cases. As such, therapists have to be flexible in their approach. Case based research offers insights into the manner in which the therapists chooses the appropriate intervention and tailors their responses to suit the moment to moment needs of the client. This kind of information is of immediate practical utility as it offers practitioners guidelines and suggestions as to how to proceed with specific issues that arise in their own work with clients. They can then integrate this knowledge into their own practice.

Thirdly, practitioners have been found to show limited interest in reading research reports published in journals (Edwards et al., 2004). Among the reasons cited is that most research pertaining to the testing of clinical models is presented in the form of samples and averages. This information is of limited utility to practitioners as it bears little relation to the individual clients they encounter in their own work. In contrast, information presented in case studies tends to captivate the reader more so than research reports using multivariate methods, particularly because it captures aspects of the phenomenology of the therapist's and client's experiences. This makes it more accessible to practitioners and increases the likelihood that they will read information based on case study research (Goodheart, 2005).

Another advantage of case based research is that it is more appropriate and feasible within the context of a developing country where resources are limited and practitioners' differ in terms of their level of training and clinical expertise and where clients tend to be diverse (Edwards, 2005c). RCT's are dependent on the presence of a clinical context in which a large number of clients can be regularly and systematically assessed by a group of practitioners trained in the particular treatment model. Currently, in South Africa, such a clinical context does not exist (Edwards, 2005c). In addition, there are limited funds available for conducting such trials which are usually expensive and demanding on resources. As such, case studies offer an alternative and more feasible approach for testing clinical models and providing practitioners with needed insights to address the problems they face when working with limited resources and diverse and complex cases (Casper, 2007; Edwards, 2007; Salkovskis, 2002).

(ii) Rigor in case study research

Despite the utility of case-based research, particularly as it pertains to this research project and the context in which the study is being carried out, studies that fall largely within the interpretive paradigm are often criticised and discredited owing to concerns surrounding their rigor (Messer, 2007). Rigor, in this regard, refers to the quality of the study. In the positivist paradigm, rigor is generally established by determining the internal validity, external validity (i.e. generalisability), reliability (i.e. stability) and objectivity of the study. However, the rigor of the case study method or other methods generally grounded in the interpretive paradigm cannot be achieved by using identical methods to quantitative studies and therefore a parallel system has been developed (Guba & Lincoln, 1994; Lincoln & Guba, 2000; Midgley, 2009; Morgan, 2007; Morrow, 2005). Guba and Lincoln (1994) propose the following parallel criteria: credibility (versus internal validity), transferability (versus external validity) dependability (versus reliability) and confirmability (versus objectivity). The present project incorporates this parallel system to ensure that the study is rigorous.

Credibility concerns the trustworthiness of the findings. It involves an evaluation of whether the research findings represent a credible conceptual interpretation of the information that has been drawn from the participants' original data (Guba & Lincoln, 1994). To address credibility, I used four techniques. Firstly, I provided 'rich, thick descriptions' involving detailed and intensive descriptions of the research participant, the therapeutic process and the context in which treatment occurred. Secondly, I enlisted a third party assessor to determine the degree of correspondence between the original data and the therapy narrative. The assessor evaluated verbatim transcripts against audio recordings and contrasted these with the therapy narratives. Thirdly, the evaluation forms completed by the assessor are provided (see Appendix D-J) thereby enhancing the trustworthiness of the information. Fourthly, my supervisor, Prof Dave Edwards, interrogated the therapy narratives and the interpretations to ensure correspondence between these aspects and the case.

Transferability parallels the concept of generalisability used in quantitative studies (i.e. the degree to which quantitative findings can be projected across a broad population from which an experimental sample was originally randomly selected). Guba and Lincoln (1994) emphasise that achieving generalisability is simply not possible in qualitative research because it requires the

original situation and the situation to which findings are to be generalised to be similar if not identical. The existence of local or real-world conditions makes such generalisation extremely challenging. For this reason, the goal in qualitative studies is to provide rich descriptions of data in context as this allows others to make decisions about whether there is sufficient similarity between two contexts so that findings can be transferred from one context to the next. This has been described earlier in terms of the creation of case law (see section 2.2.1. (i)). In this study, this process is enhanced by the use of multiple rather than a single case study approach. Different contexts or circumstances are therefore provided thereby increasing the likelihood that findings in one study can be applied to another. Furthermore, this research project adds to an existing database of cases (Davidow & Edwards, 2005; Payne & Edwards, 2007; van der Linde, 2007) thereby further facilitating the creation of case law.

Dependability parallels the quantitative concept of reliability which is based on the assumption that findings can be replicated or repeated. Reliability is achieved through the use of tightly controlled experimental designs. However, when it comes to qualitative research in real-world settings, such tight control is not possible (or desired). Dependability is achieved by ensuring that the arguments provided are complete, "allowing the reader to follow and understand it without unexplained leaps from argument to conclusion" (Williamson, Radford, & Bennetts, 2003, p. 131.). The use of a third party assessor and supervisory input ensured the flow of arguments in the case studies. Dependability is also achieved by accounting for the various contextual and other facets that influenced the research process which, in this study, can be seen in the use of 'thick descriptions' and reflexivity (*see section 2.8.*).

Confirmability overlaps with dependability and concerns the degree to which the results of a study can be confirmed by others. In quantitative research this concept is parallel to objectivity and the extent to which findings can be replicated by independent researchers using the same procedures. In this sense, the confirmability of this study has been enhanced due to the presence of an existing case series (Davidow & Edwards, 2005; Payne & Edwards, 2009; van de Linde, 2007). These case studies have demonstrated that the principles and procedures used in case-based research within the context of treating rape victims can be replicated.

2.2.2. CLINICAL METHODOLOGY

The Ehlers and Clark (2000) Cognitive Model for the treatment of PTSD constitutes the basis of the clinical methodology for this research project. Although no formal treatment manual is currently available, the Ehlers and Clark group have published extensive guidelines on assessment, formulation and treatment (Clark & Ehlers, 2005; Ehlers & Clark, 2000; Ehlers et al., 2005; Ehlers et al., 2002; Grey et al., 2002). The model is formulation driven thereby ensuring that the needs of the client are prioritised and that interventions are tailored to target the dominant components of the client's presentation. The treatment protocol is divided into two stages, namely an assessment phase and a treatment phase.

(i) Assessment phase

The aim of the assessment interview is to conduct a traditional complete clinical assessment that forms the basis for a diagnosis and case formulation and informs the direction of the treatment programme. The critical aspects focused on in the assessment phase have been previously discussed (*see section 1.5.4. (i)*).

(ii) Diagnosis

The diagnosis is based on the guidelines provided by the DSM-IV-TR (APA, 2000).

(iii) Case Formulation

The case formulation is essentially a hypothesis that is inductively generated regarding the aetiology and persistence of a client's presenting problems (Persons & Thompkins, 2007). A cognitive behavioural case formulation (Beck, Rush, Shaw, & Emery, 1979; Craske, Barlow, & Meadows, 2000) describes the cycles that link the client's maladaptive beliefs with emotions, behaviours and symptomatic reactions and provides information about the origins of the client's difficulties (Persons & Tompkins, 2007). Each case formulation is tailored to a particular client and therefore allows for a flexible and idiosyncratic understanding of the client's dynamic and ensures that psychological problems are prioritised in a meaningful way (Tarrier, 2006). The flexibility of the Ehlers and Clark (2000) model allows updating of the contents of the case formulation to include relevant information obtained at a later stage. This permits a more comprehensive conceptualisation of the case and ensures that interventions are suited to the

specific nature of the client's difficulties throughout the treatment process (Ehlers & Clark, 2000; Edwards, 2009).

In the research project, schema theory (Young et al., 2003) was also used to inform the case formulation. Schema theory incorporates concepts from cognitive-behavioural therapy, attachment theory, object relations theory and psycho-analytical theory to form a unifying theoretical framework. The framework is especially useful in helping the therapist make sense of chronic, pervasive problems and to organise these difficulties in a manner that is easily accessible and comprehensible. Young et al. (2003) define schemas as a pervasive theme or pattern consisting of memories, emotions, cognitions and bodily sensations regarding oneself and one's relationship with others. Schemas generally form in childhood (or adolescence) and are "reality-based representations of the child's environment" (Young et al., 2003, p. 9) and are elaborated throughout life. Schemas can either be positive or negative but Young et al. (2003) specifically focus on early maladaptive schemas (EMS) that arise from "unmet core emotional needs in childhood" (p. 9). These authors identify eighteen early maladaptive schemas which they group into five broad categories called 'schema domains'. These schemas domains include: disconnection and rejection; impaired autonomy and performance; impaired limits; other-directness and; over-vigilance and inhibition. Young and Brown (2003) created a schema questionnaire (YSQ-S3) to assist the therapist in identifying the client's predominant schemas. Young et al. (2003) developed schema therapy on the basis of their conceptual model and the approach is particularly useful for treating the chronic characterological aspects of a client's condition. However, as these authors emphasise, schema therapy is not meant to treat acute psychiatric symptoms. Their theoretical concepts and treatment approach have received growing support (Farrell, Shaw, & Webber, 2009; Lee, Taylor, & Dunn, 1999; Lobbestael, Van Vreeswijk, & Arntz , 2008; Rijkeboer & van den Bergh, 2006).

Once the case formulation and treatment plan are generated these aspects are discussed with the client who is then invited to raise any concerns or to add any other issues to the treatment plan. As such, although the treatment of PTSD forms the primary aim of the Ehlers and Clark (2000) model, the inherent flexibility of its treatment protocol ensures that difficulties encountered in other areas can be systematically and comprehensively addressed.

(iv) Treatment stage

The Ehlers and Clark (2000) model is designed around three treatment goals namely; modifying excessive negative appraisals of the trauma and its sequelae; reducing re-experiencing by elaboration of the trauma narrative and discrimination of triggers and; dropping dysfunctional behaviours and cognitive strategies. A variety of cognitive-behavioural strategies can be used to achieve these goals and these aspects have been comprehensively discussed (*see section 1.5.4. (iii)*).

(v) Rigor in the application of the treatment model

To ensure the appropriate application of the treatment protocol, I was supervised by a cognitive therapist, Prof Dave Edwards, who is accredited with the Academy of Cognitive Therapy and has received training with the Ehlers and Clark group. Supervision and case management occurred on a weekly basis and allowed for monitoring of the implementation of the treatment protocol.

2.3. DUAL ROLE OF CLINICIAN AND RESEARCHER

For this research project, I was the therapist, researcher and author of this study. I have a Master's in Counselling Psychology. I am a registered counselling psychologist and have also received training in cognitive-behavioural therapy. I am not certified with the Ehlers and Clark group but I was closely supervised and mentored by a cognitive therapist who has received training with this group of researchers.

Various theorists have observed (McNair, Taft, & Hegarty, 2008; Yanos & Zeidonis, 2006) that there are both critical advantages and ethical concerns when assuming the dual role of clinician and researcher. One advantage of being a clinician-researcher is the ability to report clinical findings in a way that is meaningful and accessible to other practitioners (Goodheart, 2005). Clinicians are trained to carefully observe and monitor the responses, both verbal and non-verbal, of a client as well as their own experiences and reactions. They are also trained to reflect on these latter experiences and reactions and the various influences that contributed to these aspects. As a result, clinicians can provide a depth of understanding about the psychotherapy process (e.g. information about the process that informs their choice of intervention) that cannot necessarily be conveyed as meaningfully when a third party researcher reports on a therapy

process (McNair et al., 2008; Yanos & Ziedonis, 2006). A second advantage of being a clinician-researcher is that one is in an ideal position to integrate implicit and procedural clinical knowledge into the analysis and interpretation of the data (McNair et al., 2008). Clinicians possess a wealth of knowledge that they draw on when responding to their clients and they can make this explicit in the research process and thereby offer insights that are clinically and contextually relevant. A third advantage of the clinician-researcher is that they can choose research questions that are relevant to a specific real-world setting and continue to care for the specific population that is being researched even after the study has been completed (Goodheart, 2005; McNair et al., 2008). For these reasons, clinician-researchers can provide a needed bridge between research and practice communities (Yanos & Zeidonis, 2006).

There are specific ethical considerations when assuming the role of clinician-researcher and one such consideration involves "the internal clash between the clinical mandate [to do what is in the best interests of the client] and the scientific mandate [to pursue the aims of the research project] with all appropriate rigor" (Yanos & Ziedonis, 2006, p. 250). According to Miller, Rosenstein and DeRenzo (1998, cited in Yanos and Zeidonis, 2006) one method of resolving this conflict is for the clinician-researcher to embrace their dual roles and develop a "coherent moral identity" (p. 251) "that promotes good ethical judgement" (p.251). Despite the significance of these ethical aspects, such conflicts or internal clashes generally occur within the context of randomised controlled trials where clinicians have a mandate to strictly adhere to the treatment manual and are therefore limited in terms of their flexibility. In contrast, in effectiveness research in the context of real-world settings, clinicians are encouraged to be flexible in their approach and responsive to the needs of the client rather than applying the treatment model in a rigid fashion. Ehlers and Clark (2000) also advocate for therapists to find a middle ground between structured application of the approach and flexibility in responding to the client's needs and capacities. The manner in which this balance was achieved in the present study is included as part of the phenomenology of the case narratives and can be seen in my clinical decision making. For example, in certain circumstances I chose not to conduct a reliving in the assessment phase despite this being indicated in the model because I did not feel that it was appropriate given the client's resources and capacities (*see section 5.2.1. (i) and 5.3.1. (i)*). By maintaining an awareness of the needs, limitations and capacities of a client I was able to make sound ethical judgements.

2.4. RESEARCH SAMPLE SELECTION

This research project used a convenience sample. The criteria used to select participants, the recruitment method, the process involved in selecting clients and the characteristics of the sample are further described below.

2.4.1. INCLUSION CRITERIA

For participants to be included in the study they had to: be above the age of 14; meet full criteria for PTSD as stipulated in the DSM-IV-TR (APA, 2000) and PTSD should have developed in response to rape or attempted rape; understand English and; provide consent for treatment and the use of information obtained in the course of treatment to go towards the purposes of this research project. The exclusion criteria for participation in the study included: not being able to understand English and; suffering from psychosis or mental retardation.

2.4.2. RECRUITMENT METHOD

To recruit participants for the study I visited the only government hospital in the town and spoke to staff (doctors, nurses and a social worker) and explained the nature of the research project and requested that they refer victims of sexual trauma. I provided them with recruitment posters (*see Appendix A*[2]) and requested that they circulate these around the hospital. I visited community clinics and spoke to nurses and nursing supervisors and provided them with the recruitment posters. I contacted community orientated organisations and advertised the research project to staff at these institutions. These organisations included a university student counselling centre and psychology clinic, social welfare organisations and non-governmental organisations (NGO's). I distributed the posters to these organisations and placed them in central parts of the town. I visited a number of schools in the area and explained the research project to staff and requested that they refer any students affected by sexual trauma. I alerted local psychologists to my research project and requested that they refer clients who wanted to participate in the research. I received ten referrals in total. The referral sources included the above mentioned community orientated organisations, schools and self-referrals.

[2] Please note that I use my patronymic, Anita Unni, in the poster instead of my full surname.

2.4.3. SCREENING INTERVIEW

Following the referral, I personally met with each client and explained the nature of the research process and the aims of the research project. I advised each client that I was still willing to provide them with psychotherapy even if they did not meet criteria or if they preferred, I could refer them to another professional. Each of the screening interviews lasted approximately ninety minutes. In these interviews I closely questioned each prospective client about the nature of the traumatic event and their symptomatic reactions and the effects of the trauma on their lives. For some clients it was the first time they had been invited to speak about their trauma and so it was an emotional experience and I had to reassure and calm them.

All ten clients agreed to participate in the research project and I provided them with a consent form. The consent form (*see Appendix B*) explained that participation in the research project would in no way compromise the process or professional standards of therapy and sought permission for therapy sessions to be audio-taped. In addition, the consent form provided information about the professionals who would have access to the documented information pertaining to their therapy process namely, psychology professionals bound by the standard regulations of confidentiality. Furthermore, clients' were informed that one of the aims of the project was to produce publications, including publications of case studies. They were advised that in the event of publication a pseudonym would be used and identifying details would be altered to protect their anonymity. It was explained that information regarding the case material would only be shared with the clinician's supervisor and the research team. Clients were invited to address any concerns that they had about the research project at any stage in the process. All clients indicated that they were satisfied with the measures taken to ensure their confidentiality and wanted to participate in the project. For those clients below the age of eighteen, consent was also obtained from their parent or guardian (*see Appendix C*).

Ten clients were referred in total and seven were selected for the case series. Two clients were excluded from the study because they terminated prior to the completion of the assessment process. One of these clients experienced problems with her family and reported that she could not attend session without first resolving these issues and after two sessions, she did not return to therapy. A second client, who was repeatedly raped in childhood, felt that she was not ready to confront her trauma and decided to discontinue treatment after three sessions. A third client's

therapy process occurred over an extended period of time (approximately three years) and due to the length of treatment, it could not be included as part of the study.

2.4.4. SAMPLE

The seven participants chosen for the study varied in terms of their race, age, socio-cultural, economic and educational background. Four participants were black women from disadvantaged community backgrounds while three participants were white women from urban environments. Three participants were adolescents, three others were in their early twenties and the fourth participant was in her early forties. Four participants had college education, two were in high school and one had only received a primary school education. Six of the participants were South African citizens while one was a North American citizen. She was included in the study so as to enhance cross-case comparisons to determine if any specific contextual factors interfered with the application of the treatment model. Three of the black participants were first language isiXhosa speakers while the fourth was a first language isiZulu speaker. All four of these latter participants could understand English but only three of them were fluent in spoken English while the fourth spoke mostly broken English. As such, she was encouraged to speak isiXhosa whenever she experienced difficulty expressing herself in English as I can understand isiXhosa relatively well. The white participants in the study were all first language English speakers.

The participants also differed in respect of the nature of the sexual trauma they experienced. Three participants were exposed to a drug facilitated sexual assault (DFSA). One participant was raped on a single occasion when she was ten years old. Another participant was raped by three perpetrators in the course of a single night and one of these assaults included a gang rape by two men. Two participants in the study were subjected to repeated instances of sexual victimisation from childhood onwards. Furthermore, there were significant differences in the time period between the perpetration of the trauma and the client's presentation in therapy as well as differences in terms of the relationship to the perpetrator.

The diversity inherent in the sample meant that it was useful for the creation of case law *(see section 2.2.1. (i))*.

2.5. DATA COLLECTION

The following data was used for the purposes of this study.

2.5.1. AUDIO RECORDINGS AND TRANSCRIPTS OF THERAPY SESSIONS

With the client's permission, I recorded each session and on the basis of these audio recordings I transcribed each and every session, verbatim. Transcription refers to the process of transforming spoken words into written text and there are various conventions for transcribing material (Poland, 1995). However, when working within the context of the interpretative qualitative paradigm the only requirement is that the transcript must be an accurate and thorough verbatim account of what was said by the individuals' concerned (Braun & Clarke, 2006; MacLean, Meyer, & Estable, 2004; Poland, 1995). Verbatim transcription refers to "the word-for-word reproduction of verbal data, where the written words are an exact replication" (Halcomb & Davidson, 2006, p. 38) of the spoken words. In the verbatim transcripts I included non-verbal cues such as silences and these were reflected in the presence of three periods (i.e. ...). In addition, I included the emotional reactions (e.g. crying, laughing, angry, etc) of the client so as to enhance the phenomenological aspects of the material.

Poland (1995) and other researchers (Fasick, 2001; Davidson, 2009) have emphasised the necessity of establishing rigor in terms of transcriptions especially since they form an integral part of the material on which the research is based. In this study, such rigor was established through the use of a third party assessor. This assessor held an Honours degree in Psychology and was selected for MA Counselling Psychology programme. To determine the rigor of the transcripts she: randomly selected one session from each client's completed treatment sessions; compared the transcript for the chosen session with the audio recording for that session and; completed an evaluation form (*see Appendix E-J*). The evaluation form assessed whether: any additions, distortions or omissions were present in the transcript; the number of such additions, distortions or omissions (i.e. number of words or sentences); and if present, whether these additions, distortions or omissions altered in any way the intended meaning of the communication.

2.5.2. SESSION RECORDS

Shortly after a session with a client, I created a record from memory of the events that occurred in the session. I documented aspects of the therapy process that stood out for me and included information about my experience of the session and my reflections on the client's process. In addition, I kept the research questions in mind and made note of any aspects of the session that were of particular interest in terms of the research study.

2.5.3. SELF-REPORT SCALES

I administered self-report questionnaires during the assessment interviews and throughout the treatment process for those clients who were fully conversant in spoken and written English. The self-report questionnaires provided to clients were the following:

(i) The Beck Depression Inventory (BDI-II)

The BDI-II (Beck, Steer, & Brown, 1996) is a twenty-one item measure that indicates the presence and severity of depression in adolescents and adults. Each item category consists of a graded series of four self-evaluative statements. Numerical values (0, 1, 2 and 3) are assigned to each statement to indicate degree of severity of a symptom category. The sum of all item scores indicates the severity of depression. Scores between one and thirteen indicate minimal depressive symptoms; scores between fourteen and nineteen indicate mild depression; scores between twenty and twenty-eight indicate moderate depression; and scores between twenty-nine and sixty-three indicate severe depression.

(ii) The Beck Anxiety Inventory (BAI)

The BAI (Beck & Steer, 1993) is a twenty-one item measure that indicates the presence and severity of symptoms of anxiety. The respondent is required to rate on a four point scale ranging from zero to three the extent to which s/he has been bothered by each symptom of anxiety over the preceding week. The items in the scale are summed to obtain a total score. Scores ranging from zero to seven indicate normal levels of anxiety; scores between eight and fifteen indicate mild symptoms of anxiety; scores between sixteen and twenty-five indicate moderate symptoms of anxiety and; scores between twenty-six and sixty-three indicate severe anxiety symptoms.

(iii) The Posttraumatic Stress Disorder Scale (PDS)

The PDS (Foa, Cashman, Jaycox, & Perry, 1997) is a forty-nine item instrument designed to assist with the diagnosis of PTSD. The first part of the PDS consists of a short checklist comprising twelve potentially traumatic events. The respondent is required to indicate whether s/he has either experienced or witnessed any of the traumatic events included in the checklist. In the second part of the instrument, respondents are required to describe their most upsetting traumatic event. The third part of the PDS consists of seventeen items that represent the core symptoms of PTSD and parallel DSM-IV-TR (APA, 2000) diagnostic criteria for the disorder. These core symptoms include five re-experiencing symptoms, seven avoidance symptoms and five arousal symptoms. Respondents are required to rate, using a four-point scale, the severity of the symptom indicated by each of the seventeen items. The symptom severity score, ranging from 0 to 51, is determined by summing the client's responses to the selected items. Scores ranging from one to ten indicate mild symptoms of PTSD; scores from eleven to twenty indicate moderate symptoms; scores from twenty-one to thirty-five indicate moderate to severe symptoms and; scores between thirty-six and fifty-one indicate severe symptoms. The final section of the scale includes nine items and assesses impairment in different areas of functioning. For the purposes of this research project, clients were only provided with the seventeen item rating scale to assess the nature and severity of their PTSD symptoms. The assessment interview was used to determine the nature of the traumatic event that led the client to seek therapeutic help and if the client had experienced any other traumas that required clinical attention. In addition, the interview was used to gauge the impact of the trauma on the client's life. For these reasons, sections one, two and four were not provided to the client.

2.5.4. RECORDS OF HOMEWORK ASSIGNMENTS AND PSYCHO-EDUCATIVE MATERIAL

I kept records of all written homework assignments completed by the client and copies of all psycho-educative material (e.g. information sheets, pamphlets, etc) that I provided to clients. Written homework assignments usually involved the client providing a detailed narrative of the trauma. The psycho-educative material I provided was determined by the client's needs and their particular presentation *(see Appendix K-M)*

2.5.5. RECORDS OF TELEPHONIC AND EMAIL CONTACT AND CONTACT WITH THIRD PARTIES

I documented, in the session record, any contact that I had with a client outside of session and the nature of this contact. This included telephonic or email contact. I also made a record of any contact that I had with third parties and the nature of this contact.

2.6. DATA REDUCTION

There were three levels of data reduction in this study. The first level was the assessment summary and involved a concise and thematic description of the information obtained during the assessment interviews about the client's personal history and presenting concerns. It also included information relevant to the research questions such as: whether there were any aspects influencing the client's engagement with the therapist; whether therapeutic interventions were used at this stage and the motivation for this and; if there were any contextual aspects that impacted on assessment or use of interventions.

The second level was the creation of a case formulation on the basis of the information obtained from the assessment interviews. The case formulation was organised in terms of predisposing, precipitating and maintaining factors that were understood to have contributed or to be contributing to the client's presenting problems *(see section 2.2.2. (ii))*. This is essentially an interpretative step in which certain hypothesis are generated about the client's problems. The therapy process subsequently reveals the extent to which these hypotheses are accurate and allows for the updating of the case formulation in light of new information. This process of updating is reflected in the case study.

The third level of data reduction involved the creation of each therapy narrative. This was achieved through synoptic thematic analysis and entailed identifying, analysing and reporting on themes or patterns that occurred in the data set and were relevant to the research questions. I first familiarised myself with the data and focused on coding the data. Familiarisation involves "careful reading and re-reading of the data" (Rice & Ezzy, 1999, p. 258) in an active way and identifying patterns and meanings. Coding refers to the process of identifying a feature of the data that appears interesting (Fereday & Muir-Cochrane, 2006). In familiarising myself with the

data, I first began with the session record and took note of the points that I had made in respect of the specific therapy session. I then went through the transcript and searched for the evidence of these features and also for any other aspects that emerged that were relevant to the research question. This process was made significantly easier because, while transcribing, I had highlighted and labelled specific features of the session that confirmed the points in the session record or that were of interest in respect of the aims of the study. Through this process, I was able to generate a list of ideas regarding the aspects in the data item (i.e. a specific session) that were of interest. I then repeated this process for all the sessions of a specific client and, in doing so, I identified themes or patterns across the data set. For example, one of the clients in the case series displayed marked avoidant behaviour from the outset of her therapy process. I had noted this in the session record and kept this in mind while transcribing and so I highlighted (i.e. coded) the relevant aspects of her transcript in which she had engaged in avoidant behaviour. In reviewing all her transcripts, it was clear that avoidance was a repeated feature of her presentation and therefore this aspect became a theme. After listing the patterns that I uncovered from reading and re-reading the material, I then selected the theme or themes that were important in respect of the research questions and subsequently described these aspects in the therapy narrative.

To ensure rigor in terms of the identified themes, a third party assessor was enlisted. After having compared the transcript with the audio recording, she was instructed to compare the therapy narrative of the chosen session with the transcript using an evaluation form. The assessor was provided with the Ehlers and Clark (2000) article which contained comprehensive information about the treatment model and therapy procedure. She was instructed to read the article and use it as a point of reference to determine if aspects relevant to the treatment model were comprehensively included or omitted from the narrative. She was also asked to determine: whether the final narrative was representative of the main features of the session; if the theme or themes identified were relevant to the session and; if these aspects were accurately represented in the narrative. In addition, she was instructed to identify if anything significant was missing from the final narrative that was relevant to the research questions or was simply interesting in terms of the case. Through this process, I was able to obtain information that either corroborated or were divergent from my own perspectives regarding a case and this enabled me to ensure that the subsequent therapy narratives were inclusive.

The assessor evaluated six of the case studies. The decision to include the seventh case study (*The case of Zinhle*) was made after compiling the first three cases on clients from disadvantaged community settings. This latter case was subsequently found to offer a different perspective on the treatment of client's from disadvantaged backgrounds and a decision was therefore made to include it as part of the case series. However, by the stage this decision was made, the third party assessor was no longer available and there was insufficient time to find a new assessor.

2.6.1. WRITING THE THERAPY NARRATIVE

The therapy narrative was a chronological account of a sequence of events that occurred in each session. It was thematic in that the sequence of events included was specifically selected on the basis of the research questions. These questions included: What was the goal of the session? Was this goal achieved and what was the process involved in reaching the goal? If the goal was not achieved, what aspects served as impediments? In addition, the therapy narrative was phenomenological in that it reflected my experience of the client and treatment process and the client's experiences. Furthermore, I ensured that there was complementary between the narratives and the self-report scores. For example, in terms of her self-report scores in the fourth therapy session, one of the clients (Emmy) in the case series no longer met criteria for PTSD but I still undertook imaginal reliving in that session. I therefore had to explain my reasons for doing so namely, that the client and I had agreed that it was possible she would experience intrusions in response to triggers when she eventually returned to the scene of the trauma. As such, to prevent this reliving was indicated.

The process of writing therapy narratives was not linear but iterative and reflexive. In many instances I had to rewrite therapy narratives based on my findings from other cases. In reviewing a specific client's treatment process, for example, I would come across features that I had also encountered in an earlier case. This would necessitate my going back to that earlier case and determining where and in what context this feature was present. I would then rewrite the narrative to also ensure that this feature was adequately represented. This process essentially facilitated cross-case comparison in that it enabled me to identify similarities and differences across cases. Furthermore, I found that through literature reviews and by going through other South African case studies, I became aware of certain features present in the literature that were

relevant to the cases in this project. I then had to go back to the therapy narratives to ensure that these aspects were illuminated.

2.7. DATA INTERPRETATION

Data interpretation occurred in two phases.

2.7.1. PHASE ONE

The first phase involved a case by case interpretational analysis based on questions arising from the goals of the research. To achieve this, the treatment narrative was re-examined with the following questions in mind: Was the model useful in treating the particular client? Which aspects of the therapy process contributed to significant change? Which components of the therapy process and the therapist's responses did the client find most beneficial? Were there any personal client-related aspects or contextual features that impacted on the implementation of the treatment model? Once the salient aspects were identified, I reviewed literature in search of information that further illuminated these features of the client's presentation and treatment process (i.e. the identified themes). I subsequently chose the explanation that best fit the data and then generated an interpretation of the mechanisms that, for example, contributed to: the client's particular dynamic in session; symptomatic reactions and; the outcome of the treatment process. To ensure rigor in terms of the interpretation used, my supervisor reviewed the therapy narrative and the interpretation to ensure it was credible. These interpretations can be found at the conclusion of each case study under the heading "Discussion".

2.7.2. PHASE TWO

The second phase involved cross-case comparisons. This entailed looking across the documented cases and identifying the aspects that client's shared in terms of their background, responses to interventions and any other shared features that impacted the implementation of the model. The cross-case comparison also entailed looking for themes or patterns that characterised the accounts of only certain clients to determine the variability in responses to treatment (Barker et al., 2002). I subsequently did a literature search and looked for information that shed light on these identified aspects as well as information that supported or challenged the role of these features in influencing treatment outcome. I subsequently used this information to further

interpret the data. To establish rigor, my supervisor reviewed this material to ensure that the interpretations used were relevant to and reflective of the case series.

Three of the participants in the case series experienced DFSA and these cases were interpreted separately in addition to being included in the final interpretation of all the cases. This was done because DFSA presents with specific challenges for assessment and treatment and few studies have investigated the issues that arise for individuals who experience this form of trauma. The interpretation of the DFSA cases followed the same approach discussed above.

2.8. REFLEXIVITY

Reflexivity in qualitative research is grounded in the epistemological assumption that it is impossible for the researcher to remain outside or apart from that which is being researched (Angen, 2000). The aim of reflexivity is to investigate the "ways in which a researcher's involvement with a particular study influences, acts upon and informs such research" (Nightingale & Cromby, 1999, p. 228). Reflexivity therefore involves "an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining 'outside of' one's subject matter while conducting research" (Nightingale & Cromby, 1999, p. 228).

2.8.1. PERSONAL HISTORY

With respect to my background, I am an Indian woman and my family immigrated to South Africa in 1987 when I was a child. I was raised in the Transkei which represented a homeland state. The town I lived in was an ANC stronghold and violent conflicts often broke out between supporters of this political group and other liberation fighters as well as the security forces. One particularly strong memory I have of this period involves walking to school when I was eight years old, accompanied by three of my classmates and seeing a vehicle parked near the town's sports field with blood splattered all over the windshield. One of my classmates told me that the vehicle belonged to the son of a prominent activist in the town and he was executed with a bullet to the head the night before.

A second memory I have of this time involves waking up in the middle of the night to the sounds of rapid gunfire and explosions. My family remained huddled in the main bedroom of our house until dawn when the shooting ceased. I later learnt from a friend in primary school that her neighbour, another prominent black activist in the town, and his family were slain in their homes that night and this had been the source of the gunfire. I later passed their house on my way home from school and noticed the many bullet holes that riddled the walls. My friend wanted a closer look inside the house and despite being afraid I was curious to see what had happened. We approached the house but froze once we neared the two large main windows that offered a view of the living room. The interior of the house was covered with broken glass and blood. I distinctly remember seeing an elegant skirt on the floor with blood pooled around it. My friend, one of the few white student's whose family had decided to remain in the town despite the unrest, also noticed the skirt. She then wondered out loud whether she could take it from the house, give it a good clean and then keep it for herself. I remember feeling unsettled and wondering how she could possibly wear a skirt that had been covered in the blood of a murdered woman. Her father, who was also the principal of our school, subsequently dissuaded her from any such inclinations but her sentiments remained with me. In later years, I wondered how a situation could arise where a nine year old showed no qualms about walking into the home of a recently murdered neighbour to retrieve a desired piece of clothing.

When I was an under-graduate student in psychology, I was horrified when I heard a news report on television about the rape of Baby Tsepang, a nine month old child. At the time, this event shattered my assumptive world. I wondered how anyone could possibly conceive of raping a baby. I also wondered where God was and how, if there was a God, such an incident could possibly have happened. I did not lose my faith in God but my belief in a just and meaningful world was severely shaken. As an intern counselling psychologist, I began to see an increasing number of rape victims presenting for treatment at the counselling centre where I worked. I was taken aback by the sheer number of women presenting with histories of sexual abuse. The majority of the women I treated were disclosing their sexual trauma for the first time and I felt a deep empathy for their suffering and also anger at what had been done to them. These experiences motivated my interest in the field of trauma research.

2.8.2. REFLEXIVITY IN THE STUDY

There were three distinct levels of reflexivity in this study. The first level occurred in the context of the therapy session. For example, in treating one of the client's in the case series (i.e. Khuselwa) who had been exposed to multiple sexual traumas from childhood onwards, I felt a similar sense of disillusionment with the world that I had experienced after hearing the news of Baby Tsepang. After our second session in which she disclosed her rapes, I felt a sense of dejection and sadness. I wondered what I could possibly offer her and whether anything that I gave would ever be enough to help her heal. This level of reflexivity was captured in the session records and in the therapy narratives in which I include my reflections, feelings, intuiting and thinking about my experiences of the client and therapy process.

The second level of reflexivity occurred while writing the therapy narratives. For example, while compiling the case narrative for another client (i.e. Sanele) who had also been repeatedly victimised from childhood onwards I experienced a marked sense of frustration, anger and revulsion at her neediness. While I had treated her I had felt frustrated at her unwillingness to be more pro-active in caring for and protecting herself but I had not felt angry or been repulsed. One day I found myself unable to continue writing her case study and for the next few days I experienced troubling nightmares. The most distressing of these involved my witnessing a person of indiscernible gender lying on a bed with snakes penetrating their body and subsequently transforming them into a vampire and then into a Medusa type figure.

I subsequently further researched Greek mythology (e.g. Niz, 2005) to learn about the Medusa legend. One prominent version of this myth speaks of Medusa as a beautiful woman and a priestess of Athena, the Greek Goddess of wisdom. Poseidon, the Greek God of the sea, raped Medusa in the temple of Athena. At the time of the rape, Medusa beseeched Athena to help and protect her from Poseidon but the goddess simply turned away. One version of this myth indicates that Poseidon was more powerful than Athena and so she could not intervene to stop him. Athena subsequently punished Medusa for the rape by transforming her into a hideous monster and as a result she was doubly victimised. I subsequently worked with my supervisor to unpack this dream. I believed that the snakes in the dream represented the people who had brutally hurt this client and transformed her into someone who was extremely needy (hence the vampire). I also came to realise that I had felt helpless to protect this client from the dangers in

her environment and my sense of powerlessness was enhanced by Sanele's inability to protect herself. This was apparent in her re-victimisation whilst she was in treatment. These insights subsequently informed my interpretation of her case.

The third level of reflexivity occurred during the stage of data interpretation after therapy narratives had been created and when I reflected on each client's treatment process. Through such reflection I was able to identify certain commonalities in my experiences of specific clients and as a result I had to return to certain therapy narratives and ensure that these aspects were brought out. This was particularly the case with one client (Lori). Lori was one of the first women that I had seen as part of this research project and I had often felt lost and confused in her narratives while in session (these aspects are captured and comprehensively described in the case narrative). However, I was not able to conceptualise these aspect to my satisfaction until I treated two other clients (Khuselwa and Sanele) and had written their therapy narratives and interpreted their cases. I then realised that these two clients shared certain critical features with Lori. In this instance, aspects of one client's presentation shed light on the therapy process of another. This further demonstrates the reflexive and iterative process of constructing case studies. I subsequently re-wrote Lori's case to bring out these particular features.

2.9. PRELUDE TO THE CASE SERIES

Seven case studies were created for the purposes of this research project. Each case study includes: biographical information about the client; a summary of the assessment process, case formulation and treatment plan; a narrative of the therapy process; a summary of the responses to the self-report scales (where available) in the form of a graph and; an interpretation of the salient themes in each case within the context of the research questions. A key aim of this study is to examine the treatment of PTSD in response to sexual trauma. As such, the case series is organised in terms of the nature of the sexual trauma the client was exposed to. Two clients, Zinhle and Lulama, were exposed to what Herman (1992a, b) conceptualises as isolated, discrete traumatic events. Two clients, Khuselwa and Sanele, were subjected to repeated and multiple episodes of victimisation. Three clients, Anna, Emmy and Lori, suffered drug-facilitated sexual assaults (DFSA). These case studies are presented in the next chapter.

RESULTS: THE CASE SERIES

CHAPTER 3: PTSD IN RESPONSE TO ISOLATED SEXUAL TRAUMAS

Two clients, Zinhle and Lulama, were exposed to isolated sexual traumas and their case studies are presented below.

3.1. CASE 1: ZINHLE

Zinhle was a nineteen year old, isiZulu speaking, first-year university student. She had lived with her family in a township community on the outskirts of a major South African city. However, after receiving funding for her tertiary education she relocated to further her studies in the University town. Zinhle had been raped at the age of ten and, four months prior to her entry into treatment, the perpetrator of her rape had been killed due to his involvement in gang activity. The news of his death led to her reviewing the trauma and this triggered a resurgence of her symptomatic reactions and she decided to seek help to cope with her distress.

3.1.1. THE ASSESSMENT PHASE: RESULTS

The assessment process with Zinhle consisted of four interviews of approximately sixty minutes duration each. She was seen twice a week during this process.

(i) Assessment interviews

A2: BDI: 17; BAI: 21; PDS: 24

<u>Building a narrative of the trauma</u>

In the initial two assessment sessions, I focused on gathering information about the traumatic event. I explained to Zinhle the nature of my role as her therapist and emphasised that I wanted to help her cope with her trauma. I then invited her to share her experiences with me and she was clearly relieved and proceeded to describe the traumatic event.

Zinhle reported that her neighbour was the wealthiest family in their community and that as a young child she was often baby-sat by their neighbour's housekeeper. During these periods, the neighbour's five teenage sons would expose themselves to her, undress her and touch her body. They threatened to hurt her if she disclosed their behaviour to her parents and so she kept the

abuse a secret. Their abusive behaviour did not escalate to sexual molestation or rape because Zinhle was removed from her neighbour's care. This was after her mother (Hlengiwe) decided to stop working to better care for her four children on a full time basis. I determined that in her childhood years, Zinhle had not experienced any severe symptomatic reactions (e.g. intrusive re-experiencing) in relation to the abuse but she had feared her neighbour's sons from then onwards.

When Zinhle was ten years old, one of her neighbour's sons developed a romantic interest in her older sister (Zodwa) and started intimidating Zodwa. Zodwa eventually disclosed the matter to her parents who intervened and put a stop to his behaviour. One afternoon, a few weeks after her parent's intervention, Hlengiwe sent her eight year old son (Mandla) to a nearby shop, owned by their neighbours, to purchase vegetables for a dish she was preparing for supper. Half an hour later there was still no sign of Mandla and Hlengiwe then requested that Zinhle visit the store and find out what was keeping him. Zinhle, however, refused because she feared running into the neighbour's sons but her mother interpreted her behaviour as disobedience and became angry. As a result, she conceded and went to the store and found her brother playing with their neighbour's sons. She insisted that he return home but he pleaded that they wait until he finished his game. Zinhle then became angry and informed him that she was returning home and that if he did not return with her their mother would be extremely upset. The man who intimidated her sister then intervened and informed her that he had to speak to her and pulled her aside and walked with her towards a van situated in the back-yard of his house.

Once they approached the van he violently pulled her inside and started to remove her clothing. She screamed and tried to exit the vehicle but found that she could not release the locking mechanism. She then started banging on the windows. The perpetrator subsequently became more aggressive and held her down and then started searching the floor of the car and Zinhle had felt confused by his actions. He eventually brought out a plastic packet and used this as condom before raping her. Zinhle had screamed throughout the ordeal and banged on the doors of the locked van and cried for her mother and brother. Mandla eventually heard her screams and ran to the van but he could not grasp what was happening. He eventually located their neighbour's other sons and demanded that they open the van. Once it was open, Zinhle got out and ran home and locked herself in her room. While in her room, she felt extremely distressed

and lay down on her bed and the memory of the rape kept replaying in her mind. I asked after her thoughts at the time and learnt that she had feared that the perpetrator would chase after her and enter her room and try and kill her. She also feared that she might have become pregnant or contracted the HIV virus.

The following day Mandla insisted that Zinhle tell their mother what had transpired in the van and she eventually conceded. Hlengiwe was extremely angry after hearing of the trauma and reprimanded Zinhle for not alerting her to the situation earlier. She subsequently contacted her husband (Vusi) who hurriedly returned home. Vusi and Hlengiwe immediately confronted the perpetrator's father who dismissed the issue and informed them that if they tried to prosecute, he would ensure that they lost the case. After the confrontation, Zinhle's parents took her to the hospital and the police station where they opened a case docket. The perpetrator was arrested shortly thereafter but released on bail. Following the perpetrator's arrest, members of the community became aware of the situation and offered Zinhle and her family support and care. The case went to trial three months later and Zinhle and her younger brother were required to testify. However, the perpetrator was eventually acquitted due to insufficient evidence and conflicting statements by Zinhle and Mandla. Following the verdict, certain community members began to change their attitude towards Zinhle and her family and accused them of fabricating the story to obtain some of their neighbour's wealth. They also told Zinhle that if the story was true, she was solely to blame for the rape. Their rejecting and hurtful behaviour prompted Zinhle to isolate herself for years following the trauma and she refused to leave her home except to attend school and extra-curricular sporting activities.

Following her narrative, I asked Zinhle how she was coping and she reported that it was a huge relief to finally be able to speak openly about her experiences and she was grateful that I was willing to hear her story. I learnt that in the weeks and months following the trauma, her parents enforced a silence surrounding the rape and she now believed that their behaviour had been aimed at protecting her from becoming distressed. However, at the time, she had desperately wanted to talk about the rape and receive comfort and reassurance. After the trial, Zinhle's parents sent her to live with a relative in a different city for six months. Zinhle believed that this was to protect her from the negative behaviour of the community and from any encounters with the perpetrator but, at the time, she had felt rejected and abandoned. Once she returned home,

the silence surrounding the rape was even more pronounced and she felt even more alone and abandoned.

Zinhle reported that her parent's behaviour had also been motivated by their assumption that for her to recover she needed to forget about the trauma. However, she interpreted their silence to mean that they held her responsible for the rape. As a result, she distanced herself from them. She refrained from sharing her experiences and feelings and only discussed arbitrary issues with her parents. She had also been extremely angry with her younger brother and elder sisters (Zodwa and Amahle) for following their parent's directives in keeping silent about the trauma. For this reason, she distanced herself from them. Zodwa and Amahle moved out of the family home two years after the trauma to pursue their careers and Zinhle only saw them occasionally. She subsequently found it difficult to reconnect with them and establish a meaningful relationship.

Building social support

Despite having the option of studying at a university situated in her home city, Zinhle had chosen to study at an institution in a different province to escape her memories of the trauma and her family situation. However, she felt intensely alone and isolated and this was exacerbated by her difficulties establishing close friendships. Zinhle feared that if other people learnt that she had been raped as a child they would react negatively towards her by blaming her for the trauma and rejecting her. She also assumed that she had nothing positive to share with others about her childhood and adolescence. For these reasons, she maintained superficial relationships which left her feeling lonesome.

I was very concerned about Zinhle's social isolation and I focused on helping her form a closer relationship with her family. I psycho-educated her about the effects of sexual trauma on a victim's family and explained that her parents, like many people, had not known about the psychological effects of rape. I emphasised that they had not realised the necessity of the victim speaking about the trauma and had assumed that for a victim to heal, she needed to forget. I used Socratic questioning to help her fully appreciate that their actions had not been malicious but was simply motivated by an inaccurate assumption and their desperate desire to shield her from further distress. I stressed to Zinhle that, from their actions (e.g. confronting the

perpetrator's father, reporting the case to the police and taking the case to trial), it was clear that they did not blame her for the trauma and instead held the perpetrator solely accountable and wanted to ensure he was punished for hurting her. After my comments, Zinhle appeared surprised and then sad. When I reflected on this, she started crying and reported that she had not fully realised that her parent's and siblings had merely been trying to protect her. She indicated that she now appreciated that they had not known that what she had really needed was to speak about the trauma and be comforted. I affirmed this and emphasised that her family had never intended to harm her.

I proposed to Zinhle that she begin to reconnect with her family and suggested that she either write to them or telephone them on a weekly basis and share her experiences of varsity. Zinhle first wanted to reconnect with her sisters and decided that she would contact Zodwa. I actively encouraged her. I advised her to identify a few stories to share so that she would have something to say and not feel anxious or awkward and she agreed. In our third session, Zinhle was elated and reported that she had contacted Zodwa and told her that she wanted them to be friends. To her marked surprise her sister apologised for not taking the initiative and establishing a relationship with her earlier. She invited Zinhle to keep in touch with her and provided her with extra funds to make phone calls to her twice a week. I used this incident to further illustrate to Zinhle that her siblings loved and cared for her and, from her sister's responses, it was apparent that she wanted to know her. I actively encouraged Zinhle to stay in touch with her sister and to gradually build a relationship with her other siblings as well as her parents. She now believed that she would be able to achieve this.

Investigating post-trauma reactions

In the weeks and months following the trauma, Zinhle had experienced severe flashbacks that took the form of nightmares involving being trapped in the van and being raped. She coped with these intrusions by suppressing her memories of the trauma and not thinking about the assault and her symptoms gradually declined after a year. Zinhle displayed avoidant behaviours after the rape in that she had been afraid to enter any van that resembled the one in which the trauma occurred. Her school mini-bus was similar to this vehicle and she experienced intense anxiety whenever she was in the bus. She avoided being seated in the front seat as this was where the trauma had occurred. Zinhle also avoided looking or venturing into the back-yard of her home so

that she would not have to see the perpetrator's house. In addition, she felt extremely jumpy and overly alert when in her community and as a result, she secluded herself at home after school.

For years following the trauma, Zinhle had wished and prayed that the perpetrator would be severely injured and die a gruesome death and, after hearing of his murder, she experienced intense feelings of guilt. She believed that she had somehow caused his death through her wishes and prayers. I normalised her reaction and explained to Zinhle that it was expected that she would have wanted to hurt the perpetrator given the damage he had caused to her life and her family. She was clearly relieved by my comments. I used Socratic questioning to help her appreciate that the perpetrator had been involved in criminal activity and this came with risks which included being injured and killed. She had therefore not done anything to instigate his murder.

At the age of fifteen, Zinhle established a close friendship with a girl (Imani) in her class who lived in a completely different neighbourhood and, despite her negative expectations, she decided to tentatively disclose the trauma to Imani. To her surprise Imani wept for her and offered her comfort and reassurance and she believed she had finally found a trustworthy and reliable friend. Zinhle later became involved in a romantic relationship with Imani's older brother (Nathi) who was also studying in high school. At the time she had not believed she would be able to enter into romantic relationships because of her negative attitude towards men. Due to the rape, Zinhle believed that all men were untrustworthy and would hurt her if given a chance. She therefore decided that she would never be romantically involved or get married. However, as her friendship with Imani grew, she became more acquainted with Nathi and experienced him as being warm, kind and supportive. She eventually disclosed the trauma to him and he was extremely angry on her behalf and comforting and supportive and she felt able to trust him. The relationship ended after Nathi relocated to pursue his tertiary education. Zinhle reported that, despite having being involved with Nathi, she still harboured negative beliefs towards men and this interfered with her establishing friendships with any of the young men she met. Whenever she interacted with a man, she experienced intense feelings of anger and would eventually walk away from the conversation. I explained to Zinhle that the anger that she experienced was actually intended for the perpetrator but since she had not been able to voice her outrage at having been victimised, her anger was being misdirected at others who were entirely innocent.

This resonated with her and she reported that she wanted to be able to hold a conversation with a man without feeling angry and establish friendships with the male students that she met.

Crisis management

Zinhle was markedly distressed when she arrived for our final assessment session and reported that she had experienced a nightmare involving the rape and her being trapped in the van and these dreams had left her badly shaken. She had also experienced a dream in which the perpetrator approached her and attempted to befriend her. Zinhle believed that the perpetrator was trying to reach her through her dreams to seek forgiveness. This left her feeling distressed because she could not conceive of forgiving him given the damage he had wrought on her life. I focused on stabilising her by first normalising her experiences. I explained to Zinhle the concept of triggering and emphasised that because she had spoken about the trauma in detail for the first time, her memories of the rape had been activated. I psycho-educated her about PTSD and used the 'cupboard analogy' to describe information processing in memory. I explained that because of the frightening nature of her ordeal, her mind had not been able to make sense of what was occurring. As a result, information about the trauma had simply flooded in and had not been properly organised in memory which caused her symptoms. Zinhle was initially extremely relieved to learn that her symptoms were normal reactions to the trauma but she then appeared distressed and asked whether it was possible to ever recover from PTSD. I reassured her that PTSD could be treated and explained that this entailed processing the trauma memory by visualising the trauma and vividly describing what had occurred. Zinhle was relieved to hear this and enthusiastically reported that she wanted to immediately engage in a reliving. I proposed to her that we conduct the reliving in our first therapy session as we had almost reached the close of our current appointment. I advised her that sessions involving reliving usually took more than an hour and Zinhle reported that she would absent herself from one of her lectures so that she could devote at least two hours to our subsequent session.

3.1.2. DIAGNOSIS

On the basis of the assessment interviews and Zinhle's scores on the self-report scales (BDI: 17; BAI: 21; PDS: 24) she was diagnosed with the following:

(i) PTSD

Zinhle met diagnostic criteria for PTSD and experienced intrusive memories related to the traumatic event. Her intrusions took the form of nightmares involving being trapped in the van in which the trauma had occurred and being raped by the perpetrator. Zinhle experienced symptoms of hyper-arousal and felt overly alert, jumpy and easily startled when in her community. This reaction was also triggered when she had to enter motor vehicles that resembled the van in which the rape had occurred and so she avoided these situations. In addition, she avoided venturing into the back-yard of her house or looking at the perpetrator's house as this generated feelings of distress. Zinhle first met diagnostic criteria for PTSD in the months following the trauma but her symptoms gradually declined in intensity after a year. However, four months previously, she received news of the perpetrator's death and this prompted her to think about the rape which led to the re-emergence of her PTSD symptoms.

(ii) Major Depressive Disorder (Single episode, moderate)

Zinhle met diagnostic criteria for major depression. She believed that the rape had contributed to her family growing apart and her hesitance to form meaningful relationships which left her feeling sad and alone. In addition, she assumed that, by remaining silent about the rape, her family held her responsible for the trauma and she felt hurt, rejected and abandoned. Furthermore, Zinhle believed that by wishing for the perpetrator's demise she had somehow contributed to his murder and she felt extremely guilty. This enhanced her depressed mood.

3.1.3. CASE FORMULATION

(i) Predisposing factors

Zinhle was raised in a loving and caring home environment and felt particularly close to both her parents. Her father (Vusi) was the sole bread winner in the home and he worked late hours but every evening he ensured that he spent time with his children. Zinhle's mother (Hlengiwe) spent her days caring for her children and she provided them with routine and stability. She encouraged Zinhle to share any problems she was experiencing. Hlengiwe also consistently disciplined her children by admonishing them whenever they behaved in a way that she disapproved.

When Zinhle was ten years old she was raped by a neighbour and her parents had not known how to support her in coping with the trauma. Vusi and Hlengiwe believed that for their child to recover, she needed to forget what had occurred. As a result, they enforced a silence surrounding the rape refusing to discuss what had occurred. Zinhle interpreted their silence to mean that they blamed her for the rape and did not care about her and she felt hurt, angry, abandoned and alone. Zinhle's community was initially supportive of her family following the rape but, after the trial, a few community members reacted negatively towards the family. They accused Zinhle's family of fabricating the story to gain some of their neighbour's wealth. They also told Zinhle that if the story were true, she was to blame for the trauma. She had felt extremely distressed by their behaviour and unable to turn to her family for support. Shortly after the trial, Zinhle's parents sent her to live with a relative for six months to protect her from any encounters with the perpetrator. However, she interpreted their behaviour as rejecting and felt even more abandoned. Following her return home, her family's silence surrounding the rape had become even more pronounced and despite desperately wanting to share her distress, she felt unable to broach the topic. As a result, she suppressed her memories of the trauma in an attempt to cope.

(ii) Precipitating Factors

Four months prior to her entry into therapy, the perpetrator of her rape was murdered. After hearing of this, Zinhle started thinking about the trauma and this led to a resurgence of her symptomatic reactions. She felt markedly distressed and decided to seek professional help after registering at varsity.

(iii) Maintaining Factors

Zinhle's coping strategies contributed to the maintenance of her symptoms. She refrained from revealing her distress to others lest they react in an unsupportive and hurtful manner and this prevented her from receiving the care and support she needed. It inhibited her from disconfirming her maladaptive assumptions regarding the availability and responsiveness of those close to her. This contributed to her feeling sad, alone and isolated. Furthermore, her reluctance to share the trauma with others and to express her feelings in relation to her ordeal inhibited her from processing the traumatic event. These aspects maintained her symptoms.

3.1.4. PRESENTATION OF TREATMENT PLAN

I discussed the case formulation and treatment plan with Zinhle in the fourth assessment session. I explained that from the initial interviews I had identified the following areas as requiring intervention. I invited her to share her thoughts about each of these areas and to include in the treatment plan any other areas that she believed required intervention.

- PTSD symptoms: I identified Zinhle's PTSD reactions (e.g. intrusive re-experiencing in the form of nightmares and flashbacks; avoidance of reminders such as being in the back-yard, looking at the perpetrator's house, or entering into certain vehicles; and hyper-arousal including feeling jumpy and overly alert when in her community). I then explained how PTSD developed and the strategies used to target symptoms (e.g. imaginal reliving) in terms of the treatment model. I advised Zinhle that, to address her avoidance, it would be necessary for her to gradually expose herself to the situations she avoided. This included: looking at the perpetrator's house; venturing into her back-yard; walking in her community and; approaching vans that resembled the one in which the rape occurred. I explained that this would aid 'then versus now' differentiation and allow her to appreciate that these situations were no longer dangerous. Zinhle reported that she wanted to make a concerted effort to enter these situations when she returned home. I emphasised that, with successful processing of the trauma memory, these situations would lose their ability to trigger intrusions and anxiety reactions.
- Social Isolation: I acknowledged the necessity of Zinhle establishing more meaningful relationships. I then emphasised that to achieve this we need to work on addressing the negative beliefs that inhibited her from engaging with others. This included her belief that: others would reject her because she was a rape victim; she had nothing positive to share about her life and; all men were untrustworthy and could potentially hurt her. Zinhle affirmed that these were the beliefs that prevented her from connecting with others and that she wanted to address these negative assumptions.

Zinhle did not have anything else to include in the treatment plan but reported that she would let me know if she wanted to add other focus areas. She indicated that she felt confident about the treatment plan and was eager to begin processing the trauma memory. The treatment plan involved seeing Zinhle once a week for six to twelve therapy sessions.

3.1.5. THERAPY NARRATIVE

Zinhle was seen once a week for five therapy sessions of between sixty and ninety minutes each.

Therapy session 01

Focus area: PTSD

In the session, I focused on targeting Zinhle's PTSD reactions. She arrived early for the appointment and reported that she wanted to process her memories of the trauma but feared becoming emotionally overwhelmed. I normalised her fears and explained that reliving had the potential to be harrowing but that her distress would not be indefinite. I emphasised that she had coped extremely well with the initial retelling and actively argued that this was evidence that she could tolerate a reliving. I also reassured Zinhle that I would work with her to address any adverse reactions that arose from the reliving. She was then more confident about engaging in the procedure.

I proposed to Zinhle that she draw the layout of her house and that of the perpetrator to help her visualise what had occurred and she agreed to this. After drawing the layout and explaining the content of her drawing, Zinhle closed her eyes and I guided her to relive the trauma memory. I learnt that on the day of the trauma she had not been able to locate her brother at the store and had gone to their neighbour's house in search of him. The perpetrator answered the door and informed her that Mandla was playing with his siblings inside and she was welcome to join them. She declined and remained just outside the door and started calling to her brother. Mandla eventually shouted back that he wanted to finish his game and Zinhle felt angry with him for keeping her waiting at the house of the people she feared. As she waited the perpetrator began to make advances towards her and she felt uneasy and embarrassed. He told her that she was an attractive girl and asked her if she had a boyfriend. Zinhle had felt stunned at his question as she was only ten years old. Her brother and his friends then appeared and a girl who lived across the street also came into the yard and they all began to chat and joke. Zinhle then felt safer knowing that her brother and another girl were now present.

After a few minutes, the perpetrator told Zinhle that he needed to tell her something in confidence and suggested that they move away from the group and take a walk further into the back-yard. She felt anxious but obliged because she did not think any harm would come to her

since there were so many people nearby. As they walked the perpetrator gradually manoeuvred her towards a van stationed at the periphery of the compound. As soon as they reached the vehicle, he violently grabbed Zinhle's arm and forced her into it and she felt shocked and confused. He then started to undress her and she cried for help but the van was too far away for anyone to hear her screams and she tried banging on the door. As the perpetrator was raping her, she heard her mother angrily calling for her and Mandla to return home. She immediately stopped screaming as she feared that her mother would be intensely upset with her for not returning home timeously. She then heard her brother's footsteps as he ran past the van in search of her and so she started banging on the door and crying. Mandla eventually heard her and tried to pry the door open but could not. He then summoned the perpetrator's brothers and demanded they open the van. They wrestled with the back door and just before they could pry it open, the perpetrator quickly dressed and hurriedly left the vehicle.

Once her side of the vehicle was open, Zinhle started crying and her brother noticed that she was not fully clothed and assumed that she had been involved in some tryst and started mocking her. She felt hurt and ashamed and fumbled with her clothing and then dashed home. As she lay on her bed she kept staring at the window fearing that the perpetrator would try to break it open and then kill her. The next day she woke up early and took her clothes off and threw them in a garbage bag. She spent more time than usual bathing herself as she felt dirty and wanted to wash the perpetrator off of her. At the breakfast table Mandla continued to mock her and threatened to tell their mother about the incident if she did not purchase a chocolate bar for him at school. She conceded but after getting the chocolate bar Mandla insisted that she disclose what had occurred to their mother. After her disclosure to Hlengiwe, Mandla isolated himself in his room for the rest of the day and Zinhle felt hurt and alone.

After the reliving, I asked Zinhle how she was coping and she reported that she felt anxious but very relieved and proud that she had been able to speak about the trauma in such detail. I encouraged her and explained that her ability to relive the trauma was reflective of her capacity to tolerate her memories.

It was clear that Mandla had been shocked to learn that his sister had been raped that night and guilty that he had mocked her and for this reason, he had secluded himself in his room. However,

Zinhle interpreted her brother's behaviour as further evidence that he was not concerned about her. I used Socratic questioning and helped Zinhle to appreciate that her brother had felt horrified, guilty and angry with himself for not returning home with her timeously that night and for teasing her immediately after the rape. I explained that Mandla had been a nine year old child at the time of the trauma and he had also needed support to cope with the rape and had not known how to care for her. I emphasised that he had not meant to hurt her. Zinhle appeared tearful after this and reported that she had not considered this before. At the close of our session I advised Zinhle on the methods she could use to calm herself in the event that she felt distressed outside of therapy (e.g. deep breathing exercises or having a warm bath). She reported that she intended to relax after the session.

Therapy session 02 [BDI: 10; BAI: 19; PDS: 12]

Focus area: PTSD; Enhancing social support

I asked after Zinhle's experiences since the reliving and learnt that she had absented herself from all her lectures that day and used the time to relax and calm herself. She had lain on her bed and thought about the rape and the reliving. She also thought about how she had grown apart from her family and had felt extremely sad and cried. She then experienced intrusive memories of being in the van and of the rape itself. However, she did not feel overly distressed because she realised that these were unprocessed fragments and the trauma was over and she had survived. She believed that, since she had coped with the reliving, she could tolerate these intrusions and, instead of avoiding her memories, she allowed herself to dwell on each intrusion and experience the emotions that were evoked. After a few hours the flashbacks ceased and Zinhle reported that the subsequent day she felt as if a "rock had been removed" and that she was "free". I was surprised by Zinhle's reaction to her intrusions and explained that her behaviour was further evidence of her strength and resourcefulness in being able to cope with the effects of the trauma. She agreed with me and believed that she was well on the road to recovering.

In accordance with the treatment plan, I used the session to enhance Zinhle's social support base by targeting the maladaptive beliefs that inhibited her from engaging with others. It was clear that the rape had dominated her memories of her childhood and adolescence and for this reason she assumed she had nothing positive to share with others about her life. I therefore used guided discovery and helped Zinhle to reflect on her childhood and adolescence and identify memories

of times when she felt joyful and connected to others. She engaged well with the task and shared her memories of: helping her mother prepare meals for the family; getting up to mischief with her younger brother; watching movies with her older sisters and being cared for by them and; spending weekends with Imani and Nathi. Zinhle was surprised and tearful that she had disregarded these memories and I emphasised that she had much to share with others that was positive about her life.

I actively argued that she was in no way to blame for the trauma and again emphasised that, given their actions, her family clearly did not believe she was responsible for the rape. I used Socratic questioning to help her realise that her community members had been extremely malicious and irresponsible in blaming a ten year old child for her victimisation. I used Imani's and Nathi's responses as evidence that there were others who understood that she was innocent. In addition, I actively encouraged her to spend time with her fellow students and to engage with them rather than isolate herself in her room. I later learnt that Zinhle spent evenings in the common room of her university residence rather than alone in her room and she was gradually developing friendships with three of the young women that she lived with.

Zinhle contacted me two days prior to our third session and reported that she needed to prepare for her exams and was coping well and requested she be absented for two sessions. She was extremely apologetic and I explained to her that I understood that her academic work was a priority and we arranged to have two more sessions shortly after her exams.

Therapy session 03 [BDI: 9; BAI: 0; PDS: 6]

Focus area: Social support

Two weeks later I saw Zinhle for her third therapy session. I determined that she had not experienced any intrusions and was feeling much happier and lighter. She reported that she had decided to establish contact with her eldest sister. To her surprise Amahle had also been extremely excited to hear from her and shared humorous stories with her about her life. Zinhle had thoroughly enjoyed the conversation and believed she was gradually healing the rift that separated her from her siblings. However, she was still hesitant to share her life with them as she was extremely unaccustomed to interacting with her sisters and feared they may react negatively towards her. I encouraged Zinhle and emphasised that her hesitance in revealing herself was

related to the novelty of the situation and as she came to know her siblings, she would feel freer with them.

Zinhle reported that she desperately wanted to reconnect with her parents but she still had difficulty reconciling their behaviour following the trauma. I enquired further and learnt that in the months following the rape Zinhle had written letters to her parents telling them she was hurting and needed their support. However, they had not changed their behaviour towards her and this still left her feeling hurt and angry. I subsequently closely questioned Zinhle about her letters and learnt that she had not addressed the sealed envelopes but had simply left them lying around her room. She had assumed that her parents would notice and read them. I reflected on the possibility that her parents had not been aware that the letters were intended for them and had not opened the envelopes because they had not wanted to invade her privacy. Zinhle was markedly surprised and reported that she had not considered this possibility and had simply assumed they had not cared about her. She then sobbed and reported that she wanted to share her experiences of the trauma with her parents but did not know how to go about speaking to them. I proposed to her that we plan how best to go about this in our subsequent session which would be our final session before the five week long university holidays.

Therapy session 04

Focus Area: Crises management

Zinhle had received word from her mother the previous day that her cousin had been shot and killed but she did not know of the circumstances surrounding the murder. Zinhle did not have a close relationship with her cousin but she was still fond of him and felt shocked and horrified at his death. I focused on stabilising her and explained that it was expected that she would feel shocked by this news as it was completely unexpected. I emphasised that she was returning home the subsequent day and would be able to determine exactly what had occurred. Zinhle reported that she had not yet absorbed the news of her cousin's death and that it would be helpful for her to be with her family at this time and I affirmed this.

In these circumstances, it was not appropriate for Zinhle to speak to her parents about her trauma and I advised her to approach them at a later stage during the holiday period. I helped her to prepare for her eventual conversation by role playing what she intended to say. Zinhle

wanted to share with her parents her sense of having been abandoned after the trauma and her desire to establish a closer relationship with them. I encouraged her to imagine how her parents might respond and to predict the reactions she feared receiving. Zinhle worried that her parents might react by admonishing her for not approaching them earlier. I reminded her that she had not been able to reach out to her parents because their silence surrounding the trauma had left her feeling hurt and alone. She decided that she would explain this to them in the event that they reacted as she predicted. I also advised Zinhle to write down her dialogue and to visualise speaking to her parents and she decided to use this technique.

Zinhle reported that she had established a friendship with a male student in her class but feared that her negative attitude towards men could potentially damage the relationship. I used Socratic questioning and guided discovery to help Zinhle realise that the perpetrator's actions did not generalise to all men. I used her relationship with Nathi and her father as evidence that there were men who were caring and respectful towards women and who would not hurt her. I emphasised that the rape was an isolated incident and that she had positive experiences with men and she should not disregard these memories. Zinhle believed that she would require more time before she felt able to trust men and establish close relationships with the men she liked. However, she was determined not to let the rape deter her and I encouraged her to maintain her friendship.

Therapy session 05 [BDI: 0; BAI: 0; PDS: 0]

Endings

Five weeks later Zinhle made an appointment to see me and I determined that her symptoms had completely resolved. She reported that while at home she had felt confident about her ability to cope with the trauma memory and had ventured into the back-yard of her home. She had looked at the perpetrator's house and had not felt anxious or experienced intrusions. Zinhle had also not been perturbed by the sight of the vans parked in the back-yard of her neighbour's house. In addition, she had walked around her community and had not felt overly alert or jumpy. It was clear that the trauma memory had been processed and I reflected on this and emphasised that Zinhle had been courageous in the steps she had taken to confront her memories and address the impact of the rape.

I asked after her cousin's death and Zinhle reported that her mother had been the most upset at the loss and that the rest of the family were not as close to her cousin. As such, they had not been as affected and so they consoled and comforted Hlengiwe.

I also learnt that during the holiday period Zinhle had tried to form a closer bond with her parents and her siblings by actively sharing with them her experiences at varsity. Her family had been very attentive, interested and caring and she had felt loved and supported. Zinhle believed she first needed to re-establish a connection with her parents before she could feel safe enough to speak to them about the trauma. She felt that she had initiated this process during the holidays and I acknowledged this and encouraged her to continue to share her life with her family.

I asked Zinhle how she felt about therapy and she reported that she believed she had achieved her treatment goals and therefore did not need to continue. She reported that her symptoms had resolved and she felt more connected to her family and had established friendships at varsity and was in a much more positive space. I affirmed that she had made remarkable progress and encouraged her to foster her relationships. I invited Zinhle to return to therapy if she ever felt that she needed to and she agreed to this.

Subsequent contact

Five months later Zinhle contacted me briefly and reported that she had decided to relocate and move back home and pursue her studies at the university in her home city so that she could be closer to her family. It was clear she had successfully reconnected with her parents and siblings and did not feel the need to stay apart from them. She thanked me for helping her cope with the trauma and I wished her well with her future.

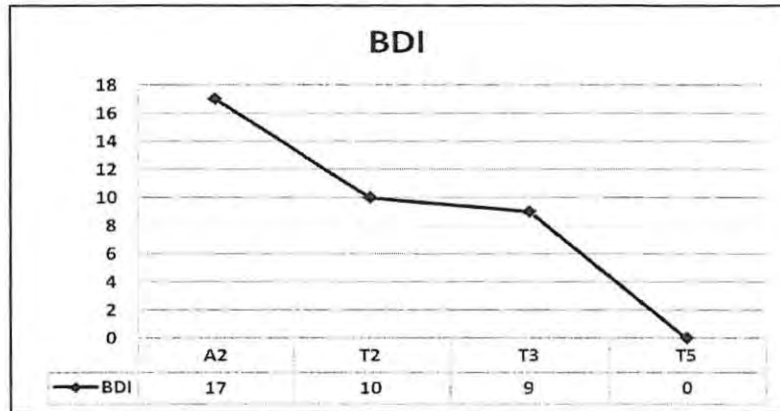
3.1.6. RESPONSE TO THERAPY

According to the self-report scales, Zinhle had completely recovered from her symptomatic reactions at the conclusion of her treatment process. Responses on the self-report scales are displayed in figures 1 to 3.

(i) BDI

[Symptom scores: 1- 13 = Minimal; 14-19 = Mild; 20-28 = Moderate; 29-63 = Severe]

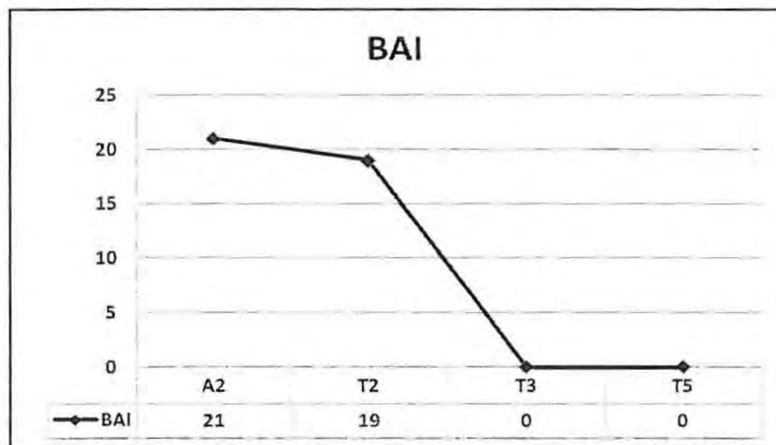
Figure 1: ZINHLE BDI SELF REPORT SCORES



(ii) BAI

[Symptom scores: 0-7 = Normal; 8-15 = Mild; 16-25 = Moderate; 26-63 = Severe]

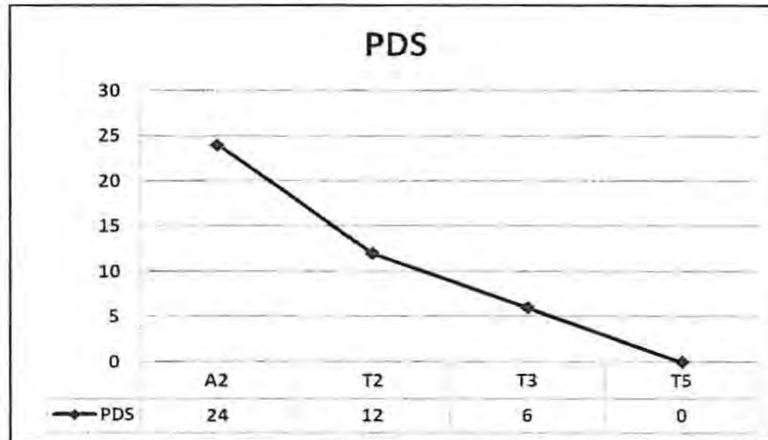
Figure 2: ZINHLE BAI SELF REPORT SCORES



(iii) PDS

[Symptom scores: 1-10 = Mild; 11-20 = Moderate; 21-35 = Moderate/Severe; 36-51 = Severe]

Figure 3: ZINHLE PDS SELF REPORT SCORES



Zinhle presented with clinically significant symptoms of depression (BDI: 17), anxiety (BAI: 21) and post-traumatic stress disorder (PDS: 24) at the outset of treatment. There were substantial decreases in her symptoms of depression (BDI: 10) and PTSD (PDS: 12) by her second therapy session and a minor decrease in her anxiety levels (BAI: 19). The changes in her depressive symptoms are attributable to the interventions used to enhance her social support base. This included: psycho-education about the effects of trauma on a victim's significant others; addressing her negative assumptions regarding the behaviour of her family and; actively encouraging her to form connections with her siblings and fellow students. These interventions prompted Zinhle to establish contact with her sister and the positive response she received left her feeling less isolated and alone. In addition, her feelings of guilt associated with her belief that she had contributed to the perpetrator being murdered was normalised and this improved her mood. The reduction in Zinhle's PTSD and anxiety symptoms were the result of psycho-education in the fourth assessment session which normalised her PTSD symptoms and imaginal reliving in the first therapy session which facilitated processing of the trauma. Reliving revealed to Zinhle that she could tolerate exposure to the trauma memory and she was able to engage in self-initiated exposure to intrusions which further facilitated processing. After her second therapy session Zinhle cancelled two subsequent appointments owing to academic commitments. By our third session two weeks later she experienced residual symptoms of depression (BDI: 9) and PTSD (PDS: 6) while her anxiety (BAI: 0) had completely resolved. The therapeutic focus thereafter was

on enhancing her social support base. This involved targeting the negative assumptions that inhibited her from forming close relationships with her family and sustaining relationships with men. There was a five week break from therapy after our fourth session and when Zinhle returned her residual symptoms had completely resolved (T5: BDI: 0; BAI: 0; PDS: 0). While on holiday, Zinhle had confronted the situations she usually avoided because they reminded her of the trauma and she found that she was no longer distressed by these situations. She also managed to reconnect with her family and these changes led to the complete resolution of her symptomatic reactions.

3.1.7. DISCUSSION

Zinhle's rapid recovery with short term therapy was the result of her readiness and motivation to engage with treatment. In terms of Prochaska's and DiClemente's (1982) classic stages-of-change model, Zinhle was clearly in the preparation stage when she entered into treatment. She recognised that the trauma had severely affected her life and relationships and wanted to recover from her symptoms and form more meaningful connections with others. She rapidly moved into the action stage during the assessment process itself. According to the model, in the action stage, the individual "modifies their behaviour, experiences, and environment in order to overcome their problems. Action involves the most overt behavioural changes and requires considerable commitment of time and energy" (Prochaska & Norcross, 2001, p. 444). Zinhle acted on her goal of establishing more meaningful relationships with her family by contacting her sister (*see A3*) and disclosing her need to form a friendship with her. In addition, she took active steps to address her social isolation. She started spending time in the common room of her residence and socialising with fellow students rather than isolating herself in her room.

Zinhle's transition from the preparation to action stages were facilitated by therapeutic responses that took into account her needs and capacities. I was acutely aware that Zinhle was extremely socially isolated and that one of her primary goals for treatment was establishing meaningful relationships and so I intervened to enhance her social support base. This entailed addressing the maladaptive assumptions that inhibited her from reaching out to others and forming relationships and validating her needs for care and support. I psycho-educated (*see A1-A2*) Zinhle about the impact of trauma on a victim's family and used Socratic questioning to help

her appreciate that her family did not blame her for the trauma. I helped her realise that their behaviour was based on inaccurate assumptions about what was necessary for her to recover (i.e. that she needed to forget). I actively encouraged her to reach out to her family by contacting them and sharing her life with them and advised her to gradually establish friendships with her peers. The positive results she achieved, such as her sister responding with warmth and eagerness to form a friendship with her, further motivated her. As a result, she felt less alone and more supported and confident about her ability to change her situation. Following the third therapy session, Zinhle contacted her eldest sister and the positive support she received prompted her to decide to take active steps to reach out to her parents and I once again matched the therapeutic interventions to suit her needs. I used role-play to help her prepare for her disclosure and, in the holiday period after this session, she approached her parents and initiated the process of establishing closer ties with them.

Zinhle experienced intrusive memories in the period prior to our final assessment session and I responded by psycho-educating her about PTSD and the treatment model and she was extremely eager to initiate treatment as can be seen in her comments in the session. She was also willing to devote additional time to processing her trauma memories which further reflected her movement to Prochaska's and DiClemente's (1982) action stage. Zinhle's willingness to engage with treatment was related to her realising through psycho-education that her symptoms were normal reactions and could be treated. Before this she had not understood her post-trauma symptoms (e.g. intrusions) and assumed she would have to live with these reactions for the rest of her life. As such, she was extremely relieved to learn that PTSD did not have to be a permanent condition. Zinhle coped well with imaginal reliving in the first therapy session and in the period after the session she engaged in self-initiated attempts at exposure by allowing herself to stay with her intrusive memories rather than avoid them (*see T2)*. Her self-initiated efforts at exposure were the result of: psycho-education which helped her appreciate that her intrusions were simply unprocessed fragments and; to the interventions aimed at strengthening her inner resources. For example, in the first therapy session, I explained to Zinhle that her ability to retell and relive the trauma was indicative of her strength and capacity to manage her memories of the rape. I emphasised that any distress that she did experience from intrusions would not be permanent but would eventually dissipate. This motivated her to engage in exposure on her own. In the assessment phase, I explained to Zinhle the necessity of addressing her avoidance of

trauma-related stimuli and when she returned home she continued with the treatment plan by confronting the situations she usually avoided. She ventured into the back-yard of her home and looked at the perpetrator's house and walked around in her community. Her motivation to change and the active steps she took to achieve her goals contributed to the complete resolution of her symptomatic reactions.

3.2. CASE 2: LULAMA

Lulama was a sixteen year old, isiXhosa speaking, high school student who lived in a disadvantaged township settlement situated on the outskirts of the University town. She was referred by her school teacher shortly after my visit to her high school to publicise the research project. Lulama's school teacher (Zamiwe) notified her caregivers (her mother and grandmother) that she was seeing a psychologist to help her cope with the trauma. She had been raped five months prior to her referral for treatment. Due to her unfamiliarity with the town and the therapy process, Lulama requested that her non-identical twin sister (Lindiwe) remain with her during the course of her treatment. As part of the research agreement, Lulama and her sister were provided with transportation costs and with lunch. They used public transportation to commute to and from therapy and lunched in my office prior to the start of each session.

3.2.1. THE ASSESSMENT PHASE: RESULTS

The assessment process consisted of five sessions of between forty-five and sixty minutes each. Lulama was seen twice a week during this process and she often arrived late for these sessions. Her lateness, in conjunction with the time taken for her to lunch in my office (between twenty and thirty minutes), meant that our meetings were usually cut short to ensure she was able to acquire transport so that she could return home before dark.

(i) Assessment interviews

Building a narrative of the trauma

It was Lulama's first visit to a psychologist and I used our initial two sessions to psycho-educate her about psychotherapy and obtain information about the traumatic event. I explained that in therapy she was welcome to share any problems that were affecting her and my role involved helping her to cope with these difficulties. I emphasised that appointments were scheduled and it

was necessary to keep to the appointed times. I then invited Lulama to raise any concerns she had about psychotherapy or any aspect of our relationship and she asked whether I had ever treated a rape victim. I explained that this constituted the main focus of my research and then invited her to share her story with me.

Lulama offered a brief factual description of the trauma. She smiled, laughed and chuckled while narrating her experiences. It was clear she was trying to emotionally distance herself from her narrative, possibly because of her uncertainty about whether she could trust me to respond with empathy. Lindiwe, her twin sister, sat silently throughout the session.

Initial retelling

Lulama had been raped on the evening she had been visiting her close friend (Fezeka). That evening Fezeka's mother requested that her daughter and Lulama purchase a carton of milk from a nearby store. While at the store Fezeka met her boyfriend and one of her acquaintances and asked Lulama to return the purchase to her mother on her own as she wanted to spend time with her boyfriend. Fezeka suggested that her acquaintance accompany Lulama and he agreed. As they walked to Fezeka's home, the acquaintance started making unwanted advances towards Lulama. At first she ignored them but he then groped her and she protested loudly and started screaming and crying. She noticed a police car approaching and signalled for the officers to stop but the perpetrator intervened. He explained to the police that Lulama was his girlfriend and they were involved in a domestic dispute. The police did not enquire further and simply drove away leaving Lulama stranded. The perpetrator then became aggressive and dragged her to his house which was situated in another neighbourhood and raped her. Following the assault, he released her and she fled home but before she could reach her house, she was accosted by two other men. They pushed her to the ground and searched her for money and dragged her to an empty warehouse where they raped her. After the assault, they released Lulama and she ran to Fezeka's house which was situated much closer than her own home. Fezeka's parents immediately contacted the police and called for an ambulance to collect Lulama. They accompanied her to the hospital and assisted her in filing a case at the police station.

Immediately after returning home, Lulama disclosed the rapes to her family which included her mother, twin sister and grandmother. She laughingly stated that her mother (Thando) had been

angry and accused her of provoking the attacks by walking around at night and called her various derogatory names (e.g. "whore"; "bitch"). Thando also told her that it would have been better if she had been killed that night. Two days after her rape, Lulama spotted the perpetrators of her gang rape[3] walking along a street close to her home. She felt afraid and reported the incident to her grandmother (Nomthandazo) who immediately phoned the police. The rapists were arrested but released shortly thereafter on bail while the case was being investigated.

Following her narrative, I reflected on the trauma she had endured and her courage in being able to share her story with me and asked her how she was coping. Lulama hesitatingly reported that she was worried that I would blame her for the rapes as her mother had done. I emphasised that this was not the case and she was innocent and the perpetrators were the only ones responsible for the trauma. I offered her a pamphlet I had compiled about rape myths (*see Appendix K*) and explained the meaning of the word 'myth' and went through the document with her. I emphasised that walking alone at night was not an invitation to be raped and advised her to comprehensively go through the document while at home. I offered Lulama another document containing information on RTS (*see Appendix L*) to help her further appreciate that I was aware of the impact of rape and she did not need to hide her experiences from me. I went through the document and asked her how she felt knowing that others experienced these reactions. Lulama was clearly relieved and reported that she felt markedly less alone. I invited her to take the document home with her.

I asked after Lulama's caregivers and the possibility of my speaking with her mother but she reported that her mother abused alcohol and that her mood and behaviour were often unpredictable. For this reason, she did not want her to be involved in her therapy process. The family did not have a landline in the home and neither her mother nor grandmother owned a cell phone which made contacting them difficult. Furthermore, her grandmother did not speak English and this posed an additional barrier. Zamiwe had notified her caregivers that she was in psychotherapy and given the challenges involved in contacting her family, I decided against any immediate action in this respect.

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[3] The use of the word 'gang rape' from this point forward is used in the lay sense to refer to rape perpetrated by more than one assailant.

Lulama missed her third appointment and I tried to contact her on her cell phone which she received as a gift from a relative but there was no answer.

She made her next appointment but arrived ten minutes late accompanied by Lindiwe who sat quietly for most of the session. I asked after the missed appointment and learnt that her older sister (Zandile), who lived in a different province, had been involved in a bus accident and the family had been awaiting news as to her welfare. They later learned that she had incurred minor injuries. I explained to Lulama that it was important she notify me if she was unable to keep an appointment. I emphasised that if she did not have funds to make a call she was welcome to send a text message stating that I should "please call her" as these messages can be sent free of charge. She agreed to this arrangement.

Lulama had read the documents I had given her and reported that she wished she could show the perpetrators the pamphlet on RTS so they could understand the hurt they had caused. She believed this would deter them from perpetrating further rapes. I reflected on the hurt they had inflicted and psycho-educated her about the causal mechanisms underlying PTSD. I used the metaphor of a 'cupboard' to describe the processing of information in memory. I explained that because traumatic events were extremely frightening, people were often unable to fully understand or make sense of what was happening to them. As a result, information flooded in and was not properly organised in the cupboard (memory) and this caused symptoms. I emphasised that it was our job in therapy to help organise this cupboard by speaking about the trauma in detail. Lulama understood my explanation but reported that she had not spoken about the trauma in detail to anyone because she feared being overwhelmed. I encouraged her by explaining that we would proceed at a pace she was comfortable with and she could notify me at any time during the narrative if she felt it was too difficult for her to continue. I explained that we would then pause the retelling and allow her time to recover. Lulama then agreed to speak about her ordeal in more detail and I asked after her thoughts and feelings during each stage of her narrative. She still smiled and often chuckled as she spoke.

Second retelling

Lulama reported that she had often seen the first perpetrator in her community but did not know much about him. That night he introduced himself as they left the store and spoke to her about

his life and his family and she felt bored by his chatter. He also told her that he liked her and wanted her to be his girlfriend. Surprised, she had simply dismissed him but he then grabbed her arms and held her tightly and she assumed he was going to threaten her and insist she be his girlfriend. However, when he groped her she felt extremely angry and screamed for help. A passing police van stopped and two police officers enquired after the commotion. They left after being told by the perpetrator that he was having an argument with his girlfriend. The perpetrator then dragged Lulama to his house and she cried and screamed for help but was ignored by the pedestrians she passed. She believed that the pedestrians assumed that a domestic dispute was underway and did not want to get involved. After he dragged her into his bedroom, the perpetrator locked the door, placed the key under his pillow and forced Lulama to get on to his bed and violently removed her clothes. She then realised she was going to be raped. She cried and screamed during the assault and believed the perpetrator would kill her after raping her. However, afterwards he told Lulama that she should find somewhere to sleep in his house. When she begged him to release her, he eventually conceded. Before fleeing his house, Lulama told the perpetrator he would be put in jail for his actions.

She had felt extremely frightened as she walked through empty streets late at night. All she could hear was the sound of dogs howling. As she approached Fezeka's neighbourhood, Lulama sensed she was being followed and quickened her pace. She then felt someone violently shove her to the ground and two men held her firmly down and searched her. After realising she had nothing of material value on her, they forced her to accompany them to a nearby shed. At this point, Lulama quickened the pace of her narrative. She reported that once they entered the shed, both perpetrators had raped her and after the assault she had run to Fezeka's house. It was clear the second assault had been particularly traumatic and it was difficult for her to speak about her ordeal.

Following the narrative, Lulama appeared distraught and reported that a specific part of the trauma kept replaying in her mind but she did not feel able to speak about it. I believed it was important to respect her capacities and not compromise her trust and so I did not push her further and instead focused on stabilising her. I normalised her reaction by explaining that her experiences had been extremely traumatic and it was expected she would feel distressed. I emphasised that as she became more accustomed to speaking about the trauma, these reactions

would cease. Lindiwe then asked to use the toilet and I used her absence to ask Lulama if she felt comfortable telling her story with her sister present. She reported that she did not keep secrets from her sister and she wanted Lindiwe to remain with her during her sessions. She then stated that she felt encouraged because she had been able to speak about the trauma in detail. I acknowledged her strength and emphasised that speaking about the rapes and going through the events of that night allowed her to gain mastery over her memories.

I asked after Lulama's experiences in the aftermath of the trauma and learnt that Fezeka's parents had first taken her to the police station where she provided a statement detailing the trauma and opened a case docket. She was then taken by ambulance to the local hospital where she received medical attention and a forensic exam was conducted using a rape test kit. The attending nurse explained the necessity of this exam and that it would be sent to the laboratory for analysis. As a result, Lulama had not felt distressed at having a male doctor examine her. She was also provided with pre-and post-test HIV counselling and administered an HIV test. Lulama was HIV negative and was therefore given post-exposure prophylaxis (PEP). The nurse explained to Lulama the nature of this medication and advised her to visit the hospital the next week to obtain the second dose of PEP. She also encouraged Lulama to come to the clinic once a week for a month so that her condition could be monitored. Lulama reported that she had been terrified of contracting HIV and followed the nurse's advice. She was administered the HIV test three months after the trauma to account for the window period and was found to be HIV negative.

After returning home the day of the trauma, she told her family about what occurred and her mother responded harshly. In the days following the trauma, Fezeka and another friend (Mandisa) visited Lulama and supported and consoled her. The police inspector in charge of her case also visited and requested that Lulama accompany him to the site of the trauma (the shed in which she had been gang raped). He took pictures of the shed but did not contact her thereafter to inform her of the progress on her case. For a week following the trauma, Lulama had been afraid to leave her house lest she encountered the perpetrators and had absented herself from school.

After returning to school, she found that her peer group had received news of the rapes and, instead of being supportive as she expected, they taunted her and told her the rapes had

occurred due to her own negligence and refused to associate with her. After this, Lulama avoided them and spent her school break times on her own in an empty classroom or with her sister. Due to their taunting, she also found it difficult to concentrate in class and this affected her academic performance. She struggled to remain at the top of her class and took on additional homework assignments to maintain her grades. Lulama's boyfriend also distanced himself from her after she disclosed the trauma to him and this prompted her to end the relationship as she found his behaviour hurtful. I asked Lulama if she had become romantically involved with anyone thereafter and she reported that she had not.

Through close questioning, I learnt that Lulama interpreted the behaviour of her mother, peers and boyfriend as signifying that she had been contaminated by the rapes. She believed that the perpetrators' semen remained in her body after the trauma and was causing other people to view her as "dirty", "ugly" and "untrustworthy". As a result, she believed she would no longer be able to establish fulfilling relationships or have a promising future.

Towards the close of the session, I sought Lulama's permission to contact Zamiwe as I was concerned about the behaviour of her peers and she agreed to this. Zamiwe told me she had intervened on two occasions to deter Lulama's peers from taunting her and had spoken to the parents of the students responsible. Unfortunately, these appeals had limited impact. She suggested that I provide her with information about the effects of rape so that she could circulate this around the school. Zamiwe believed this could deter students from taunting Lulama. I offered to provide her with material on rape myths and RTS and she was grateful for this.

Consultation with Department of Social Services

I had to halt our fourth assessment session to consult with the Department of Social Development because Thando had evicted Lulama and Lindiwe from their home. She informed them that she had relinquished responsibility for them and they were to fend for themselves. I took the sisters to the Departmental offices and consulted with a senior social worker who arranged for them to temporarily reside with an Aunt and Uncle. With Lulama's permission, I alerted the social worker to the rape and the situation in their home including her mother's abusive behaviour and the need for her caregivers to take a more active interest in her welfare. The sisters were allocated to another social worker whom they were to meet the next day. Later

in my office, I asked Lulama and Lindiwe how they felt speaking to a social worker and learnt that Lulama feared her mother's reaction. I reassured her that the social worker would ensure that their home environment was a safer place and actively encouraged Lulama to meet with her.

Lulama arrived twenty minutes late for our fifth session and reported that Lindiwe had to participate in extra-curricular sporting activities and could not make the meeting. After determining that our session times suited her, I explained to Lulama that it was important she arrived timeously for our appointments as I could only see her during certain times. Once again, she agreed to do so. After meeting the sisters, the social worker had arranged to meet the whole family. During this meeting, she warned Thando to stop abusing her children or she would be arrested for child abuse and advised Nomthandazo to become more involved in caring for and supporting Lulama. The social worker also arranged to monitor their home situation on a weekly basis. This intervention resulted in Lulama feeling much safer and less dejected at home because her mother stopped blaming her for the trauma and her grandmother started actively supporting and caring for her.

The social worker insisted that Thando and Nomthandazo visit the police station to enquire after the progress on Lulama's case and also to consult with me. They were told by the police that the investigation was being halted until the results of the blood tests arrived from the labs, in about two weeks. In assessing rape victims, legal procedure stipulates that doctors need to use rape test kits to collect evidence (e.g. semen) that could facilitate the prosecution of a perpetrator. A rape test kit was used during Lulama's examination and after the arrest of two of the perpetrators, samples of their blood had been sent to the labs for comparison. I advised Lulama to maintain contact with the police to ensure that the case was being attended to and later learnt that she contacted the police every alternate week.

Thando had not scheduled to meet with me and I was not available when she arrived at my office. I wrote a letter to her, with Lulama's consent, and introduced myself and explained the reasons for Lulama entering therapy and invited her to contact me. I shared the content of my letter with Lulama and she was comfortable with it. Thando never replied but Lulama reported, in our second therapy session, that her mother had received my letter and appreciated my

gesture and thanked me for my help. She also indicated that it was unlikely I would receive any further response from Thando.

Building a narrative of the gang rape

In our fifth assessment session, I asked after Lulama's experiences of providing a more comprehensive narrative of the trauma and learnt she felt "relieved" after the retelling and had been surprised she had coped with sharing the trauma in detail. She believed she was now putting together her memories of that night instead of suppressing them.

Lulama had experienced two intrusions after the second retelling when she had lain down on her bed. I explained the concept of triggering and emphasised that because she had been raped on a bed this object had become a trigger for her memories of the assault. I asked Lulama if she felt able to discuss her flashbacks and she believed she could cope with this. It was clear she was now feeling more confident about her ability to manage her memories and more secure in therapy. As I questioned Lulama closely, she tried to avoid showing her feelings by using a neutral tone, avoiding eye contact and keeping her head lowered. One of her intrusions consisted of an image of the first perpetrator raping her. It was associated with intense fear and the thought "he's going to kill me" to prevent her from giving evidence that might lead to his arrest. The second intrusion was from the gang rape and involved an image of one of the assailants lifting a brick and hurling it. At the time, Lulama believed the brick was intended for her and the perpetrator wanted to kill her and this was reflected in her peri-traumatic appraisals ("I'm going to die").

I asked Lulama if she felt able to elaborate on the gang rape and she agreed to try. She once again avoided revealing her emotions and I had to consistently prompt her to gain information about what had transpired. The moment Lulama became aware of the two perpetrators stealthy approaching her, she felt terrified and thought she was going to be killed. This was reflected in the thought "they're going to stab me". After searching her, the perpetrators forced her to accompany them and she believed they were taking her to a shebeen. I asked after this assumption and learnt that Lulama's cousin had been sexually assaulted and repeatedly stabbed approximately a year ago after being given copious quantities of alcohol in a shebeen. Her cousin had experienced severe amnesia for the assault and Lulama believed the perpetrators intended

to force her to drink alcohol thereby rendering her amnesic so as to evade the authorities. Instead, they took her to an abandoned shed.

Upon entering the shed, she noticed broken bottles and bricks strewn along the floor and thought the perpetrators intended to stab her with a broken bottle. However, they shoved her to the ground and she realised she was going to be raped again. After the first assailant had raped her, he insisted that his friend do the same. However, the second assailant refused. Lulama had felt relieved believing the second assailant was protecting her. The first assailant then started throwing bricks at his accomplice while insisting that he rape Lulama. The second assailant eventually conceded and Lulama felt betrayed by his actions. They both raped her twice. Lulama had screamed and cried throughout the ordeal and, immediately after the rapes, she found she had lost her voice. Following the assaults, the first assailant stepped out of the shed and told his accomplice he was going to purchase cigarettes and Lulama should not be released. Lulama believed the first assailant intended to kill her when he returned. After his departure, the second assailant told her she should flee and try to return home and Lulama then dashed out of the shed. Following her narrative, Lulama reported she felt afraid and was worried she would be raped again. I reassured her that the trauma was over and she was in a safe place. I advised her on the practical methods she could use to protect herself including not staying out late at night, purchasing pepper spray and walking home with a group of friends rather than on her own. She was much calmer after this.

I explained to Lulama that I was providing Zamiwe with materials to educate the students about the impact of rape and she was grateful for this. I requested she deliver the package to her teacher and I later learnt that she did so.

3.2.2. DIAGNOSIS

Lulama was not a first-language English speaker and had difficulty interpreting the self-report scales. Her diagnosis was based on close questioning in the assessment interviews.

(i) PTSD

Lulama met diagnostic criteria for PTSD. She experienced two intrusive memories of the trauma. These intrusions occurred almost on a daily basis (i.e. at least four to five times a week) and were

triggered whenever she lay down on her bed at night and whenever she saw the perpetrators in her community. She experienced heightened physiological arousal and felt overly alert, jumpy and easily startled on a daily basis. She usually experienced these symptoms when at school because the taunting of her peers reminded her of the trauma and left her feeling vulnerable. She also experienced symptoms of hyper-arousal when she was walking in her community due to the presence of the perpetrators in her environment. Lulama suppressed her memories of the trauma in an attempt to cope and avoided speaking about the rapes. She believed that by avoiding thoughts of the rapes she could prevent intrusions from coming to the fore. In addition, she assumed that by not speaking about the rapes, she could preclude the possibility of receiving negative responses from others. Furthermore, Lulama avoided being in the vicinity of her peers so as not to be hurt by their behaviour. These reactions persisted for five months following the trauma.

(ii) Major Depressive Disorder (Single episode, moderate)

Lulama met criteria for major depression. She felt intensely sad and despondent almost on a daily basis following the trauma and experienced difficulty concentrating on her school work. Her feelings of sadness were related to the lack of support in her environment. They were also related to her assumption that there could be some truth to the accusations that she was to blame for the trauma. Lulama interpreted the negative reactions of those close to her to mean that she had been fundamentally altered by the trauma (i.e. made dirty, ugly and untrustworthy) and would therefore not be able to have fulfilling relationships or a good future. This appraisal intensified her depressed mood. In addition, she was more easily fatigued, had less of an appetite than before the trauma and had lost interest in participating in activities she had previously enjoyed specifically socialising with her friends. These symptoms persisted for five months after the rapes. Lulama had not experienced symptoms of depression prior to this episode.

3.2.3. CASE FORMULATION AND TREATMENT PLAN

(i) Predisposing factors

Lulama was raised in an unstable home environment. Her biological parents divorced when she was three and her father terminated all contact with the family thereafter. Lulama missed her father's presence after the divorce and had not understood his reasons for not remaining in touch with his children. Following the divorce, Thando relocated to her parents' home, re-

married a year later and moved to her second husband's family home situated some three hundred kilometres away. Lulama's step-father (Andile) cared deeply for his adopted children and was particularly fond of Lulama and her twin sister. He offered them attention, warmth and affection and Lulama idolised him. When Lulama was seven her mother separated from Andile due to his repeated infidelities and moved back to her family home where they were still residing during the course of her treatment. Andile grew distant following the separation and eventually ended all contact with Thando and the children. However, Lulama continued to idolise him and believed that, if circumstances had been different, he would have remained in touch with her.

Thereafter Lulama's primary caregivers were her mother and grandmother. Nomthandazo was a caring and supportive grandparent but she tended to be authoritarian in her parenting style. She severely reprimanded her grandchildren if they disobeyed her or engaged in any conduct of which she disapproved. Consequently, Lulama feared her and avoided sharing her needs or concerns with her lest she incur her disapproval. Instead, she relied on her mother for care and emotional support. However, when Lulama was twelve, her mother's divorce from Andile was legally finalised and Thando started consuming alcohol excessively and her behaviour towards her children changed dramatically. From being caring, attentive and supportive, she became highly critical, punitive and rejecting. She regularly beat Lulama if she disobeyed her or did anything she disapproved of. Her moods became unpredictable and she would shift from being calm one moment to being highly aggressive the next. As a result, Lulama became afraid of her mother and avoided being around her lest she provoke her in any way. In addition, she attempted to remain cheerful whenever she was in the presence of her caregivers so as to avoid incurring their disapproval and to draw positive responses from them.

As a result of her experiences, Lulama developed early maladaptive schemas involving: abandonment/instability; mistrust/abuse; emotional deprivation and; subjugation. She believed she could not rely on others to care for and support her (abandonment/instability). She also expected that if she shared her concerns and feelings with others they would not be able to provide her with the empathy, care or support she needed (emotional deprivation) and would behave hurtfully towards her (mistrust/abuse). To cope with this situation, Lulama avoided revealing herself to significant others and suppressed her needs and feelings (subjugation). She tried to gain the affection and admiration of those close to her by remaining cheerful at all times

and by striving to obtain good academic grades (overcompensation). Lulama's negative core beliefs were reinforced by other experiences. These included: Thando's accusations that she had provoked the attack by walking around at night and her comment that it would have been better if she had been killed; Nomthandazo's failure to protect Lulama from her mother's verbal abuse; the mockery and ostracism from her peers and; her boyfriend's distancing from her after she disclosed the rapes to him. To cope with these negative reactions, Lulama reverted to avoidance and overcompensation.

(ii) Precipitating factors

Lulama was raped on two separate occasions during the course of one night. She had been intensely afraid during the assaults and believed that each of the perpetrators intended to kill her after they raped her. These peri-traumatic appraisals generated her symptoms of PTSD. The negative responses of those close to her led to Lulama believing that the trauma had global negative implications for her life and future. She assumed that the traumatic event had contaminated her and caused others to view her as dirty, ugly and untrustworthy. As a result, she expected that she would no longer be able to establish fulfilling relationships or have a good future. These appraisals reinforced the sense of threat associated with the trauma and intensified her symptomatic reactions.

(iii) Maintaining factors

Lulama's schemas and associated coping strategies contributed to the maintenance of her symptoms of PTSD and depression. She distanced herself from her peers and withdrew socially. She even refrained from speaking about the trauma even to people in her environment who remained supportive because she feared that they too would respond hurtfully towards her and reject her. This included her two close friends, Fezeka and Mandisa, as well as her sister and her teacher. Lulama also suppressed and concealed her feelings of distress and maintained an overly cheerful demeanour in an attempt to draw others to hers. In addition, she took on additional homework tasks (overcompensation) and dedicated herself to her school work to maintain her grades and ensure she did not incur further disapproval from her caregivers or give her peers additional reasons to ridicule her. Not speaking about the rapes prevented Lulama from receiving the attention, care and support she needed and left her feeling isolated and alone. It also prevented her from receiving information that could disconfirm her negative assumptions

regarding the impact of the rape on her life, relationships and future. Lulama suppressed her memories of the rape as she believed this would prevent her intrusions from coming to the fore and enable her to continue with her life. This had the effect of maintaining her symptoms by preventing her from emotionally processing the trauma memory.

3.2.4. PRESENTATION OF TREATMENT PLAN

I discussed the treatment plan with Lulama and explained that I had identified the following areas as requiring intervention and invited her to discuss these with me and include any other issues that she felt needed attention.

- PTSD symptoms: I identified her symptoms and explained the causal mechanisms underlying PTSD, the treatment model and the strategies used to target symptoms (e.g. imaginal reliving). Lulama understood the explanation but reported that she did not feel ready to undergo a reliving. I emphasised that we would work together to help her feel safe enough in session to undertake the procedure. I explained that for her hyper-vigilance to diminish the perpetrators had to be removed from her community and this involved actively perusing the case with the police. She affirmed that she would do this. In addition, I emphasised that Zamiwe was attempting to stop her peers from taunting her and we would monitor the situation at her school so that she could feel safer.
- Social Isolation: I explained to Lulama that it was important that she have more social support and to achieve this it was necessary to target the beliefs that prevented her from engaging with supportive others. This included: her assumption that the perpetrator's semen remained in her body and caused other people to regard her as ugly, dirty and untrustworthy and; her expectation that she would be rejected her if she approached others. She appeared sad and forlorn as I discussed this but did not comment on this focus area.

Following the presentation of the treatment plan, Lulama requested she be seen for therapy every day for two to three hours per session so as to enable her to recover quickly. Although Ehlers and Clark (2000) have an intensive version of their treatment protocol, it was not feasible to implement this in Lulama's case. Instead, I offered that we meet twice a week for two hours per session and she found this arrangement suitable and we agreed that sessions would be

spaced either two or three days apart. The treatment plan involved seeing Lulama for at least twelve sessions.

3.2.5. THERAPY NARRATIVE

Lulama was seen for six therapy sessions of between forty-five and seventy minutes. The duration of sessions had to be considerably reduced due to her tendency to arrive late. In addition, Lulama frequently missed appointments (four in total) and, as a result, she was typically seen once a week. Following our sixth therapy session, she failed to arrive for treatment for five weeks and repeated attempts to contact her proved unsuccessful. I therefore assumed she had prematurely terminated. However, after a five week absence, she arrived unexpectedly at my office and reported that she wanted to continue with treatment. I rescheduled to meet with her but she failed to keep the appointment and did not contact me thereafter.

Therapy session 01

Focus area: Addressing avoidance

I used direct empathic confrontation in our first therapy session to address Lulama's emotional avoidance. I first explained that I had noticed that she often attempted to avoid revealing her feelings in session by remaining cheerful even when speaking about deeply painful events. I emphasised that this worried me because I knew she was actually feeling sad and hurt. I then explained that I wanted her to be able to share her feelings with me rather than hide her experiences. Lulama believed that if she revealed her feelings I would no longer respond to her with warmth or kindness but would accuse her of being attention-seeking and invalidate her emotions and call her "crazy". I explained that I predominantly worked with victims of rape and was therefore familiar with the distress evoked by exposure to such a trauma and would not dismiss her feelings. I also actively argued that revealing her emotions would only make me more aware of her difficulties and allow me to better care for and support her. Lulama then silently stared at the ground for a few minutes before remarking that my comments were encouraging. She then resumed staring at the ground and would not look up at me and it was clear she was feeling unsettled and had therefore withdrawn.

I turned to Lindiwe and asked her how I could help her sister feel safe in therapy. I believed that actively including her sister in the treatment process would enhance Lulama's sense of security

and thereby challenge her avoidance. Lindiwe believed I would not respond harshly towards her sister and that given time Lulama would come to trust me. She reported that Lulama tended to hide her feelings even when speaking to her about the trauma and it was important she at least display her emotions when in therapy as it would help her recover. I then turned to Lulama and emphasised that Lindiwe did not share her assumption that I would respond negatively and that she too wanted her to share her feelings. I reiterated that I cared for her and wanted to help her heal and would remain with her throughout the treatment process. I then asked Lulama how she was feeling and she remained silent for a few more minutes before stating that she felt nervous. Before leaving our session, she reported that she would endeavour to be more open with me in future.

Therapy session 02

Focus area: Addressing maladaptive beliefs; Enhancing social support

Lulama arrived twenty minutes late to session because her grandmother had insisted she complete her chores before attending therapy. I enquired after her experience of our previous session and learnt that she felt encouraged to reveal her feelings. However, she believed she would need more time to get used to working with me before she felt safe enough to do so. I validated this and emphasised that I cared for her and believed that as our therapeutic relationship grew, she would become more trusting of me.

In accordance with the treatment plan, I focused on promoting her engagement with supportive others. I used guided discovery to help Lulama fully appreciate that although some people had responded negatively towards her, there were still supportive others in her environment. I actively encouraged her to approach these individuals (e.g. Fezeka, Mandisa and her teacher) and emphasised that self-disclosure would make them aware of her experiences and allow them to care for her. However, Lulama withdrew and stared sadly at the floor. It was apparent she was still ambivalent about approaching these people because she feared losing their support and being completely isolated.

I, therefore, focused on helping her realise that an individual's behaviour reflected their character and she could use this as a gauge to determine whom she could trust to support her. I recruited Lindiwe's assistance in this process and asked about her sister's friends. Lulama's peers

formed part of a popular clique at their school and Lindiwe viewed them as being shallow, insincere and untrustworthy. One of Lulama's valued friend's (Thembi) was the head of this clique and she was highly critical, self-centred and jealous. After hearing of the rapes, she encouraged the other students to mock and shun Lulama. I explained to Lulama that Thembi's hurtful behaviour towards her reflected her character and was not due to her being deficient in any way. Lulama was doubtful and reported that she still believed that the behaviour of her peers was related to her having been contaminated and made dirty, ugly and untrustworthy.

It was clear it was very threatening for her to realise that those she had valued and trusted were actually uncaring and insensitive people. As a result, she was attributing their behaviour to her being deficient. I proceeded by explaining to Lulama that semen did not remain in the body indefinitely but was expelled if fertilization did not occur and she had therefore not been contaminated. She was clearly surprised and I actively argued that the behaviour of her friends was reflective of their character and was not indicative of there being anything wrong with her. Lulama then appeared extremely sad and reported that she had trusted her friends and expected them to support her but instead they had hurt her. I validated her sense of betrayal and explained that the trauma had revealed the character traits of the people close to her and although some of her friends had proven uncaring there were others that still valued her. I emphasised that it was these individuals she could trust to support her and she again appeared sad and stared at the ground.

Lulama was experiencing feelings of anger towards the perpetrators and her mother. She was angry with the perpetrators for intentionally hurting her and disrupting her life. I encouraged her to express her anger through letter writing but she was reluctant to do so and feared the perpetrators would hurt her if they read the letter. I explained that the letter was meant to help her express her anger and she could destroy it afterwards but she still did not feel comfortable with this. I asked her if she felt comfortable expressing her anger towards her mother through letter writing but she feared her mother might find this letter and react hurtfully towards her. I asked Lulama what she would include in such a letter and learnt that she wanted to tell her mother she was not to blame for the rapes and had not deserved to be assaulted. She appeared sad and forlorn as she stated this and I reflected on her feelings of sadness. I also emphasised that she was in no way to blame for the trauma and it was very sad her mother did not

appreciate this. Lulama then lowered her head and stared fixedly at the ground and cried softly. It was clear that my affirmation intensified her sense of being abandoned by her mother.

After Lulama's second therapy session, I contacted Zamiwe and learnt she had received the psycho-educative materials and had circulated it and there appeared to be some reduction in the taunting behaviour of the students.

Therapy session 03

Focus area: Continued...

At the outset of our session Lulama reported she needed to disclose something to me. I learnt she had not attended school the previous day because she had not been able to find one of her school books and searching for it had delayed her and she had not wanted to be reprimanded for being late. Her grandmother had been extremely angry with her for not attending school and notified the school principal and the social worker and Lulama had been severely reprimanded by both of them. I asked Lulama if she frequently missed school and she reported that she usually never absconded from school and this was one of the few occasions in which she had been absent.

Lulama disclosed that she had become involved in a romantic relationship with Fezeka's brother (Sipho) and her grandmother disapproved of this and had summoned two police officers to tell her to end the relationship. Nomthandazo had accompanied the police to Sipho's home to ensure they warned him that he would be arrested if he continued his involvement with her granddaughter. Lulama reported that she had subsequently ended her relationship with Sipho. Nomthandazo's actions appeared excessive and so I asked Lulama about Sipho. I was shocked to learn he was forty-three years old and she had begun this relationship three weeks after the rapes. She had not disclosed this during the assessment interviews despite my asking her if she was romantically involved. I explained to Lulama that the relationship was inappropriate given their age difference and emphasised that Sipho was old enough to be her father. She reported that she had been sternly warned by the police and her grandmother about the inappropriateness of her association with Sipho. Her grandmother had also notified the school principal and the social worker about Sipho and they had both sternly warned her against any further involvement with him. This had prompted her decision to end the relationship. Given the

well-meaning but extreme reactions she had received, I did not believe it would be helpful if I too warned her about Sipho especially since she had ended the relationship.

Lulama had been invited to spend the weekend at her friend's (Mandisa's) family home which was in a city three hundred kilometres away but she did not intend to notify her caregivers of her intention to stay with Mandisa. I was very concerned and explained to Lulama that she needed to tell her grandmother and request her permission otherwise her caregivers would be extremely distraught by her sudden disappearance. Lulama was unconvinced and believed her grandmother would disapprove of the visit and it was better for her to simply abscond. I argued that she would be travelling to an unfamiliar city and for her safety it was important she notify her caregivers. I emphasised that her mother, grandmother and the social worker might severely reprimand her when she returned if she failed to notify them of her intentions. Lulama was intimidated by this prospect. I advised her to contact Mandisa's parents and request they get in touch with Nomthandazo and notify her that they had invited Lulama to spend the weekend with them. Lulama agreed to this arrangement.

Lulama had experienced a nightmare involving the gang rape that left her feeling angry and sad. She reported that she had wanted to cry after the nightmare but her tears would not come. I invited her to share her nightmare with me and to express her feelings of anger and sadness but she did not feel able to. I established that she was still experiencing visual intrusions but these flashbacks no longer occurred on a daily basis. Instead, she experienced them only two to three times a week. However, her symptoms of hyper-arousal continued to occur every day. It was clear the retelling had facilitated some processing of the trauma memory but it was not sufficiently laid down in autobiographical memory. However, I decided against using exposure-based interventions at this stage because Lulama was still not secure enough in therapy to fully engage with such work. She also had limited access to reliable sources of social support and this meant she would have to cope with her distress on her own when outside of therapy.

I asked after her experiences of her school environment and she confirmed Zamiwe's reports and indicated that the mocking of her peers had diminished but Thembi continued to taunt her. She still believed that the negative responses of her peer group and Thembi were related to her being a dirty, ugly and untrustworthy person. It was apparent Lulama found it very challenging to

accept that the negative reactions of her peers had implications for them and not for her. I therefore guided her to identify the characteristics of those that responded negatively towards her (e.g. Thembi) and asked her if their reactions were not in keeping with their character. I also emphasised that some of the people whom she had regarded as friends were actually selfish and insincere and had never truly cared about her. In addition, I used her relationship with Sipho and Mandisa's invitation as evidence that the trauma had not altered people's perceptions of her. I actively argued that if she was dirty, ugly and untrustworthy Sipho would not have become involved with her and Mandisa would never have considered inviting her home and introducing her to her family. I explained to Lulama that I did not believe she had been contaminated by the rapes and did not regard her as an ugly or dirty or untrustworthy person. Instead, I saw her as a good, caring and worthwhile individual. She then appeared sad and tearfully remarked that she now realised that she did not deserve to be treated in such a hurtful manner because she had not done anything wrong.

Non-arrival

Lindiwe arrived forty minutes early for our next appointment and reported that Lulama was still on her way. I requested she remain in the waiting area till her sister arrived. At the appointed time, Lulama had still not arrived and I invited Lindiwe into my office while I awaited her sister. I enquired after her experience of session and Lindiwe reported that she was glad to be able to help her sister. I remarked on my surprise at her sister's involvement with Sipho and learnt that Lindiwe had advised her sister about the relationship but Lulama had been adamant that she wanted to pursue it. Lindiwe believed her sister's decision had been influenced by her desire to receive expensive gifts from Sipho. However, it was also apparent that Lulama's involvement with Sipho was motivated by her need to compensate for the negative responses of those close to her and to feel attractive, valued and cared for. She had not disclosed her relationship because she did not want to relinquish what she believed to be a primary source of support and validation. From Lindiwe's remarks, I suspected that Lulama might renew her contact with Sipho and I decided that it was necessary to address this with her. Thirty minutes later, Lulama had still not arrived and I advised Lindiwe that it was best that she return home. Lulama did not arrive for the session and missed our subsequent appointments the following week. Her sister also failed to arrive to these meetings. I attempted to contact Lulama telephonically but there was no

response. I contacted Zamiwe and she offered to speak to Lulama about keeping to her therapy appointments.

Late arrival

Lulama made the next session alone but she arrived two hours late. I enquired after her absence from session and she silently stared at the floor for a few minutes before reporting that she had loaned her phone to a friend. She had therefore not been able to notify me that she would not be able to make our sessions. She also excitedly told me that she had obtained her grandmother's consent to visit Mandisa's home and I was relieved to hear this. I once again explained to Lulama that I was only able to see her at specific times and it was very late and I worried for her safety and wanted her to return home before dark. I advised her that I would be able to see her for our next meeting and encouraged her to make the session. Before concluding our meeting, I enquired after the police investigation into her case. I learnt that she had contacted the police and had been told that they were still awaiting test results and the investigation was still underway. The perpetrators were therefore still present in her community. I obtained her permission to contact a prominent public prosecutor in the town to determine the legal recourse available to her.

Non-attendance

Lulama did not attend session for another two weeks and I was unable to contact her or Zamiwe telephonically. In the interim period, I contacted the public prosecutor and was advised that Lulama needed to write a letter to the Office of the Public Prosecutor expressing her concerns that her case was not being appropriately attended to by the police. I was also advised that it would be helpful if Lulama could provide as much information as possible in the letter. This included: the case docket number; full names of the perpetrators and; the date on which the rapes occurred. This information would benefit the Public Prosecutor's Office in investigating the matter.

Therapy session 04

Focus area: Touching base

After a two week absence, Lulama arrived accompanied by her sister on the day her second sessions of each week were usually scheduled. I had not seen her for therapy for about four

weeks. I asked after her missed appointments and learnt she had been on holiday for the preceding two weeks and had extended her stay at Mandisa's home. I explained to Lulama that for us to progress with her treatment she needed to attend sessions consistently. I emphasised that I was very worried that her inconsistent attendance would inhibit us from doing the work necessary to help her heal but she did not respond and only stared at the floor.

I used the session to touch base with Lulama and investigate her symptomatic reactions. I learnt that Lulama had disclosed the trauma to Mandisa and tentatively revealed her feelings of sadness and hurt. To her relief, her friend had responded with affection, care and support. Mandisa also asked Lulama if she could disclose the trauma to her own family (i.e. her parents, sisters, grandparents and aunts) and despite her fears that they would react as her mother had done, Lulama agreed to this. To her surprise and relief, Mandisa's family had been genuinely concerned for her welfare and responded to her with kindness and warmth and asked after the traumatic event. This prompted Lulama to share her experience with them in detail and to reveal how scared and hurt she had felt. After her retelling, Mandisa's family offered her comfort and reassurance and explained that she had survived the trauma and should focus on achieving her goals. They invited her to visit them during subsequent school holidays and indicated that they enjoyed her presence in their home. I asked Lulama how she experienced their responses and learnt that she now fully appreciated that the trauma had not contaminated her and that people who genuinely cared for her would not respond hurtfully towards her. Her mood had considerably improved since the visit and she reported that she was much happier.

Through close questioning, I established that since the visit to Mandisa's home Lulama's symptoms of depression and PTSD had substantially decreased. The supportive responses had challenged her maladaptive beliefs regarding the impact of the trauma on her ability to establish fulfilling relationships. It also reinforced her initial assumption that she was in no way responsible for the assaults. This significantly improved her mood and she felt lighter and more confident about speaking about the traumatic event to reliable others in her environment. Mandisa was now more supportive of Lulama when they were at school and this prompted her to spend less time in isolation.

I investigated her PTSD reactions and found that her symptoms of hyper-arousal had decreased substantially and she no longer felt jumpy and overly alert on a daily basis. Instead, she experienced these reactions occasionally when she was walking in her community. In addition, her intrusion involving the first assault had ceased completely. However, she continued to experience the intrusion involving the gang rape at least twice a week and this left her distressed. It was clear that her second retelling at Mandisa's home had promoted further processing of the first assault but not of the second trauma.

I proposed to Lulama that she provide a detailed written account of the gang rape and suggested this as a homework task and she reported that she felt confident that she could do this. I explained that the written narrative needed to be comprehensive and include her thoughts and feelings at each stage of her ordeal and advised her to bring this to our subsequent session. My decision to have her write about the trauma at home was based on two factors. Firstly, I was concerned that her erratic attendance at session would inhibit work on the trauma memory and contribute to the persistence of her symptoms. Secondly, Lulama's home environment was safer and more supportive and she had more social resources outside of her family to help her cope with any distress she experienced.

Lulama had not renewed contact with Sipho since returning from Mandisa's home the subsequent week. I enquired about him and learnt that Sipho was a wealthy business man in the community and was known for having a violent temper and for being controlling and possessive. He was also rumoured to have fathered four children from four different women and was suspected of having AIDS. I asked Lulama what had motivated her to become involved with Sipho given his reputation and learnt that, when they had first met, she had not known much about him and believed that he was in his early twenties. Through giggles, she remarked that Sipho frequently bought her expensive clothing and jewellery items and she enjoyed his attention and affection. Lulama had not engaged in sexual intimacies with Sipho because she did not feel comfortable with sexual contact given the trauma and due to the rumour that he had AIDS. In addition, Lulama believed that Sipho did not want to have a sexual relationship with her and that he simply enjoyed her company. I learnt that when they were together they mostly listened to music and talked.

From her attitude towards Sipho I sensed that Lulama might re-initiate contact with him. I therefore explained to her that, given Sipho's reputation for having a short temper and being controlling, it was highly probably that he could become violent and harm her. I emphasised that it was extremely inappropriate for a man of Sipho's age to be involved with a sixteen year old school girl and she would be placing herself in a vulnerable position if she renewed contact with him. Lulama laughingly remarked that Sipho never became angry with her. I hypothesized that she did not want to see him as a threatening figure because she still wanted his care and attention. I therefore turned to Lindiwe and asked for her opinion on her sister's involvement with Sipho as I believed that with her support it might be possible to dissuade Lulama from the relationship. Lindiwe reported that she did not approve of Sipho and believed that if he even saw her sister with another man, he would probably beat her. Lulama laughed this off and I emphasised to her that Sipho's short temper meant that any small incident could provoke him and lead to her being harmed. I emphasised that she had been through a significant trauma and many people had behaved hurtfully towards her and it was important that she not perpetuate that harm by placing herself at further risk. Lulama then appeared sad and I emphasised that I was aware that she was fond of Sipho and he had provided her with comfort and care when she had felt most dejected but that I was worried that he could hurt her. She acknowledged this and indicated that she would give thought to my remarks.

I explained to Lulama that I contacted a public prosecutor and had been advised that she needed to write a letter to their office explaining the difficulties she was experiencing in having the perpetrators arrested. I offered to help her construct the letter and she agreed to this. I advised her that it would be helpful if we had the full names of the perpetrators. I asked her if anyone in her community knew the assailants' names and Lulama indicated that there were many people who did and she would enquire into this.

Therapy session 05

Focus area: Promoting safety

Lulama arrived ten minutes late for our session the subsequent week accompanied by Lindiwe and apologised for her lateness stating that due to traffic on the roads, her taxi had not been able to arrive timeously on campus.

Lindiwe informed me that while walking home with one of her friends she had seen one of the men involved in perpetrating her sister's gang rape and he had stopped and stared at her as she walked past. She reported that she had felt very frightened and thought that he intended to harm her. I advised Lulama to notify the police that the perpetrators were behaving in an intimidating manner towards her sister. I also advised her to inform her grandmother of this incident and insist that Nomthandazo accompany her to the police station to report the matter. I pointed out to her that the police had intervened immediately after Nomthandazo had contacted them regarding the issue with Sipho. It therefore appeared that she had some leverage in dealings with the police and it was important Lulama use this to ensure that action was taken. She indicated that she would speak to her grandmother and I encouraged her to do so immediately upon her return home.

I was still concerned about the possibility of Lulama renewing her relationship with Sipho and asked her if she had any contact with him and she went quiet and appeared embarrassed. After a few minutes she reported that three days previously Sipho had insisted that she visit him late in the evening but she refused and told him she would see him after school and not later that day. When she arrived at his house, he became extremely angry with her for not obeying him and repeatedly hit her and she fled in tears. After this incident she decided to end all contact with him. I expressed my sadness that Lulama had been hurt and explained that Sipho was a dangerous person and it was best she not continue to associate with him. Lulama believed it was best she not enter into romantic relationships with anyone in the near future. I explained that this was not the solution but that she needed to be more discerning when it came to the people she chose to be with. I explained that there had been certain warning signs that Sipho was not a suitable person for her to date and these included his age, his aggressive and controlling behaviour and his relationship history and reputation within the community. I emphasised that she needed to consider such factors before getting involved in a relationship and she remarked that she would try to be more discerning in future.

Lulama mentioned that she had completed the account of the trauma but had forgotten to bring it to session. I advised her that it was important that she bring the assignment to session and requested that Lindiwe remind her to do so.

Therapy session 06

Focus area: PTSD

Lulama arrived on time for our sixth session and appeared jubilant. After I reflected on this, she held out two sheets of paper and I discovered she had received two awards for academic excellence at her school's prize-giving ceremony. I congratulated her and emphasised that the awards were evidence that she was reclaiming her life. Lulama believed that the awards were indicative of her recovering and indicated that she realised that the trauma did not have adverse consequences for her ability to achieve her goals. She excitedly stated that her grandmother had attended the prize-giving and had been proud of her for her achievements. Lulama's grandmother also intended to visit the police station some time during the week to report the threatening behaviour of the perpetrator towards Lindiwe.

Thembi had suddenly stopped her taunting behaviour and I asked after this but Lulama was uncertain as to what motivated the sudden change in her behaviour. She explicitly hypothesised that it could either be related to her not having received any academic awards and feeling belittled by Lulama's achievements or because the other students were distancing themselves from her because she was critical and self-involved. With the change in Thembi's behaviour Lulama felt even safer at school and had begun to socialise more during her break times rather than secluding herself in a classroom.

Lulama had brought the homework assignment to session but it was a brief (slightly over one page long) and largely factual account of her ordeal that resembled the verbal account she had given during our first assessment session. I learnt that while writing the account she felt as though she were re-experiencing certain parts of the trauma (specifically those related to the gang rape) and felt extremely afraid. I reflected on her courage in being able to write about her experiences and asked Lulama if she felt able to talk about the narrative. She reported that she feared the perpetrators would magically appear outside my office and try to hurt her if she did so. It was clear that the exercise had intensified the sense of current threat associated with the trauma and I focused on stabilising her.

I explained to Lulama that she had reported the assaults to the police and had spoken about the rapes in session on two occasions and the perpetrators had not suddenly appeared and tried to

harm her. I emphasised that she was in a safe place and the trauma was over but Lulama was still unconvinced. I proposed to her that we disprove her assumption through imaginal reliving. I explained that by reliving a less threatening aspect of the trauma she would better appreciate that the traumatic event was in the past and she was in a safe place. I reassured her that we would pace the reliving and allow her sufficient time to recover if she felt distraught. She then agreed.

I began the reliving at the point where she was about to leave Fezeka's house and paused the scene the moment she met the first perpetrator. Lulama felt afraid after the exercise and believed the perpetrators would magically appear outside and so I asked Lindiwe to check if this was the case and she reported that there was not a single person outside. However, Lulama still felt afraid. I reminded her of the mechanisms underlying information processing during a traumatic event and explained that the fear she associated with the rapes was still active because a part of her mind was unaware that the trauma was over. I suggested we both go outside and determine if she was safe and she agreed to this. I walked outside with Lulama and she reported that she saw she was safe but still felt afraid. I reiterated that this was because the memory of the trauma had not been sufficiently processed and that, once the memory was laid, down her fear would abate.

After returning to my office, I again explained to Lulama that for the trauma memory to be processed it was necessary to update her intrusions through reliving and she agreed. However, before I could fully engage Lulama with reliving, I heard loud snoring coming from Lindiwe and, with some difficulty, I managed to rouse her from her nap. She was clearly embarrassed she had fallen asleep. There was not sufficient time for another reliving especially since Lulama would need stabilisation after the procedure. I explained this to her and she was clearly relieved and reported that she still felt afraid. I used safe space visualisation to help her feel calmer and guided Lulama to visualise being in a place in which she felt most safe. She imagined sitting on the grass beside her step-father (Andile) in the back-yard of his family home. After the exercise, she reported that she felt much calmer. I advised her to use the technique when she felt anxious or afraid at home and she agreed to this.

Absence from therapy

Lulama missed our subsequent three appointments. I repeatedly attempted to contact her telephonically and eventually reached Fezeka and asked her to notify Lulama that I was attempting to contact her. However, I did not hear from Lulama thereafter. I attempted to contact Zamiwe but found she was on leave. I also tried contacting her school telephonically but received no answer.

Surprise visit

Five weeks later, Lulama unexpectedly arrived at my office and reported that she had obtained a part-time job at a local retail store and for this reason she had not been able to make her sessions. I enquired after her reasons for not notifying me of this or attempting to reschedule since the retail store was located within walking distance of the campus. Lulama did not respond and I asked her if she wanted to continue with therapy and she reported that she did. I explained that I had another appointment in ten minutes but I could see her in two days time and she agreed to this arrangement. I emphasised that if the appointment did not suit her she should feel free to tell me immediately so that we could find an alternative time that suited both of us but Lulama stated that she could make the meeting. She did not arrive for the appointment and I did not hear from her thereafter.

3.2.6. RESPONSE TO THERAPY

At intake, Lulama was suffering from clinically significant symptoms of PTSD and depression that had persisted for five months prior to her entry into therapy. She experienced intrusive memories and symptoms of hyper-arousal on a daily basis and engaged in avoidant behaviours. This included not thinking or speaking about the traumatic event and isolating herself from others (e.g. her peer group) so as not to be reminded of the trauma. Lulama's depressive symptoms were characterised by feelings of sadness and dejection that occurred on a daily basis. Her depression also manifested in difficulties concentrating on her school work and in her feeling less interested in participating in activities that she had previously enjoyed (e.g. socialising with her friends).

Between the first assessment session and the third therapy session there was a reduction in the severity of her PTSD reactions in that she no longer experienced intrusions on a daily basis but

instead two to three times a week. This change is attributed to the crises interventions used in the assessment phase and included: psycho-education about PTSD; normalising symptomatic reactions; challenging self-blame and; promoting safety in her home environment. These interventions led to Lulama feeling less distressed and safe enough to provide comprehensive verbal accounts of both the assaults as can be seen in the second and fifth assessment sessions. However, her emotional avoidance while providing these narratives inhibited her full engagement with the trauma memory and contributed to the persistence of her symptomatic reactions.

Lulama missed her appointments for three weeks after our third therapy session and when she returned for our fourth session, there were dramatic improvements in her PTSD and depressive symptoms. Her intrusion involving the first assault had completely resolved and the only intrusion that remained involved the gang rape. Her symptoms of hyper-arousal had also drastically reduced in frequency and severity in that she no longer felt overly alert, jumpy and easily startled on a daily basis but only occasionally when she was walking in her community. In addition, her avoidant tendencies had decreased and she began to participate more in social activities and was more willing to speak about the traumatic event to others in her environment. Furthermore, her symptoms of depression had resolved and she felt much happier and more confident about her life and future. The improvements in her symptoms were the result of interventions used to manage negative social reactions, enhance her use of social resources and address her maladaptive appraisals of the trauma. This included: consulting with her school teacher to address the taunting behaviour of her peers and promoting safety in her school environment; using guided discovery and Socratic questioning to target her maladaptive appraisals about the implications of the trauma for her life and future and; identifying reliable others in her environment and actively encouraging her to share the trauma with these individuals. These interventions led to Lulama disclosing the traumatic event to a friend and to her friend's family. Her self-initiated effort at exposure within the context of a caring and supportive environment further challenged her negative appraisals of the trauma. Such exposure also facilitated the processing of the trauma memory and led to the reduction in her PTSD symptoms. In addition, increased social support renewed Lulama's belief that she was still loved, valued and cared for and allowed her to engage more in social activities rather than isolating herself. This further contributed to the resolution of her depressive symptoms.

By the sixth therapy session the improvements in her symptoms were further reinforced by her receiving two academic awards at her school's prize-giving ceremony. She viewed her achievement as signifying that the trauma did not have negative implications for her future and that she would still be able to achieve her goals. Lulama's academic achievements are attributed to her tendency to overcompensate and to the interventions used to promote safety in her home and school environment. After the trauma, Lulama had found it difficult to concentrate on her school work because of the taunting behaviour of her peers and had been concerned about her grades falling. As a result, she had taken on additional homework assignments which she completed when at home. However, at the time, her home environment had not been conducive towards academic productivity as her mother consistently verbally and physically abused her and her grandmother was not actively involved in caring for and protecting her. Following her entry into therapy, interventions were targeted at enhancing safety both within her home and school environment. Her mother subsequently stopped verbally and physically abusing her and her grandmother took more interest in her wellbeing. In addition, there was a decrease in the taunting behaviour of her peers. It is highly plausible that the increased safety in her physical environment enhanced her ability to concentrate on her school work and facilitated her achieving good academic grades and receiving the awards.

Lulama prematurely terminated therapy after our sixth session. At the time of her termination she was no longer depressed and felt more confident about her life and her ability to achieve her goals. Her PTSD symptoms had decreased in frequency and severity and she only experienced one intrusion that involved the gang rape. In addition, her symptoms of heightened physiological arousal had decreased and only occurred occasionally when she was walking in her community. The presence of these residual symptoms is attributed to her not having fully processed the trauma memory and to the continued presence of the perpetrators in her environment. She only tentatively engaged with reliving in the final therapy session and did not return to treatment after this. As such, the trauma memory had not been appropriately laid down and this contributed to the persistence of her intrusion. The presence of the perpetrators in her environment maintained the sense of threat associated with the traumatic event. Seeing the perpetrators triggered her intrusive memories and feelings of hyper-arousal when she was walking in her community. I had encouraged Lulama to maintain contact with the police to ensure that her case was being attended to but limited action was taken against the

perpetrators. I had contacted the Public Prosecutors Office and was advised that she needed to submit a letter explaining that her case was not being adequately attended to. However, Lulama prematurely terminated therapy before such a letter could be constructed. At the time of her termination her grandmother had become more actively involved in the police investigation and intended to consult with the police to ensure that Lulama was protected from the perpetrators.

3.2.7. DISCUSSION

Lulama stopped coming for therapy after her sixth session and a number of factors were implicated in her early termination. These include her dysfunctional home environment, motivational aspects and issues of safety. These features are comprehensively addressed in chapter five and therefore will not be repeated here.

CHAPTER 4: PTSD IN RESPONSE TO REPEATED AND MUTIPLE SEXUAL TRAUMAS

Khuselwa and Sanele were exposed to repeated and multiple traumas from childhood onwards and their case studies are presented below.

4.1. CASE 3: KHUSELWA

Khuselwa was a seventeen year old, isiXhosa speaking high school student who lived with her mother in a township settlement on the outskirts of the University town. She was referred to therapy by a small NGO involved in community outreach projects. Khuselwa had attended a number of camps organised by the NGO for secondary school students and had disclosed to the head of the organisation (Grace) that she was a rape victim and was having difficulty coping. Grace was familiar with my research as I had advertised my work to the NGO and she had referred Khuselwa to me. Grace informed me that Khuselwa had disclosed that she had been raped at the age of twelve by her mother's then boyfriend.

4.1.1. THE ASSESSMENT PHASE: RESULTS

The assessment process consisted of eight sessions of between sixty and ninety minutes each. Khuselwa was seen twice a week during this process.

(i) Assessment interviews

A2: BDI: 28; BAI: 15; PDS: 26.

Khuselwa arrived on time for our first meeting and after taking her seat in my office she stared fixedly at the floor and would not make eye contact or interact with me. I introduced myself and explained that my job involved helping people to cope with the problems they were experiencing in their lives and invited Khuselwa to share her difficulties with me. She looked around my office and after a few minutes, reported that she had been raped for the first time at the age of twelve. She then withdrew into silence and I reflected on the hurt that such a trauma inflicted and encouraged her to share her story with me but she would not respond. It was clear she was experiencing some ambivalence about being in therapy. I reflected on this and learnt that Grace had insisted Khuselwa enter into therapy and she had not made the decision on her own accord. I explained to Khuselwa that I would not insist that she remain in therapy against her will but that I

believed it was important for her to receive help to cope with the trauma. She then reported that she would probably not return to see me. I expressed my concern for her wellbeing and explained that I wanted to help her recover from the trauma but I would not compel her to do anything against her will. She requested that I walk her out of the building and I was uncertain whether she would return.

To my surprise, Khuselwa arrived twenty minutes early for our next meeting and I invited her into my office and asked after her decision to return and she reported that our first meeting had been "fun". I explained that I needed to ask her about her personal history as this would help me to better understand her life and experiences but I found that she would either respond with cursory or one word answers or by remaining silent. I reflected on her behaviour and Khuselwa then buried her head in her lap and explained that she was very "shy" and needed to hide her face before she could talk to me. She then proceeded to speak about her trauma.

<u>Building a narrative of the trauma: Initial Retelling</u>

Khuselwa described the traumatic events in both the second and eighth assessment sessions. In the second therapy session, she provided a hasty, brief and largely factual description of the traumatic events. She did not pause during her narrative and kept her head firmly buried in her lap as she spoke. However, she frequently giggled as she narrated her experiences and this was clearly to minimise the traumatic nature of the material she described.

- Khuselwa disclosed that, at the age of twelve, she had been raped by her mother's (Nokhanyo's) boyfriend whom she had regarded as a father figure. Her mother had been attending a funeral at the time of the rape and a neighbour heard her screaming and crying and entered the house to determine what had happened. She found Khuselwa sitting on her bed crying but was not able to draw any information from her about what had caused her distress. Nokhanyo arrived home fifteen minutes later and after much persuading Khuselwa disclosed the rape. Her mother immediately contacted the police and had her boyfriend arrested. A few weeks after the arrest, Khuselwa told her mother that she could not remain in the house in which the rape had occurred because she found it distressing and the family subsequently relocated to another neighbourhood. A few months after the move, the trial against the perpetrator commenced and Khuselwa was required to testify in court and her

testimony led to the perpetrator receiving a jail sentence. Without pausing in her narrative Khuselwa reported that her next experience of sexual victimisation occurred at the age of fourteen.

- She had been raped by her then boyfriend after he had invited her to his house and as a result of the rape she became pregnant. Khuselwa hastily stated that she had aborted the pregnancy by drinking a poisonous substance that induced premature labour. She had kept the rape and the abortion a secret from her mother because she feared being blamed for the trauma. I attempted to question her further as I was worried for her physical wellbeing but she would not answer any of my questions and simply continued with her narrative. I learnt that she had subsequently been victimised at the age of sixteen.
- She had been playing outside her home one afternoon when a neighbour called to her and requested that she purchase a box of matches for him from a nearby store. After she returned with the purchase, the neighbour instructed her to place the box inside his house and once she entered the house he locked the door and then raped her. Khuselwa reported that she could not remember certain aspects of this trauma but that she was not distressed by her amnesia because she did not really want to remember what had occurred. She then continued her story and proceeded to narrate her most recent experience of sexual victimisation.
- Three months previously she had been walking home with her best friend (Nomsa) when an acquaintance had called to her and insisted that she and Nomsa accompany him to a shed situated behind his house as he wanted to show them something. After they entered the shed, he locked the door behind them and kept them captive for one month during which time he repeatedly raped them. I asked Khuselwa whether her mother had taken any steps to locate her during the month she had gone missing but she avoided this question. After their release, Nomsa had reported the kidnapping and rape to the police and an investigation had been initiated. Nomsa had also undergone an HIV test and found she was HIV positive. Khuselwa feared undergoing a similar test lest she discover that she too had the virus.

After her narrative, I felt very unsettled as I had not expected such a history of sexual violence. I responded by reflecting on Khuselwa's courage in being able to share her story with me and explained that I realised she had been severely hurt by people close to her and I wanted to help her heal. Khuselwa raised her head from her lap and looked directly at me and asked me what exactly I thought I could offer her. It was clear that she doubted that I could make any difference

in her life and I believed it was important she have a realistic perspective of what was possible in therapy. I explained that I could not undo her experiences or take away her feelings of sadness and hurt but I could offer her a space in which she could share her experiences and receive care and support and obtain some relief from her distress. Khuselwa then reverted to burying her head in her lap and remarked that she often felt suicidal. I normalised her reaction and explained that I understood why she would consider suicide an option given the hurt she had suffered. I advised her that it was important that she not engage in any suicidal behaviour while we worked towards helping her in therapy and she agreed to this.

Prior to the close of our session, Khuselwa requested to bring Nomsa to our next meeting and I agreed as I believed she could benefit from the support of her friend. I asked after her friendship and learnt that Nomsa's mother had cast her out of her own home for disclosing that her step-father was sexually abusing her and Nokhanyo had taken her in six months previously. I established that Khuselwa had tentatively revealed her victimisation at the age of twelve to Nomsa and had received care and support from her friend. However, she had refrained from disclosing the other traumas because she did not want to burden Nomsa. I walked Khuselwa out of the building and before she left she reported that she may not be able to make our next session. I reiterated that I wanted to help her but that it was solely her decision whether she wanted to continue to see me. After she left, I felt extremely saddened and experienced a sense of disillusionment with the world. I wondered how it was possible for a girl to have been raped so many times in her life without any-one knowing or caring. I also questioned my own capabilities and whether I could actually help her cope. I felt that, for Khuselwa, I did not know what recovery entailed but I wanted her to stay in therapy.

Challenges in promoting safety

Khuselwa arrived ten minutes early accompanied by her best friend and I found that Nomsa was also extremely shy and hesitant to engage with me and sat silently for most of the session. Khuselwa, in contrast, was slightly more forthcoming. She reported that, two days previously, the perpetrator of the kidnapping had arrived at her home in the evening intending to visit her mother but Nokhanyo had not been home at the time and Nomsa had been outside. Khuselwa had refused the perpetrator entry into the house and he had made derogatory remarks towards her before eventually leaving

I was extremely concerned for Khuselwa's welfare. I explained to her that it was important the perpetrator be removed from the community and that, to achieve this, she needed to report the kidnapping and rape to the police and open a case docket as Nomsa had done. However, Khuselwa adamantly refused and reported that she feared the police would not believe her because she was "only a school girl". I offered to accompany her to the police station but this response only caused her to withdraw and she remained silent for ten minutes before stating that she had "given up" on the matter because "bad things just happen". I invited her to speak further about these beliefs and learnt that she assumed she was responsible for the kidnapping. At the time she had sensed that something untoward was about to occur as she approached the shed behind the perpetrator's house but she had not given this feeling much import. As a result, she believed she was to blame for the trauma. I explained to Khuselwa that she had no way of knowing the perpetrator's intentions and emphasised that he was the only one responsible for the assault as he had made a decision to hurt her. She then reverted to silence and would not engage with me. I attempted to speak with Nomsa but she too remained silent. I advised her that it was important that she received psychological care and that I was willing to refer her to another psychologist if she wanted to enter therapy.

At the close of the session, I indicated to Khuselwa that our session time was up and I would see her soon and she reacted by stating in a petulant fashion that it was her office and Nomsa and I should leave. I responded in a neutral tone and explained to Khuselwa that I could only see her for a specific period of time and we had come to the close of our current session but I would see her soon. She immediately rose and then giggled as she left the office.

I received a letter from Nomsa in our next session thanking me for caring about her and requesting that I obtain a referral for her but the letter had no return address and she had not included her contact details. I asked Khuselwa for this information and she reported that Nomsa's mother had a change of heart and had insisted that her daughter return home. As a result, Nomsa had also been transferred to another school and Khuselwa did not know her contact details.

I was extremely concerned about the presence of the perpetrators in Khuselwa's immediate environment and I sought her consent to contact her mother and Grace but as I stated this Khuselwa immediately turned away from me and stared fixedly at the wall adjacent to her. After a few minutes, she reported that she did not want me to have any contact with her mother or with Grace and that she would terminate treatment if I did not respect her wishes. I explicitly hypothesised that she was afraid that I would disclose the traumas to her mother and that her mother would subsequently be upset with her for not telling her about these abuses. Khuselwa agreed with me but would not discuss this further. I also explicitly hypothesised that she was afraid of being removed from her mother's care in the event that I learnt that her home environment was not conducive to her wellbeing. She reported that this was also the case and then withdrew. I emphasised that I would not do anything that would jeopardise her wellbeing and that I would not contact her mother or Grace without her consent but she remained withdrawn for the rest of the session. I decided against immediately speaking to her mother or obtaining collateral information from Grace as I believed it was important to ensure that Khuselwa felt that she could trust me.

Crises management

Discovering HIV status

Khuselwa arrived thirty minutes early for our fourth appointment and after knocking on my door she walked into my office and seated herself. She was clearly attempting to prolong our sessions by arriving early but I decided to address this at a later time as she appeared extremely forlorn. I reflected on her sadness and she placed her head in her lap and would not speak with me for the next hour. I repeatedly reassured her that I cared for her and wanted to her help her cope and invited her to share what was troubling her but she remained in the same position. After the allotted hour, I explained to Khuselwa that our session had come to a close and I would see her for our next appointment and she responded by asking me for a sheet of paper and a pen. I offered her these items and she quickly scribbled on the paper and then handed it back to me. I read that she had visited a clinic earlier in the day and had undergone an HIV test and found that she was HIV positive. I was horrified at this news and shocked that a seventeen year old had been administered an HIV test without a parent or supportive other present. I expressed my shock and sadness that Khuselwa had HIV and consoled her but she reverted to being withdrawn. I psycho-educated her about the HIV virus and explained that she could still lead a rich and long life. I

repeatedly reassured her that I cared for her and would remain with her to help her cope with this news but she remained unresponsive. Forty minutes later I advised Khuselwa that we would work together towards helping her but that our session time was up and she remained in the same position and would not budge. I rose and opened the door to my office and explained that I would see her for our next session. Khuselwa then raised her head and reached into her bag and brought out a comb, lip gloss and a mirror and for the next five minutes she adjusted her hair and make up. She intermittently turned to look at me as if to determine whether I was angry with her. I waited patiently for her to finish and she eventually asked me in a petulant manner what I thought I was looking at. It was clear she was trying to push the boundaries of our session and testing to determine whether I would respond harshly towards her. I responded by stating, in a neutral tone, that I was waiting for her because our session time was up. She then rose and as she walked out of my office I remarked that I would see her soon and she responded by laughing and then quickening her pace.

Khuselwa once again arrived thirty minutes early for our fifth appointment and walked into my office and seated herself. I decided that, given her behaviour in our previous session, it was necessary to establish firmer boundaries as this would provide her with a sense of predictability and stability and prompt her to better use the allotted session time. I therefore explained to Khuselwa that I would only be able to see her for one hour and that she needed to arrive at the specified time for each therapy session and she responded by staring fixedly at the floor.

I reflected on her disclosure about her HIV status and asked her how she was coping but she remained silent. I encouraged her by explaining that she had one hour with me and that if she wanted to spend the time in silence I was comfortable with that but I also wanted her to engage with me about her troubles. Khuselwa then responded to my queries with one word answers or short replies. Through close questioning I learnt that she had been shocked to learn that she was HIV positive and at the time had "felt like dying". I once again psycho-educated her about HIV and reiterated that she could still lead a full life provided that she looked after herself. Khuselwa, however, did not believe that this would be possible and reported that she found it difficult to care about herself. I reflected on the possibility that she had difficulty caring about herself because so many people had shown such disregard for her welfare and learnt that she believed she had been raped because there was something inherently "bad" about her. I actively argued

that I did not believe Khuselwa was a bad person but she then reverted to silence and stared fixedly at the floor and would not engage with me thereafter. It was apparent that my remarks had unsettled her construction of herself.

After the allotted hour, I indicated to Khuselwa that we had reached the close of the session and she once again tried to prolong the meeting but this time by handing me her homework book and stating that she had been required to write an essay on sexual abuse. I briefly went through the essay and found that she had included a brief account of the first rape. I reflected on her courage in being able to write about her experiences and then returned the book to her and explained that we could speak more about this during our next session. She angrily reached for her bag and took out her comb, lip gloss and mirror and proceeded to adjust her hair and make up while intermittently turning to look at me and giggle. I advised Khuselwa that therapy was not the appropriate place for her to be tending to her hair and makeup and invited her to use the ladies room after our sessions for this purpose. I rose and opened the door to my office and remarked that I would see her for our next meeting. She immediately put her makeup back in her bag and laughed as she walked out of the office. Khuselwa arrived on time for her subsequent appointments and respected the one hour time limit for sessions and stopped bringing out her makeup kit.

Anniversary Reaction

At the outset of our sixth session, I asked Khuselwa how she was coping as she appeared distressed and she reported "not good" and reverted to silence. I encouraged her to share her experiences and reassured her that I cared for her. After ten minutes she offered me a hand written letter in which she reported that two days previously she had experienced an anniversary reaction in respect of the first assault and that this had left her badly shaken. She had locked herself in her room so that her mother would not notice that she was upset and had refused to come out of her room even for meals. In the letter she had also written that she did not trust anyone not even her mother. I reflected on her feelings of sadness in relation to the trauma and normalised her experience by psycho-educating her about anniversary reactions. I explained that it was expected she would feel distressed given the nature of the trauma she had endured. I reassured her that the trauma was in the past and that she had been extremely brave in prosecuting the perpetrator for the crime and emphasised that he would not hurt her again.

Khuselwa remained silent throughout the session and kept her head downcast and I felt sad for her. At the end of the session, she requested that I accompany her out of the building and as we walked towards the main door she informed me that she would not make our next meeting because she had decided to relocate to a different province to live with her aunt. I responded by remarking that I would see her next week and she appeared surprised and then dashed down the stairs and shouted back that she was fibbing and that she would see me soon. Her behaviour clearly reflected her uncertainty as to whether she could trust me to consistently care for her and be available to her.

Psycho-education about PTSD

Khuselwa appeared less distressed during our seventh assessment session but still remained withdrawn and unresponsive. I used the session to psycho-educate her about PTSD and the mechanisms underlying the disorder so as to further normalise her anniversary reaction and help her to feel less distressed. I first explained the concept of PTSD and emphasised that people often experienced symptoms of this disorder after they had undergone a severe trauma. I then used the analogy of a cupboard to describe the storage of memories. I explained that, because traumatic events were overwhelming, people were often not able to make sense of their experience and information simply flooded into the cupboard and was not properly organised. As a result, it was difficult to close the cupboard and things often fell out and the information that fell out was what was experienced as flashbacks. I explained that it was our job in therapy to organise this cupboard by taking everything out and placing it back in order. I emphasised that this meant discussing the trauma in detail including what she thought and how she felt about each trauma. I then asked Khuselwa whether she understood my explanation and learnt that it made sense to her.

Intrusions and problematic assumptions

I closely questioned Khuselwa about her intrusions and determined that her memories were triggered when she thought about the rapes and when she heard stories about sexual abuse from other people or on television. To cope with these intrusions, she suppressed her memories of the trauma believing that this would prevent flashbacks from coming to the fore. I psycho-educated her about the futility of thought suppression and to illuminate this I decided to use a behavioural

experiment. I asked Khuselwa if she could imagine a pink elephant and then try to not think of this image but she refused to engage with this task.

Through close questioning, I learnt that Khuselwa believed that the first trauma had negative implications for her future. She equated virginity with "goodness" and believed that because of the first rape she had been made completely "bad" and this left her feeling sad and dejected. She also tended to ruminate on the first assault and during these episodes she thought about how she could have prevented the rape from occurring and how to further punish the perpetrator for hurting her.

Self-blame

In our final assessment session, I investigated Khuselwa's intrusive memories of the first rape as well as her intrusions related to the time she was held captive but she would not elaborate on these memories. I asked her about the emotions that were evoked when she experienced intrusions and she reported that she felt "bad". It was evident she had difficulty recognising and labelling emotions and so I listed a series of feelings and experiences (i.e. "sad"; "angry"; "ashamed"; "guilty"; "self-blame", etc) and asked her if any of these states came to the fore when she had an intrusion. After considerable thought she chose "sad", "self-blame" and "anger". I subsequently invited her to speak about her self-blame and she reported that she realised that children were not to blame for their victimisation but she nevertheless blamed herself. I addressed her self blame by once again reminding Khuselwa that the perpetrator was the only one responsible for the assault and she had been a child and was not to blame. However, she still remained ambivalent. This can be seen in her remarks below which were taken from the transcript for the session.

> I just blame myself because anyway abuse is not the child's fault...it is never ever the child's fault...I just blame myself for nothing

I invited Khuselwa to speak about her anger but, apart from reporting that she was angry with the perpetrator, she would not speak about this any further. After a few minutes of silence and to my surprise, she requested to read a poem to me. I encouraged her and she took out a book that she had secreted behind her and positioned it directly in front of her so that it hid her face

and proceeded to read. Her first poem was about her rights and responsibilities and Khuselwa had written that she had a right not to let anyone touch her. She indicated that adults had a right to protect children and that children were innocent and no child was to blame for being abused. In addition, she wrote that adults were wrong for abusing children. After the reading I complimented her on the poem and acknowledged that children were innocent and had a right to be treated with respect and dignity and that it was wrong that adults infringed this right. I also emphasised that as a child she too had a right to be protected and that it was wrong that adults had hurt her.

She then asked if she could read something else to me and I discovered that the preceding day (two days after our seventh session) she had written about each of the rapes in her journal. It was apparent that psycho-education in our seventh session had prompted Khuselwa to write about her experiences and that in doing so she was attempting to facilitate processing and heal from the traumas. Each account was titled "My Story" and she had numerically labelled each of the traumas from "My Story 1" to "My Story 4" and had written down the dates on which each assault had occurred. She read each of these narratives to me and I found that they were much more detailed than the verbal account she had given.

Second retelling

"My Story I"

Khuselwa wrote that she had regarded her mother's boyfriend as her step-father and had trusted and loved him dearly and had not expected him to hurt her so badly. She had experienced the rape as a profound betrayal and had felt hopeless following the trauma and believed that her life and her future would never be the same. Khuselwa wrote that she thought about this trauma on a daily basis and it left her feeling helpless. After she read the first narrative, I asked her how she was feeling and she reported that she did not know. I reflected on her bravery in being able to read her story and thanked her for sharing her experiences with me. She then raised her book and asked me whether I was listening and proceeded to read her written account of the second trauma.

"My Story II"

Khuselwa reported that she had been dating her first boyfriend for a month before he invited her to his home. While in his bedroom, they had talked and kissed and it was the first time she had kissed a boy. After this intimacy her boyfriend told her that they had been dating for a month and he believed they could now further their intimacies by having intercourse. Khuselwa had felt shocked by his suggestion and told him that she did not intend to have sex until she was married. He then angrily informed her that, if she loved him, she would have sex with him but she repeatedly refused. He then locked the door to his room and forced himself on to her and raped her. Khuselwa had felt physical pain during the assault and cried and begged him to stop but he did not. A few months after the trauma she experienced severe discomfort in her stomach area while at school and notified one of her school teacher's who took her to a local clinic where she learnt that she was pregnant. Khuselwa reported that she had subsequently aborted the child and had informed her boyfriend of the pregnancy and the abortion but he immediately denied paternity. This prompted her to end all contact with him.

After the second reading, I reflected on her sense of betrayal at the behaviour of her boyfriend and on her feelings of anger and hurt but she remained unresponsive and simply stared at her book. I asked her if I could see her journal and emphasised that she did not have to show it to me if she did not feel comfortable doing so but Khuselwa immediately handed me her journal. She guided me through the material in it and I found that it was elaborately decorated with drawings of flowers and hearts. She had pasted letters from people she had met at various camps on the pages and awards she had received from her school. I complimented her on her journal and she then asked to continue reading her story and so I returned her book. She now placed it on her lap instead of using it to conceal her face and it was apparent she was feeling safer with me. As she read I realised she was narrating an assault that she had not disclosed in the second session.

"My Story III"

Khuselwa reported that one evening when she was fifteen years old a man had knocked on the door to her house and indicated that he was a friend of her mother's and requested that she let him into the house. After opening the door for him she informed him that her mother was not at home and she was alone in the house and needed to complete her homework. She suggested

that he return some other time. The perpetrator then offered to help her with her homework and she refused but he did not budge and she began to feel nervous. The perpetrator turned around and locked the door and Khuselwa started to cry because she realised that he intended to rape her. After he had raped her, the perpetrator left the house and Khuselwa did not report the assault to her mother when she returned home. After narrating this incident, Khuselwa turned the page and continued to read without pausing.

"My Story IV"

At the age of sixteen, she had been playing with her friends when her neighbour asked her to purchase a box of matches for him and when she returned he told her to place the box on a table inside a room in his house. He then followed her into the house and locked the door and dragged her to another room where he raped her. After the assault the perpetrator threatened Khuselwa and told her that if she disclosed the rape, he would kill her and hide her body in a field and she would never see her mother again. Some weeks after the trauma, Khuselwa learnt from another neighbour that the perpetrator was HIV positive. She felt extremely distressed and attempted suicide by drinking a combination of bleach and various other household detergents. Nomsa found her lying on the floor convulsing and immediately called an ambulance and Khuselwa was taken to a general hospital. After recovering a few hours later Khuselwa begged Nomsa not to tell her mother of her suicide attempt and to simply inform her that she was spending the night with a friend. Khuselwa then stopped her narrative and I noticed that the subsequent page was blank. She had not written about her most recent experience of victimisation.

I asked Khuselwa how she was coping and she reported that she was "fine" and then proceeded to page through her book. She eventually stopped at her written account of the first trauma and stared fixedly at the page. I asked after her thoughts but she would not respond and continued to stare at the page as if mesmerised. It was clear she had been emotionally overwhelmed and was experiencing a dissociative episode. I decided it was necessary to help her distance herself emotionally from her narrative and so I proceeded to call to her. Once I had her attention, I asked her about her school and her friends and after a few minutes she looked away from the page and spoke about her favourite subjects. At the close of the session, I asked her how she was feeling and she reported that she felt a bit better.

4.1.2. DIAGNOSIS

Khuselwa completed the self-report scales on only one occasion during the assessment process despite my requests that she complete the inventories at least once a week. Given the nature of her presentation, I did not push the issue. On the basis of the assessment interviews and Khuselwa's self-report scores, she was diagnosed with the following:

(i) PTSD

Khuselwa met diagnostic criteria for PTSD. She experienced intrusive memories in relation to the first sexual assault which had occurred when she was twelve years of age and these intrusions persisted for five years since that traumatic event. She also had intrusions related to the most recent trauma that had occurred three months prior to her initiating therapy and in which she been held captive for a period of one month and been repeatedly sexually assaulted. Her intrusive memories occurred when she thought about the rapes or heard stories of sexual abuse. Khuselwa experienced symptoms of hyper-arousal and felt overly alert, jumpy and easily startled when in her community and tended to constantly monitor her surroundings to determine if any of the perpetrators were in the vicinity. She avoided thinking about and speaking about the traumas and suppressed her memories of abuse as she feared that she would not be able to cope with the distress that was evoked. She feared the possibility that others would not respond to her kindly and would accuse her of fabricating her story. In addition, Khuselwa avoided situations that reminded her of the assaults and this included the house in which the first trauma had occurred and the shed in which she had been held captive.

(ii) Dysthymic Disorder

Khuselwa met diagnostic criteria for dysthymic disorder. She experienced feelings of sadness, dejection and guilt for five years since the first trauma. Her depressed mood was connected to her appraisals of the first assault in that she believed the rape had compromised her virginity and therefore made her a bad person. Her experiences of re-victimisation aggravated these negative beliefs. Khuselwa assumed that the subsequent sexual assaults were evidence that she was a "bad person" and therefore deserving of the abuse. Her re-victimisation also shattered her belief in personal control and led to her assuming that bad things simply happened and there was little she could do to protect herself or change her situation. These factors contributed to the persistence of her depressed mood.

(iii) Borderline traits

Khuselwa showed signs of personality disturbance but she did not meet criteria for any of the personality disorders. Her symptom presentation mostly resembled that of borderline personality disorder in that she experienced a self-image characterised by the assumption that she was a bad person. She also showed signs of impulsivity as were evident in her suicidal gestures and alexythymia as can be seen in her difficulties describing emotional states. In addition, she displayed a marked oscillation between needing interpersonal closeness or proximity and fearing it. This can be seen in her attempts to prolong sessions and in her behaviour at the end of therapy sessions when she would inform me that she would not make it to the next appointment.

4.1.3. CASE FORMULATION AND TREATMENT PLAN

(i) Predisposing factors

Khuselwa was raised in a neglectful and abusive home environment. Her parents divorced when she was two years of age and she resided with her mother (Nokhanyo) thereafter. Nokhanyo experienced severe problems with alcohol abuse and this affected her ability to care for and support her child. She frequently left Khuselwa at home alone and unsupervised for extended periods of time and provided her with some attention and care when she was present. As a young child Khuselwa had felt afraid to approach her mother for comfort and support because Nokhanyo's behaviour became unpredictable when she was inebriated. These early relational patterns contributed to Khuselwa developing a disorganised style of attachment that conferred vulnerability to complex PTSD (*see section 1.3.3. (ii))*.

The failure to develop an organised strategy for coping with distress leads to affective dysregulation (*see section 1.3.3. (ii)*). In Khuselwa's case, this manifested in problems recognising and identifying feelings, tolerating emotional states and using physical sensations as guides for effective action. Her difficulties in managing emotions resulted in her actively avoiding internal experiences and led to her being vulnerable to dissociation. A disorganised attachment relationship confers negative internal working models or maladaptive schemas in which the self is regarded as unworthy of care and attention and others are regarded as unavailable, unreliable and untrustworthy. For Khuselwa, her relationship with her primary caregiver contributed to her developing early maladaptive schemas involving: defectiveness shame; emotional deprivation,

abandonment/instability and; mistrust/abuse. She assumed that her mother's inability to provide her with care and affection was indicative of her being deficient in some way and therefore unworthy of love, care and protection (defectiveness/ shame). Inconsistent and neglectful caregiving contributed to Khuselwa expecting that she could not rely on other people to be available and adequately responsive to her needs (abandonment/instability; emotional deprivation). She assumed that if she expressed her needs and feelings to others they would behave in a rejecting and hurtful manner (mistrust/abuse). These schemas were subsequently reinforced by her father's behaviour following the divorce. A year after the separation Bongani remarried and encouraged Nokhanyo to let Khuselwa visit him at his new home. However, Khuselwa's step-mother did not respond kindly to these visits and was often verbally abusive towards her. Bongani did not intervene to stop these abuses despite his daughter's repeated attempts to alert him to the situation. Khuselwa interpreted her father's neglectful behaviour to mean that he prioritised his new wife and step-children more than her. As a result, she eventually dissuaded her mother from sending her for such visits and spent most of her time at home. Bongani did not enquire after Khuselwa's reluctance to visit him and only occasionally asked after her. His reluctance to remain actively involved in her life and unwillingness to protect her confirmed her core negative beliefs that she was not worthy of care and protection and that she could not trust those close to her to be available and responsive to her needs.

When Khuselwa was six years of age, her mother became involved in a romantic relationship with a man (Moeketsi) in her community who was warm, caring and supportive and he provided Khuselwa with attention and affection. However, the relationship dissolved after a year. Moeketsi did not maintain contact with the family. Khuselwa missed his presence in her life and did not understand his reasons for not staying in touch with her. His departure further reinforced Khuselwa's core beliefs that she was deficient in some way and that if she became close to other people, they would abandon her. Two years later, when Khuselwa was eight years of age, Nokhanyo became involved in another romantic relationship and after a few months her partner moved in with her. Nokhanyo's boyfriend took an active interest in parenting Khuselwa and often played with her, helped her with homework, took her to school and looked after her during her mother's absences from the home. As a result, Khuselwa came to regard her mother's boyfriend as her step-father and she felt able to turn to him when she was distressed or when she needed help. Khuselwa's relationship with her mother's boyfriend offered her the stability and security

necessary for her to develop some degree of affect regulation skills and tempered the consolidation of her maladaptive schemas. Khuselwa gradually came to believe that she might actually be worthy of love, care and support and that she could depend on other people to remain in her life and be available to her for comfort and reassurance. However, when Khuselwa was twelve years of age, her mother's boyfriend violently raped her and she experienced the trauma as a shock and a profound betrayal. Through her schooling experiences, Khuselwa had come to equate virginity with "goodness". She subsequently viewed the assault as having compromised any goodness that was in her and assumed that she had been rendered even more deficient and bad. In the immediate aftermath of the trauma, Nokhanyo had the perpetrator arrested and with Bongani's support, she assisted Khuselwa in testifying against her partner and securing a jail sentence. Khuselwa's parents behaved in an extremely supportive and caring manner in the wake of the trauma. However, due to her early experiences she still felt frightened by her mother and abandoned by her father and therefore their actions did not significantly alter her schemas.

Two years after the trauma, when Khuselwa was fourteen years of age, she became involved in her first romantic relationship with a young man she met at school. She believed him to be caring and trustworthy and one day accepted his invitation to visit his home. However, he subsequently raped her and Khuselwa experienced the assault as another betrayal of her trust. This trauma served to further reinforce her belief that she had been made "bad" by the first assault and was therefore deserving of such abuse.

In the three years after the rape by her boyfriend Khuselwa was exposed to three discrete episodes of sexual assault and these traumas served to consolidate her belief that she was a bad person and unworthy of care and protection. It also contributed to her believing that she did not have any personal control and could not protect herself from danger.

(ii) Precipitating Factors

Three months prior to her entry into therapy, Khuselwa was kidnapped by an acquaintance and held captive for one month during which time she was repeatedly raped. This incident was particularly traumatic and activated her negative core beliefs. She assumed that she was to blame for the trauma because she had followed the perpetrator to the shed behind his house

and because she had not respected her intuition that something untoward was about to occur. Despite having disappeared for a month, her mother did not make any concerted efforts to search for her or report her disappearance to the police. This further reinforced Khuselwa's assumption that she could not rely on those close to her to care about her welfare or to act in ways that ensured her safety. In addition, it further confirmed her assumption that she could not prevent bad things from occurring and that she had no personal control over her life. In the aftermath of the trauma, Khuselwa's symptoms of PTSD and depression increased and this prompted her to eventually seek help in coping with her repeated victimisation.

(iii) Maintaining factors

Khuselwa's attachment dynamics and associated maladaptive schemas contributed to the maintenance of her symptoms of PTSD and depression. She viewed other people as sources of threat and did not trust that they would be available or responsive to her needs. Khuselwa also believed that she was deserving of the abuse and that she was not worthy of protection, care and empathy. These assumptions inhibited her from disclosing her revictimisation and receiving the care and support she needed. Furthermore, her beliefs prevented her from disconfirming her maladaptive beliefs that she was a bad person and deserving of the abuse and this contributed to the maintenance of her symptomatic reactions.

4.1.4. PRESENTATION OF TREATMENT PLAN

It was clear that Khuselwa needed to be part of a long term therapy programme and I emphasised that I wanted to continue seeing her until she was in a better space. I explained that we would work towards helping her cope with the effects of the rapes on her life and try to help her heal. While I spoke about this Khuselwa assumed a crouched position in her chair and kept her head facing the ground and would not engage with me. I did not believe it would be helpful at this stage for me to label her difficulties (e.g. as PTSD, depression, etc). Instead, it was clear that it would be more beneficial to have Khuselwa take the lead in session.

4.1.5. THERAPY NARRATIVE

Khuselwa was seen twice a week for one hour per session and she made twelve therapy sessions but then stopped coming to therapy. She was subsequently seen for one session before she prematurely terminated.

Therapy session 01 [T1: BDI: 29; BAI: 8; PDS: 20]

Self-blame

I encouraged Khuselwa to take the lead in determining the content of our sessions by inviting her to share her experiences since our previous meetings and by asking her how best she would like to use our time together.

In the session she was initially unresponsive but after much encouragement she revealed that she was experiencing feelings of self-blame related to her belief that the traumas were punishment for her having done something wrong. I proceeded by psycho-educating her about the causal factors underlying sexual violence. I first asked Khuselwa if she had any ideas as to why men raped and through Socratic questioning learnt that she believed that men raped so as to punish women. I validated her assumption and explained that there were different factors motivating sexual assault and that while certain men perpetrated rape out of a desire to feel powerful and in control, others did so due to their negative attitudes towards women and their desire to punish women for some perceived wrongdoing. I emphasised that this did not imply that the woman had done anything wrong or was to blame in any way for the trauma. Khuselwa appeared sad and raised her hand and hid her face behind her palms and quickly turned to face away from me. I explained that it was expected that she would feel sad because she had been badly hurt and reiterated that she had done nothing wrong and was not to blame in any way for any of the traumas. I emphasised that the perpetrators were the only people responsible for hurting her. Khuselwa began to sob, clearly because of the affirmation that she was innocent. I reflected on her sadness and invited her to speak with me but she remained withdrawn and unresponsive. It was only towards the close of the session that I was able to draw her out by asking her about her hobbies. Before she left Khuselwa engaged in her usual ritual of informing me that she would not make it to our next meeting. This time she reported that she was going to jail because she had stabbed a boy at her school for teasing her. However, once I expressed my

concern and enquired further she giggled and told me she was fibbing and would make the next session.

Therapy session 02

Late arrival

Khuselwa arrived thirty minutes late for our second session and was extremely withdrawn. I attempted to draw her out by asking her arbitrary questions about her school and her friends but she kept her head lowered and stared fixedly at the floor. At the close of the session, she reported that she would not be able to see me in future because she had now made firm plans to relocate and reside with her aunt. After I probed further she giggled and reported that she was lying and that she would see me for our next meeting. As she walked out of the office, she remarked that she had not been feeling well and for this reason she had not felt up to talking in the session and I indicated to Khuselwa that I understood this.

Therapy session 03

Dissociation

Khuselwa was still withdrawn in our third therapy session but this time there was a defiant and punishing quality to her behaviour. She responded to all my queries by non-verbally indicating (i.e. grunting) that she wanted the question repeated but then she would not answer my query. I eventually reflected on her behaviour and she giggled and remarked that she simply wanted to hear me repeat the question. I explained to Khuselwa that I had noticed in our sessions that she found it difficult to speak with me and that she often responded with one word answers or in a cursory way or by not replying at all. I emphasised that I wanted her to feel comfortable sharing her experiences with me so that I could gain a better understanding of her life. I explained that her behaviour inhibited me from doing so and asked her how we could go about helping her to share her experiences. Khuselwa reacted by immediately turning her chair away from me and facing the wall behind her. She placed her thumb in her mouth and stared fixedly at a picture on the wall in a trance like state. I repeatedly called to her but she would not respond and it was clear that she was in a dissociative state. I continued to call her name and after ten minutes she realised that I was calling to her and turned further away so that her back was completely facing me.

It was apparent that Khuselwa had found my remarks threatening and I focused on stabilising her. I took out colouring pencils and drew a flower that resembled the ones she had drawn in her journal and placed it near her and she immediately grabbed the drawing and looked at it and kept it close to her. I subsequently explained to Khuselwa that I believed that my comments had hurt her and that I cared for her very much and had not intended to hurt her in any way. She started sobbing and I apologised for causing her distress and reiterated that I cared for her and did not mean to hurt her. Khuselwa turned around and grabbed a piece of paper from my table and started writing furiously and after ten minutes, she handed the sheet to me and turned away. In the letter she reported that she would not return to session because my remarks had upset her. She also stated that her teachers at school berated her for not participating in class and for providing one word answers and that she did not know how to converse with others apart from in this fashion. After reading the letter I thanked Khuselwa for sharing her experiences with me and again apologised for hurting her. I explained that in future I would respect her capabilities and that she could converse with me to the extent that she felt able to. I also emphasised that I wanted to work with her and that I did not want her to stop coming for session. Khuselwa then nodded and abruptly got up and dashed out of my office.

Therapy session 04

Reparation

Khuselwa brought a letter to our next meeting in which she apologised for her behaviour in our previous session and stated that she would endeavour to be more conversant and would also try to be happy. She included a poem in her letter that expressed her fondness for me. I thanked Khuselwa for the letter and poem and explained to her that she did not need to apologise to me because I had been in the wrong. I explained that I had pushed her further than she was comfortable with and in doing so I had hurt her and this had been wrong of me and I again apologised for this. Khuselwa lowered her head and stared at the floor and would not engage with me. It was clear she had not expected me to own my actions and affirm that she was innocent. Towards the close of the session, she requested to use a sheet of paper and crayons and proceeded to draw a colourful picture of a woman and then handed it to me and indicated that the picture was of me. I thanked her for the drawing and she reached into her pocket and drew out a small brown teddy bear that held a heart between its paws on which was inscribed 'I love you' and placed it near me and stated that she had bought the bear for me. It was apparent

that her gifts were attempts at reparation and I felt sad for her. I thanked her for the present and asked if the bear had a name and after learning that his name was "Lucky" I told Khuselwa that I would look after Lucky and keep him safe. I made sure to place Lucky on the table near me before each of Khuselwa's subsequent therapy sessions.

Therapy session 05

Drawing

In the session, I decided to use drawing to help Khuselwa engage with me and share her experiences. I offered her drawing materials and invited her to draw a picture but she was markedly hesitant. To encourage her I proposed that we both draw a picture that involved a house, a tree and a person and she agreed to the task but it was clear from her reaction that she was not enthusiastic about using this method in therapy. Khuselwa spent the entire hour drawing her picture which comprised a transparent house with a large, bare tree next to it. Beside the house, she had drawn a young girl holding a heart shaped balloon. The picture of the girl resembled the one she had drawn of me in our previous session. After the allotted hour, Khuselwa requested that I walk her out of the building and as we approached the main door, she hastily disclosed that she might not make the next session as she had to testify in court. Before I could enquire further, she dashed out the door and ran down the stairs. I expected that she was referring to the case against the man who had kidnapped her and I decided to enquire after this during our subsequent meeting

Therapy session 06

Feeling safe in session

I asked Khuselwa about the court appearance and she forcefully stated that she did not want to speak about this issue. I was concerned about what had transpired and so I prompted her further. I learnt that Nomsa had testified against the perpetrator but that Khuselwa had not done so because she had been afraid. I affirmed her experiences and explained that it was very frightening to visit a court house on her own and be faced with the man who had hurt her. I proceeded to enquire further about her experiences and she hesitatingly requested that I not ask her any questions in the session. I invited her to use the drawing materials to convey her experiences but she reported that she did not want to draw in session. After a few minutes, Khuselwa closed her eyes and fell asleep but she roused herself every ten to fifteen minutes and

checked to determine that I was still present and watching her. It was clear that she was feeling much safer in therapy and cared for. At the end of the session, I roused her by gently holding her shoulder and explaining that we had come to the close of our session. Khuselwa then walked to the door of my office and surprised me by remarking that she would see me soon.

Therapy session 07

Sharing poems

Khuselwa brought her journal to the session and I asked her if she wanted to share anything in the journal with me but she reported that she did not want to and would not engage with me thereafter. However, ten minutes before the close of the session, she requested to read poems to me that she had written and I encouraged her and she read out three poems. The first was about dreams and the importance of cherishing one's dreams while the second was about friendship and the support and care afforded by having friends. Her third poem was about love and Khuselwa had written about the importance of trust, unconditional love and patience. I thanked her for sharing her poems with me and encouraged her to keep writing in her journal. Before she left, she reported that after our next session it was her school holidays and she would not be able to see me for three weeks and I asked her how she felt about this prospect but she remained silent. I explained to her that I would still be here and that we would continue our work together when she returned.

Therapy session 08

Sharing poems

Khuselwa brought her journal to session once again but would not respond to any of my questions or statements about her wellbeing and so I decided to play a game with her to draw her out of her shell. I asked after her favourite food and attempted to guess the ingredients used to prepare this dish and Khuselwa giggled and laughed at all my incorrect guesses and urged me to continue guessing. She eventually revealed the items that constituted the dish and then asked me if she could read two poems from her journal. Her first poem was titled "My Life Story" and she had written it two weeks previously. In the poem she spoke about how the first rape had hurt her and contributed to her believing that she had no future. She also spoke about her best friend (Nomsa) and how she had given her hope. This poem, which Khuselwa read out to me, appears below. Khuselwa's narrative in this poem includes grammatical errors but she did not make such

errors in her poetry (*see below*) or in conversing with me. As such, these could be attributed to the nature of the trauma and her difficulty forming a clear narrative around it.

> The first [time] I was lose my virginity I thought that I was going to die because I was feeling sore in my heart and I ....thought that...it took my life and my future away...and after that rape I was feeling hopeless...I lose my hope just like that and my best friend used to say to me don't lose hope, my friend...because at the end of the tunnel there is a light ...so please my friend don't let the evil spirit play with your life and your future she said...and now when I think about it I just want to kill myself and I just thought I'm not going to survive in my life...

After the reading I consoled Khuselwa and reflected on how poetry offered her an avenue to express her feelings and she smiled and agreed with me. She read her second poem titled "Don't" that she had written the preceding week and it expressed her feelings of betrayal and anger and captured her sense of loss. This poem can be seen below.

> Don't. Don't say it. I want to know how you betray my trust...simply because of lust. Don't touch me. I don't want to feel how you are ripping my heart out of my chest without any regrets. Don't stare at me. I don't want to see the pieces of my life after you have destroyed everything....

I encouraged her to continue expressing herself through poetry and she reported that she would do so. Khuselwa turned slightly away from me and started humming and I asked after the song and learnt that it was one of her favourite songs and she frequently heard it on the radio. She started softly singing the song and I found that it was religious in nature. At the end of the session, I again emphasised that I would see her in three weeks and that we would continue our work together and she nodded.

Therapy session 09 [T10: BDI: 31; BAI: 18; PDS: 26]

PTSD

When Khuselwa returned to therapy, she immediately reported that she needed to share something with me but was afraid to say it out loud and I invited her to write it down. I learnt that during the holiday period she had participated in a camp co-ordinated by the NGO and while at the camp she had experienced severe flashbacks and had felt very distressed. In her note, she

asked me to help her cope with this reaction. I explained to Khuselwa that it was important that we speak about her experiences at the camp as it appeared that her reactions had been very upsetting and she indicated that she might be able to share her story. Through close questioning, I learnt that one of the other participants at the camp had disclosed her story of childhood sexual abuse and that after her narrative Khuselwa had severe flashbacks that had left her unsettled.

I normalised Khuselwa's experience at the camp and explained that the story she had heard had reminded her of her own experiences of abuse and triggered her memories of being victimised. I reminded her of the mechanisms underlying PTSD and emphasised that to put her memories to rest and to stop intrusions from coming to the fore she would need to speak about her experiences in detail. I explained that although she had briefly spoken about each of the traumas and written about each of them in her journal, it was necessary for her to comprehensively describe her experiences. I emphasised that this entailed including her thoughts and feelings to allow the memory to be processed and she reported that she understood this. I asked her about her intrusive memories and, after tentatively disclosing that she had experienced intrusions related to the first trauma, she cradled her head in her hands. I reassured Khuselwa that we would work together to help her cope and emphasised that she was doing really well in sharing her experiences with me.

To help Khuselwa with the retelling of the initial trauma, I drew blank squares on a piece of paper and equated the trauma memory with a cartoon strip. I explained that each block represented an aspect of the trauma with the first block representing the moment the perpetrator entered her bedroom and the last block representing her mother comforting her. Khuselwa tentatively engaged with this format and indicated that the second block represented her step-father shaking her and forcing her to wake up. I continued to encourage her and emphasised that she did not have to speak about the rape itself and we could leave several blocks blank to demarcate the scenes involving the actual assault. However, she was reluctant to continue with the narrative and I stopped the exercise and asked if she could point out which squares represented the content of her intrusions. She reported that one of her flashbacks represented the contents of the second square but she could not elaborate on the second intrusion. She revealed that one of the final blocks in the series was blank because she could not remember the perpetrator leaving her room. It was highly probable that she dissociated at that time in response to severe

emotional distress. Khuselwa appeared distressed after this process and I focused on stabilising her. I emphasised that she had coped remarkably well with the exercise and explained that the trauma was in the past and that we were trying to piece her memories together so that she would no longer be distressed by flashbacks. I then asked after the activities she had participated in while at the camp and she shared these with me and appeared much calmer after this discussion.

Therapy session 10

PTSD

Khuselwa had felt extremely sad after our previous session and I normalised this reaction by explaining that she had spoken about extremely painful events and it was natural she would feel sad. I asked Khuselwa if she felt able to continue the process we had initiated in the previous session and try to reconstruct her memories of the first trauma and she agreed to this. I prepared Khuselwa for this process by emphasising that speaking about her experiences would lead to her feeling distressed but this would subside as she became accustomed to the trauma memory. I encouraged her by reflecting on her courage in being able to speak about the trauma in our previous session.

This time I decided to create a drawing with Khuselwa of the layout of her room at the time of the first rape to help her reconstruct the events that had transpired that day and she engaged well with this approach. I learnt that she had been asleep when her step-father entered her room and she been awoken by him violently removing her clothing. I asked Khuselwa what she had been thinking at that moment and learnt that she had thought that she was going to die. Her last memory of that trauma involved the rape itself and she could not recall her step-father getting off of her or leaving the room. It was clear that she had dissociated at that point. After the narrative, I reiterated that I cared for Khuselwa and wanted to help her heal and emphasised that she had been brave in speaking about her experiences. I reiterated that the trauma was over and that we were attempting to process the memory of what had transpired. I equated the memory with a movie and explained to Khuselwa that, like a movie, the more times she reviewed it the less likely it would evoke certain emotions and she nodded but remained silent.

Towards the close of the session, Khuselwa reported that she had to reveal something to me and disclosed that she had moved into a girls' shelter (shortly after our previous session). Through close questioning, I learnt that Nokhanyo had been abusing alcohol excessively with her partner when they were at home and their erratic behaviour when inebriated left Khuselwa feeling frightened. For this reason, she asked Grace if she could move into a shelter. I explained to Khuselwa that I was pleased that she had taken steps to protect herself and emphasised that I believed she would be safer now.

After our session I constructed a letter to Khuselwa in which I reflected on her bravery in being able to speak about the trauma. I believed this would comfort and motivate her.

Therapy session 11

Stabilisation

Khuselwa had felt extremely sad and forlorn following the previous session but she would not discuss her experiences with me and only responded to my queries with one word answers or by nodding or shaking her head. Through close questioning I found that her sadness was related to her thoughts about the losses engendered by the first trauma specifically the loss of her identity as a virgin and therefore as a good person. I decided against targeting this assumption as it was evident from her reactions in our first therapy session that she was not yet able to tolerate having her view of herself challenged. Instead, I reflected on this loss and explained to Khuselwa that the trauma had hurt her severely but that she had survived and we were now in the process of helping her heal her wounds. I emphasised that I cared for her and that she did not have to cope on her own but she remained unresponsive. Towards the close of the session I asked Khuselwa about the books that she read as I was aware that reading was one of her hobbies and she reported that she enjoyed Harry Potter and then reverted to being withdrawn. I handed Khuselwa the letter that I had written to her and she held it to her chest and reported that she would read it when she was at the shelter.

Therapy session 12 [T10; BDI: 40; PDS: 15]

Stabilisation

Khuselwa was extremely sad when she arrived for our tenth session and I reflected on this but she turned slightly away from me. I asked her if there was anything I could do to comfort her and

she reported that she wanted me to draw a "big red heart" for her and to write something inside the drawing. I drew a large red heart for Khuselwa. Inside the heart I wrote that I realised she was feeling sore and heartbroken and that she was afraid to speak with me about these experiences but I believed that one day she would be able to share her pain with me. I also wrote that I cared for her deeply and was here if she needed me and that I had faith in her. I asked Khuselwa if she wanted me read out what I had written but she wanted to take the heart to the shelter with her and, after stating this, she turned completely away from me and faced the wall adjacent to her. I decided that it would be helpful to engage with Khuselwa using drawings. I therefore drew a series of hearts on different pieces of paper and inscribed them with similar sentiments to those contained in the original heart and placed each of these in succession on her lap. She drew each of these close to her and read each message and then held it to her chest. Thirty minutes later I asked Khuselwa if there was anything else that I could do to help her and she asked me if I could read to her.

I didn't have any story books in my office but I found a book (Mphahlele, 1959) that I thought was reasonable and started reading and Khuselwa turned to face me and leaned forward and paid avid attention as I read. After reading a few pages I paused and she urged me to continue and I read an entire chapter to her. Towards the close of the session I remarked that the book was not as exciting as Harry Potter novels and she agreed with me. I suggested that for our next session I could bring a novel in the Harry Potter series and read it to her and she smiled and indicated that she would like this.

Absence from therapy

Khuselwa missed her subsequent two appointments and I contacted Grace and explained that I was worried and she offered to visit the shelter and enquire after Khuselwa. Grace also disclosed to me that she found it extremely difficult to manage Khuselwa's behaviour as she tended to be disruptive and attention seeking. I learnt that Khuselwa had written letters to people at the camp and to people at the NGO explaining that she had been raped on multiple occasions and was HIV positive. However, when any of these individual's attempted to assist her by indicating that they wanted to alert her mother she would vehemently discourage them from doing so. For this reason, the people that she approached believed that she was fabricating her history so as to gain attention and sympathy and they dismissed her. I also learnt from Grace that, while at the

camp, Khuselwa had worn extremely inappropriate clothing including very short skirts. The other participants had complained about this and she had intervened and warned Khuselwa that she would have to leave the camp if she did not wear more suitable attire. After this incident, Khuselwa had gone to the centre of a large field and started crying loudly and Grace eventually had to warn her that, if she did not behave more appropriately, she would not be invited to any future camps.

The subsequent day Grace visited the shelter and reported that Khuselwa appeared well but would not speak to her and she was uncertain as to her reasons for not coming to session. I obtained the telephone number for the shelter and after several attempts I managed to reach Khuselwa. She reported that she had been ill and her school exams were underway and this had interfered with her attendance at therapy. I asked her if she wanted to continue seeing me and she reported that she did and I rescheduled to meet with her but Khuselwa did not keep the appointment. I subsequently contacted Grace and explained to her that I did not want to compel Khuselwa into returning to therapy but I was worried about her and she offered to monitor her condition while she remained at the shelter.

Subsequent meeting

Four weeks later, I noticed Khuselwa sitting outside the Psychology Department and I invited her into my office and she reported that she had come to see me the previous week but had not been able to locate me. She also indicated that she had been ill and so had not been able to make any of our previous sessions. I asked her how she had been coping since I last saw her and she reported that she was "fine" and then resumed her usual habit of responding to my enquiries with one word answers or by shaking or nodding her head. I eventually decided to review Khuselwa's goals for therapy and she reported that one of her goals was to forget about the trauma. I used the metaphor of a physical wound for the trauma memory and explained that forgetting was equivalent to simply covering up her wound and this would not help it to heal. I emphasised that to heal a wound it was first necessary to clean and disinfect it and this involved gradually speaking about her experiences and coming to terms with what had happened. Khuselwa nodded and then reverted to silence and after a few minutes she turned away from me and placed her thumb in her mouth.

I asked her if there was anything I could do to help her and she responded by laughing and stating in a mocking tone that she wanted me to write a poem to her about "peace" because she believed that it was "right to make peace with other people". I asked Khuselwa about the people in her life she wanted to make peace with and she turned away from me and dismissingly remarked that one of the girls (Bongi) at the shelter had taunted her. This had led to a physical fight in which Bongi had thrown a chair at her and then indicated that she was going to stab herself. The house mother had intervened to prevent the fight from escalating. I advised Khuselwa to write a letter to Bongi explaining that she was troubled by their fights and wanted these altercations to cease. Khuselwa nodded before once again placing her thumb in her mouth. I explicitly hypothesised that because Khuselwa had not seen me for a month she was finding it difficult to engage with me and she agreed by nodding her head. I explained that once we resumed seeing each together on a regular basis she would feel more comfortable speaking with me and she agreed. I rescheduled to meet with Khuselwa but she did not make the appointment and I contacted the shelter but could not get hold of her. I subsequently contacted Grace and after visiting the shelter she reported that Khuselwa would not speak to her either. I did not hear from Khuselwa thereafter.

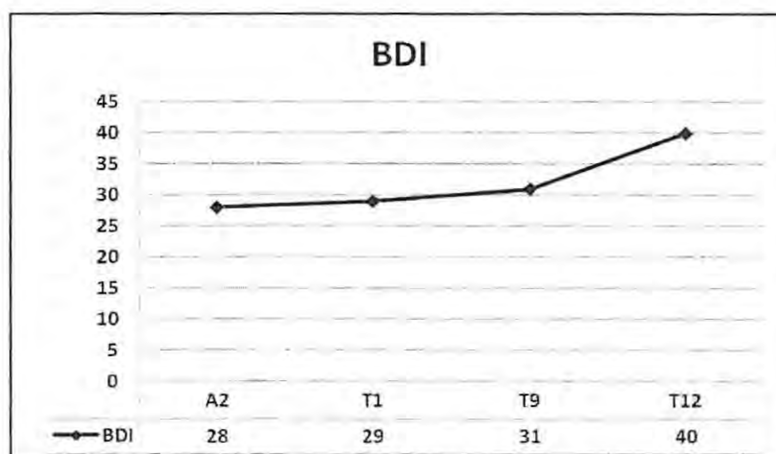
4.1.6. RESPONSE TO THERAPY

I requested that Khuselwa complete the self report scales at least once a week but she only completed these scales on four occasions during the course of her treatment process and in the ninth therapy session she neglected to complete the BAI. Responses on the self-report scales are displayed in figures 4 to 6.

(i) BDI

[Symptom scores: 1- 13 = Minimal; 14-19 = Mild; 20-28 = Moderate; 29-63 = Severe]

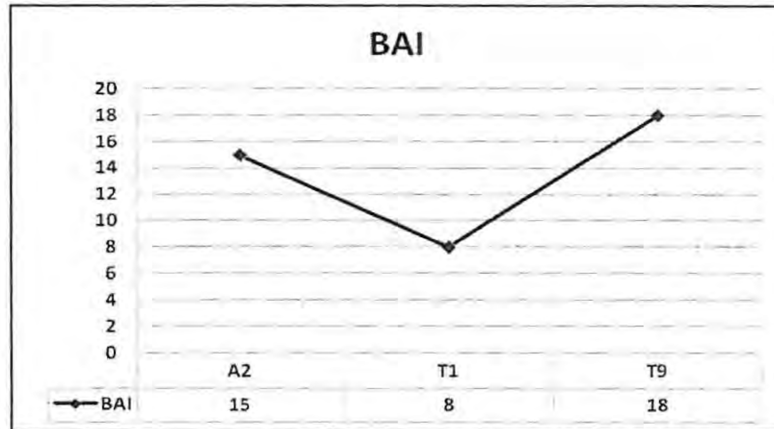
Figure 4: KHUSELWA BDI SELF-REPORT SCORES



(ii) BAI

[Symptom scores: 0-7 = Normal; 8-15 = Mild; 16-25 = Moderate; 26-63 = Severe]

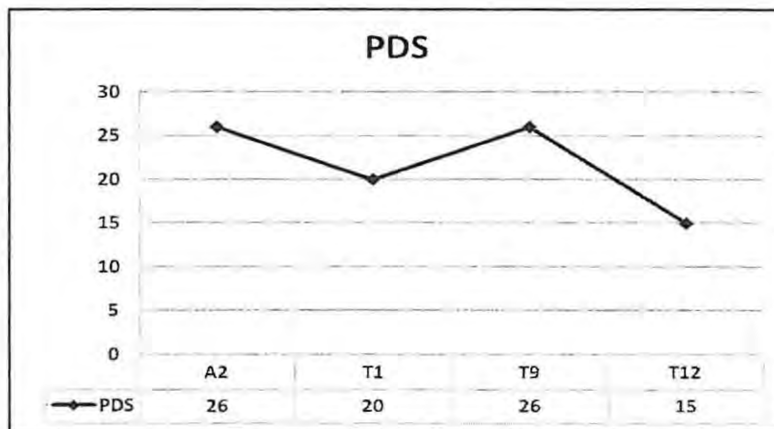
Figure 5: KHUSELWA BAI SELF-REPORT SCORES



(iii) PDS

[Symptom scores: 1-10 = Mild; 11-20 = Moderate; 21-35 = Moderate/Severe; 36-51 = Severe]

Figure 6: KHUSELWA PDS SELF-REPORT SCORES



At the outset of treatment Khuselwa presented with clinically significant symptoms of depression (BDI: 28), anxiety (BAI: 15) and post-traumatic stress disorder (PDS: 26). There was a significant decline in her anxiety (BAI: 8) and PTSD symptoms (PDS: 20) at the start of therapy but her depressive symptoms remained slightly elevated (BDI: 29). The decline in her scores is attributed to Khuselwa disclosing the traumas for the first time (A2) and to her writing a more comprehensive account of her ordeal that she read out in session (A8). Her decision to write about the traumas was the result of psycho-education about PTSD in the seventh session and due

to her feeling safer in therapy. The interventions used to promote this sense of safety included: consistently responding to her with warmth and empathy; respecting her needs in therapy (e.g. not contacting her mother or the referral agent; allowing her to bring a friend to session) and; helping her cope with the news she was HIV positive. In her written account Khuselwa did not include significant information about her thoughts and feelings during each of the traumatic events and she did not write about the most recent assault in which she was held captive for a month and repeatedly raped. This inhibited the complete processing of the trauma memory and contributed to the maintenance of her PTSD symptoms. Writing about and speaking about the rapes also activated Khuselwa's negative trauma related appraisals (e.g. that she had been made a bad person by the first rape; that she was to blame for the traumas and; her revictimisation was evidence that she was a bad person) and this contributed to the increase in her depressive symptoms by the first therapy session (BDI: 29).

There was a three week break from therapy after our eight therapy session owing to Khuselwa's school holidays and after her return her symptomatic reactions had substantially increased (T9: BDI: 31; BAI: 18; PDS: 26). This increase is attributed to her having experienced severe flashbacks related to the first trauma in the time she was away. She had attended a camp and one of the other participants had spoken about her experience of sexual abuse which served to trigger Khuselwa's intrusive memories and associated negative appraisals. The therapeutic focus was subsequently on targeting these intrusive memories by guiding Khuselwa to process the trauma through a comprehensive retelling. This process led to a substantial decrease in her symptoms of PTSD by our twelfth therapy session (PDS: 15). However, her depressive symptoms substantially increased (BDI: 40) because the retelling intensified her belief that in compromising her virginity, the first rape had made her a completely bad person. Khuselwa refused to complete the BAI and for this reason, her final scores on this scale remain uncertain but it is likely that her anxiety symptoms would have been elevated. At the time of her termination from treatment Khuselwa still experienced symptoms of PTSD and depression and given the inadequate processing of the trauma memory, it is likely that she would continue to experience these reactions.

4.1.7. DISCUSSION

Khuselwa was raised in a highly neglectful and emotionally abusive home environment. This resulted in her developing a disorganised style of attachment (*see section 1.3.3. (ii)*). This was

evident in her behaviour both in therapy and the context of her outside life. She sought proximity, care and reassurance by coming for her appointments. However, while in the therapy room she would avert her gaze from me, burry her head in her lap or turn to face away from me. These approach-avoidant tendencies were evident in her behaviour at the end of our sessions in that she frequently reported that she would not be able to make the next session. Once I responded with concern or by affirming that I would see her for the next appointment, she would immediately retract the statement and announce that she would see me soon. Her behaviour essentially reflected her uncertainty as to whether she could trust me to be consistently responsive to her needs and to be available to her.

Children with disorganised attachment are likely to have extreme difficulty using the social environment later in life for emotional coping (*see section 1.3.3. (ii)*) and this was evident in Khuselwa's lack of close friendships. She did not make any friends in childhood and predominantly spent time playing on her own. As an adolescent, she established one friendship at the age of seventeen. She also tended to be withdrawn and uncooperative as was evident in her self-reports that her school teachers frequently admonished her for not participating in class. In addition, she displayed aggressive tendencies as can be seen in her involvement in a physical fight with one of her peers while she was staying at the shelter.

Affect dysregulation and risk of victimisation

Cloitre and Rosenberg (2006) have argued that difficulties with affect regulation pose a risk for victimisation through the development of alexythymia and dissociative tendencies.

Alexythymia

Alexythymia refers to difficulties identifying and labelling emotional experiences (*see section 1.3.3. (ii)*). Khuselwa displayed signs of alexythymia in that she found it difficult to identify her emotional experiences and she possessed a very limited emotional vocabulary. For example, when asked about her experiences of our first meeting, she reported that it had been "fun". Similarly, in our eighth assessment session she responded to my enquiry about her emotional experience of reading a narrative of the trauma by reporting that she did not know what she was feeling. In addition, she used the terms "not good" (see A6) to label and to describe her negative emotional states.

Alexythymia has been argued to render the individual vulnerable to victimisation through three pathways. Firstly, difficulties identifying feeling states can prevent the individual from recognising internally generated signals of danger when in an interpersonally harmful situation and prevent them from reacting in a protect way by, for example, fleeing the situation. Secondly, alexythymia can diminish the individual's capacity to read the emotional reactions of other people and thereby detect a potentially dangerous situation. Thirdly, an incongruent self-presentation can lead to others minimizing their concerns or actively disregarding their verbal indications that they do not want to engage in certain behaviours (e.g. sexual activity) (Cloitre & Rosenberg, 2006; Cloitre et al, 1997; Larsen, Brand, Bermond, & Hijman, 2003).

It is probable that Khuselwa's difficulties identifying her emotional reactions rendered her vulnerable to victimisation. Evidence for this comes from her narratives involving the second rape perpetrated by her boyfriend and her most recent episode of victimisation in which she was held captive in a shed and repeatedly raped. Prior to the second trauma occurring, Khuselwa's boyfriend had reacted with anger to her not wanting to engage in a sexual relationship with him but at the time she had not perceived the danger inherent in this situation. It is probable that her alexythymia prevented her from differentiating between anger that was appropriate and anger that was dangerous. Similarly, with respect to the kidnapping, the perpetrator of the attack had called to her while she was walking home from school and had repeatedly insisted that he wanted to show her something in the shed situated behind his house. Khuselwa reported that she had sensed that something untoward was about to occur but she did not give this experience much import. It is possible that her diminished capacity to identify and reflect on her emotional experiences inhibited her from fully appreciating the significance of this internally generated danger signal (anticipatory anxiety) and therefore from appraising the situation as potentially dangerous. Khuselwa's symptoms of alexythymia also prevented her from receiving care and protection. She had disclosed her experiences of sexual abuse to people that she met at camps organised by a local NGO but these individuals disregarded her story and interpreted her behaviour as being attention seeking. It is possible that her affectively incongruent self-presentation caused them to disregard her concerns and prevented her from receiving the social support she needed.

Dissociation

Dissociation has been argued to arise from disorganised attachment relationships and the child's inability to synthesis their experiences into coherent meaning structures. The problematic meanings that the child takes from the relationship coalesce into three reciprocally incompatible representations of the self and the attachment figure. This includes that of self and attachment figure as 'victim', 'persecutor' and 'rescuer'. As the child's cognitive capacities develop one representation becomes dominant while the others are displaced and this allows the child to achieve a certain degree of mental and behavioural coherence. However, this coherence is shattered when the child is later exposed to interpersonally traumatic events because the experience of trauma strongly activates the attachment system. This brings forth the incompatible set of meaning structures leading to dissociation (*see section 1.3.3. (ii) for a comprehensive discussion*).

Khuselwa's experience of victimisation activated her attachment system and this led her to ascribing multiple and incompatible meanings to the traumatic events. She believed that she was both an innocent victim of harm (self as 'victim') and to blame for the rapes (self as 'persecutor', that is, bad and therefore deserving of abuse). In addition, she actively prevented others from alerting her mother to her exposure to repeated sexual abuse because she did not want to distress her caregiver (self as 'rescuer'). These conflicting meanings hampered the integration of her experiences in memory. However, over time some of these representations became more steadily processed (Liotti, 1999), specifically those related to her representation of self and other as 'persecutor', while the other representations (i.e. self and other as 'victim' and 'rescuer') remained in a dissociated state. The dominant construction of self and other that remained inhibited her from acting in ways that were protective (e.g. disclosing the rapes to her mother or to the police) because she essentially believed that she had brought the traumas on herself and that other people would regard her as responsible for her victimisation.

Khuselwa's entry into therapy activated her attachment system causing the dissociated set of meaning structures to come to the fore and she attempted to maintain some form of integration by holding on to her representation of self and other as 'persecutor'. This was evident in her behaviour during sessions. In the first session I targeted Khuselwa's assumption that she was to blame for the trauma (self as 'persecutor') and she initially responded by sobbing. She then

withdrew from me and stared at the floor as if in a trans-like state. Her sobbing was reflective of the activation of her representation of self as 'victim' but she was unable to reconcile this position with her other representations of self and this led to her dissociating. At the end of the session she fabricated a story and reported that she would not be able to make our next appointment because she was going to jail for having stabbed a boy in her school. This reaction represented her attempt to reinforce her construction of self as 'persecutor' and therefore maintain some level of integration. Khuselwa arrived half an hour late for our subsequent appointment and remained unresponsive and withdrawn. At the close of the session, she fabricated another story and remarked that she had made plans to relocate to a different province and would not be able to see me in future. Her behaviour again reflected her struggle to maintain an integrated sense of self and she assumed that ending therapy would be the solution to this dilemma.

Khuselwa attempted to elicit reactions from me that would allow her to maintain her representation of other as 'persecutor'. I had imposed time limits on our sessions and at the close of our fourth and fifth assessment sessions Khuselwa tried to prolong the session. She did this by bringing out her cosmetic bag and adjusting her hair and make-up while intermittently turning to look at me and laughing in a mocking and derisive way. Her behaviour was meant to provoke me to react with anger and allow her to represent me as a persecuting figure. Khuselwa repeatedly refused to complete the self-report scales despite my encouraging her to do so. It is probable that her refusal reflected her use of punitive strategies aimed at eliciting certain responses from me (e.g. anger) that would confirm her representation of others as hurtful (i.e. others as 'persecutor'). Khuselwa attempted to provoke me in our third therapy session but my response caused her to dissociate as it activated two incompatible representations of self and other. In the session, she had attempted to provoke me by responding to all my enquiries with grunts and, after I reflected on her behaviour, she mockingly remarked that she merely wanted to hear me repeat each question. I responded by reflecting on the impact of her behaviour in inhibiting my ability to help her and this led to her dissociating for about twenty minutes. My remarks had essentially caused two incompatible representations to come to the fore namely, that of myself as 'persecutor' and as being helpless. Evidence for these representations comes from her behaviour following her episode of dissociation in that she reacted by admonishing me for not respecting her capabilities and then threatened to end therapy (i.e. she behaved in a

punitive way towards me which corresponds to the construction of self as 'victim' and other as 'persecutor'). In the subsequent session, Khuselwa apologised for her behaviour in a letter and indicated that she would endeavour to be more forthcoming in session. In addition, she produced a teddy bear that she had purchased for me and drew a picture of me. Her behaviour was reflective of her wanting to reassure and comfort me and rescue the situation which corresponded to a representation of self as 'rescuer' and other as 'victim'. Khuselwa's inability to form an integrated representation of self and others played a critical role in her propensity to dissociate.

The tendency to dissociate is argued to lead to victimisation through two pathways. Firstly, dissociative tendencies can lead to a diminished capacity to experience the anticipatory anxiety that accompanies threatening or dangerous situations. This prevents the individual from responding appropriately when faced with a harmful situation. Secondly, being in a dissociative state can cause the individual to appear dazed, confused or distracted making them vulnerable targets for predatory people (Cloitre & Rosenberg, 2006; Ford & Courtois, 2009; Noll, Trickett, & Putnam, 2003). It is probable that Khuselwa's tendency to dissociate rendered her vulnerable to victimisation by preventing her from being attuned to potentially threatening situations and by making her a vulnerable target for predatory people. Evidence for this comes from her behaviour prior to the third trauma in which she was raped by a supposed friend of her mother's. Khuselwa had been at home alone that evening and the perpetrator had knocked on her door and indicated that he was a friend Nokhanyo's but she did not recognise him as being one of her mother's friends. Regardless, she opened the door to him and only after he ventured into the house, did she notify him that her mother was not at home and that she was alone. Khuselwa only recognised the potential danger inherent in the situation when the perpetrator moved to close the door. It is probable that due to her dissociative tendencies she did not experience the anticipatory anxiety associated with a stranger entering her home at a time when she was entirely alone and vulnerable.

Disorganised attachment style and early termination

Given Khuselwa's attachment dynamics, it was critical to ensure she felt safe in therapy and able to trust that I would be available and appropriately responsive to her needs and feelings. I achieved this by: setting boundaries in terms of sessions times (see A5; A6); having her determine

the content of sessions; respecting her capacities; not prompting her to delve into areas that she found threatening and; by admitting and apologising for any lapses on my part (e.g. see T4; T5). These responses gradually fostered trust and safety for Khuselwa as was evident in her increased engagement in session. For example, she read her poetry to me (T7; T8), joined me in a game in which I guessed the ingredients used to prepare her favourite foods (T8), sang her favourite song (T8) and even had a nap in session (T6).

Although Khuselwa was starting to feel safer in session, the experience of having someone respond to her with empathy, care and affection was also highly threatening. It conflicted with her dominant construction of herself as a "bad" person and of other people as sources of threat. These negative representations intensified after she experienced severe flashbacks in the period prior to our ninth session. I intervened by explaining to her the necessity of retelling and then guiding her to describe the intrusive memories. However, the experience of retelling left Khuselwa feeling intensely sad because it brought to the fore the memory of the moment in which her world had been completely devastated. It also activated her attachment needs and she more directly sought my care and affection by requesting in our twelfth therapy session that I draw a big red heart for her and inscribe it with a message and that I read to her. I obliged by drawing various hearts for her and by inscribing each of these with a message in which I explained to her that understood that she was heart sore and that I cared for her and had faith that she would be able to heal from her wounds. In addition, I read to Khuselwa and later suggested that for a subsequent session I read from one of her favourite books. It is possible that Khuselwa, despite desperately needing care, was markedly threatened by my responding to her with warmth and affection because it conflicted with the dominant representation of self that had been intensely evoked by her flashback (i.e. self as deficient and "bad" and therefore not deserving of care and empathy). Her inability to reconcile or integrate my responses with her construction of self led to her withdrawing completely from therapy and she did not return to session for four weeks thereafter.

After her absence, Khuselwa unexpectedly arrived at my office and reported that she had tried to locate me the preceding week but had not been able to. She indicated that she wanted to continue with therapy and so I reviewed her treatment goals and learnt that one of her main goals for treatment involved "forgetting" the traumatic events. I subsequently explained that this

was not the solution and used the metaphor of a physical wound to emphasise that forgetting was equivalent to simply covering up the wound rather than tending to it and helping it heal. It is conceivable that Khuselwa construed my response as hurtful and invalidating of her needs. She possibly interpreted my remarks as indicative of my wanting to subject her to further hurt by having her relive her ordeal and this corresponded to her construction of others as persecutor. Half way through our session, Khuselwa requested that I write a poem for her about peace and how to go about making peace. However, after close questioning she dismissed this request and reported that she actually wanted to establish a truce with a girl at her shelter with whom she had an altercation. It is possible that Khuselwa's request that I write a poem for her about peace was reflective of her need to form a truce with me that would allow her to feel safe enough to continue being in therapy. In the absence of such a truce, she did not feel able to return and feared I would not be available or responsive to her needs.

4.2. CASE 4: SANELE

Sanele was a twenty-three year old isiXhosa speaking woman from a disadvantaged community background. She was employed as a car guard in the town and was referred by a student (Donna) whom she had befriended while on duty. Donna had advised Sanele that she needed professional help to cope with her situation and suggested that she see a therapist. Sanele had been raped seven months prior to her entry into therapy and believed that the assault was related to her being a lesbian identified woman.

4.2.1. ASSESSMENT PHASE: RESULTS

(i) Assessment interviews

Sanele was seen for ten assessment sessions of between thirty and fifty minutes each. She could only come to session in the evenings (after 5pm) as she worked full time and appointments were shortened to allow her to return home before it became too dark. Sanele was moderately fluent in English and could understand the language reasonably well but experienced difficulty communicating in English. I proposed bringing in a translator but she adamantly refused and reported that she did not trust people and did not want others privy to her life. I subsequently encouraged her to speak isiXhosa whenever she found it difficult to convey her experiences in

English as I understood the language reasonably well. I asked Sanele for clarification whenever I experienced difficulty following her narrative.

I psycho-educated Sanele about my role as a psychotherapist and explained that I helped people cope with their problems. I emphasised that each session was time limited and she needed to keep to her appointments. I invited her to share her difficulties with me but she reported that she did not feel ready to speak about the trauma. It was clear that she needed to develop a bond with me before she felt safe enough to speak about her ordeal and so I did not push her into a retelling. I investigated her post-trauma reactions and learnt that Sanele had been feeling suicidal since the rape and I contracted with her and she agreed that she would not engage in any suicidal behaviour while in therapy. I also advised Sanele to contact me in the event that she felt suicidal. Shortly after ten o'clock that night she telephoned and I assumed that she was in distress but she reported that she had called to tell me that she "loved" me and "missed speaking with [me]". I felt disconcerted by these sentiments but I was aware that she merely wanted contact and I explained that I looked forward to working with her and would see her soon. It was apparent that I needed to set more appropriate limits on my availability. While discussing this in our next session, Sanele reported that she did not understand why I insisted on only seeing her at certain times and for only a limited period of time. She appeared hurt and angry and reported that none of her friends behaved in this manner towards her. It was then clear that Sanele did not fully appreciate that our relationship was not a friendship. I once again explained that I was a psychologist and treated patients and she was my client. She was clearly surprised and reported that she had not completely understood my role. Sanele appeared sad and through close questioning I found that she assumed my job was similar to a medical doctor's and that she would only be seen for one or two appointments. I explained that therapy could either be short or long term depending on her needs and Sanele was very relieved to hear this. I emphasised that I wanted her to use our session times to discuss her difficulties and to work with me towards helping her cope. I explained that she was welcome to contact me after session but that this should be limited to times when she was distressed and she smiled and stared at the floor and it was clear she was embarrassed at having contacted me. I reassured her that I understood she had wanted to speak with me at the time but that I wanted her to use our sessions for this purpose. I emphasised that I wanted to know more about her and encouraged her to share her experiences with me.

Medical care

I found that Sanele's two primary concerns were determining her HIV status and tending to her severe inter-menstrual bleeding which had begun after the rape. She was admitted to hospital after the trauma but no HIV test had been performed. Instead, a blood sample had been drawn and she was told that this would be sent for analysis. I found this untoward given that it was hospital protocol for rape victims to be given an HIV test. I closely questioned her about her experiences at the hospital and she disclosed that the attending doctor had shouted at her for drinking and told her that the rape had occurred because of her excessive alcohol consumption. This had left Sanele feeling distressed as she did not understand why the doctor had behaved so insensitively towards her. Sanele had been given a course of medication by the attending nurse and told to follow a specific regimen in taking this but she was not told about the nature of the pills she was given or its intended purpose. Given that she was required to follow a regimen, it was highly probably that she was given PEP. However, Sanele was uncertain whether she had strictly adhered to the regimen and this concerned me. In addition, she had been physically examined by the male doctor and a rape test kit had been used but the necessity of this procedure had not been explained to her. As a result, she had felt distressed during the exam.

Sanele had been menstruating at the time of the trauma and subsequently experienced inter-menstrual bleeding whenever she thought about the rape or had trauma-related intrusions. In addition, if she noticed that she was menstruating (i.e. saw blood on her underwear), she would experience flashbacks of the rape. However, because of the insensitive treatment she had received, she had been reluctant to revisit the hospital or even see a nurse at the local clinic. She reported that she was worried that the nurses might ask her about her sexual identity and tease her because she was homosexual.

I subsequently arranged an appointment for her at a private clinic and accompanied her to ensure that she received necessary medical care. The research grant covered the costs of her medical treatment. I psycho-educated Sanele about HIV testing and prepared her for the possibility that she could be positive by asking her to envisage how she would react to this news. She believed that she would simply have to continue with her life. I explained that people could still lead a long life even with the virus provided they looked after themselves and took medication. At the clinic, a white, older male doctor attended to Sanele. He explained in a

mixture of English and isiXhosa that he needed to examine her vaginal area to identify whether she had an infection. He apologised for the discomfort this might cause and emphasised that it was the only way he could determine what the problem was. Sanele indicated that she understood his explanation. I remained with her during the exam and the doctor found that Sanele had a severe vaginal infection. He prescribed medication and advised her to visit a clinic after completing the course so that she could obtain drugs that would regulate her menstrual cycle. She refused to undergo HIV testing during the consultation and reported that she did not feel ready to know her results.

During the doctor's physical exam, Sanele experienced an intrusive memory of the rape and was very distressed and after the consultation I stabilised her. I explained the concept of triggering and learnt that the doctor was the same height and build as the perpetrator. I subsequently helped her with 'then versus now' differentiation and she was able to identify the differences between the doctor and the perpetrator. This included that the perpetrator was obese while the doctor was fit and his intentions were not to hurt her but to help her. Sanele requested that I accompany her to the clinic to obtain the second part of her medication and I explained that, due to other commitments, I could not devote the time to do so. She was clearly disappointed and I encouraged her and emphasised that I believed that this was a task she could accomplish on her own. I later learnt that she had visited the clinic and obtained the necessary medications.

Problematic coping strategies

I advised Sanele that, given her inter-menstrual bleeding and the course of medication she was taking, she needed to care for herself in terms of her diet. She laughed and reported that she rarely ate proper meals because she did not feel hungry. When she did eat, it was usually a piece of fruit or a glass of juice. I enquired further and found that, prior to the trauma, Sanele had a reasonably good appetite but after the rape she locked herself in her small flat and did not eat for two weeks to punish herself for having been assaulted. She believed that the trauma had occurred because she had befriended the perpetrator and accompanied him. After her two weeks of self-enforced isolation she found that the sight of food prompted her to think about the rape and all the difficulties she had experienced in her life. As a result, she would not eat. However, Sanele could eat when in the presence of others because they served to distract her from thinking about her life. It was clear that food had become associated with the trauma and

activated her self-blame and this prevented her from eating. To break this link I explained to Sanele that she was in no way to blame for the trauma. I actively argued that she had not known the perpetrator's intentions and he was solely responsible for the rape. I advised her on the necessity of eating regular, healthy meals. She was clearly surprised and reported that, as a child, her mother only fed her "amasi" (sour milk or butter milk) and mealie meal porridge and she did not know it was important to eat vegetables and meat products.

Sanele started consuming alcohol (beer) excessively in the weeks following the trauma. She reported that she drank between four and seven one litre bottles of beer a day to help her forget about the rape and sleep at night. Before the trauma, she had also consumed alcohol and drank approximately two to three one litre bottles of beer on a daily basis at least three to four times a week. I was extremely concerned and psycho-educated her about the adverse effects of alcohol on her body. In addition, I explained to Sanele that visiting the shebeen at night and drinking alcohol to the point of intoxication was not safe but she laughed this off and reported that she enjoyed visiting the shebeen. I actively argued that she was placing herself at risk for further harm and if she was attacked when intoxicated she would not be able to protect herself. She then reported that she did not know any other way to cope with her problems but she would try to reduce the amount of alcohol she consumed. I advised her not to visit or leave the shebeen on her own but always with a group of her friends. I later learnt that she tried (mostly unsuccessfully) to only drink one or two one litre bottles of beer a day and to eat more regularly. However, she continued to visit the shebeen on a daily basis, mostly on her own.

Crisis Management

Following the fourth assessment session, I was on leave for a week and I explained this to Sanele well in advance but as we approached the time for my departure she was extremely distressed and reported that she believed I would not return. I reassured her and explained that I lived and worked in the town and would have to return. She was unconvinced and reported that she would only believe me once she actually saw me and requested that I write a motivational letter that would keep her going. In the letter I explained to Sanele that I was aware that she was feeling alone and hurt and I cared for her and when I returned we would continue our work together. I proposed to Sanele that I call her mid-week. However, she was opposed to this because she was not very conversant on the phone and did not want to burden me while I was away or have me

spend money on calls to her. I then suggested that I text message her mid-week and she was more amenable to this. On the day prior to my departure I received a call from Sanele around five in the evening telling me she was outside my office and demanding to know where I was. I was slightly taken aback and explained that we did not have an appointment that day and I would see her when I returned and she then stated "fine" in an angry tone and hung up. It was clear that she was angry that I was not immediately available to her and because I was leaving. I did not call her back as I felt it was necessary to establish limits. Early the next morning I received a text message from Sanele wishing me well and I decided to only respond to her mid-week as arranged as this would help to create a sense of predictability.

In the week I was away, I received five text messages from Sanele reminding me about her situation and telling me she was looking forward to my return. I experienced these messages as being highly intrusive and felt a sense of annoyance at her constantly needing my attention. I responded twice and affirmed that I would see her when I returned. Apart from these messages, late one night, Sanele sent two text messages fifteen minutes apart telling me she was in tears and did not know how to cope but that I "should not call" or "worry about [her]". It was clear she was distressed and, given our arrangement, I decided to contact her. Sanele had been summoned to testify in the trial against the perpetrator and she was very afraid at having to be in the same room as this man. I reassured her she would be protected in the court house and explained the procedure involved in testifying and advised her to ask a friend to accompany her. I encouraged her to contact me immediately after her court appearance and she agreed to this. Two days later, Sanele called and was very distressed and reported that she had fainted upon seeing the perpetrator and felt extremely disappointed and angry with herself. She was extremely self-critical and called herself various derogatory names (e.g. "stupid"; "useless"). I normalised her reaction and explained that it was extremely frightening to face the man who had hurt her. I emphasised that she had been brave in appearing in court but my remarks did not assuage her. She reported that she did not have any one to turn to apart from me and that when she was distressed I was away. It was clear she was angry with me for not being with her and I reassured her that I cared for her and was returning in a short while. I subsequently learnt that the perpetrator had been convicted based on the testimony of other witnesses.

When I returned Sanele reported she could not make our appointment because she was involved in a soccer team and had to practice. It was apparent she was still upset with me for having gone away and I responded by affirming that I wanted to see her and encouraging her to meet with me. In the fifth assessment session, Sanele requested to disclose some information she had previously kept secret. I learnt that three weeks previously her girlfriend (Mbali) had been hospitalised due to a heart condition and had died. I was shocked but Sanele smiled while she said this and it was clear she was minimising her distress. I responded by expressing my shock and sadness at this news but Sanele simply dismissed this and reported that she had decided to forget the incident and simply move on. She would not speak any further about the loss. I asked her if she felt comfortable talking about Mbali and she was slightly more forthcoming. Sanele had been involved in a romantic relationship with Mbali for five month and had met her while they were waiting at a taxi rank. Mbali was in her final year of high school and Sanele had been very fond of her. However, Mbali's parents were not aware she was homosexual and for this reason, Sanele saw her very rarely but she enjoyed the times they did spend together.

I asked Sanele about her experience of being a lesbian identified woman and learnt that she first realised she was attracted to women when she was ten years old. In late adolescence she had established her first romantic relationship with a woman (Nombulelo). The relationship ended after six months when her partner relocated to another town. Sanele had been extremely saddened by Nombulelo's departure. Two years later, Nombulelo died after having been diagnosed with AIDS and Sanele was shocked and deeply saddened at the loss. She had undergone an HIV test shortly thereafter and was relieved to find she was HIV negative. Sanele disclosed her sexual orientation to her mother sometime after the loss and her mother had been supportive.

HIV Status

The government hospital that treated Sanele after the rape notified her that her blood test results were ready and she decided she now wanted to learn her HIV status and insisted that I accompany her. In government hospitals patients generally have to wait in queues for long hours before being attended to. I therefore explained to Sanele that, due to other commitments, I could not devote an entire day to a hospital visit and she dismissingly reported that she could cope on her own. It was clear she was discouraged by my response and I invited her to see me

after receiving her results and she agreed to this. Sanele waited in a queue at the hospital for five hours only to find that her test results did not include one for HIV. She was markedly disappointed but did not think to ask the attending nurse to perform an HIV test. Such testing was provided free of charge at the hospital. Instead, she immediately left the hospital and came to my office and reported she was feeling intensely dejected and wanted to give up on the whole matter. I empathised with her frustration and encouraged her to visit a local clinic where testing was also done for free. Three hours later Sanele returned to see me and reported that the nurse had refused to test her because she was menstruating and I found this absurd. She was extremely forlorn and believed that no matter how hard she tried, she could not achieve her objectives and it was best she simply give up. I advised her that this was not the solution and that I believed she was capable of achieving her goals. I subsequently arranged an appointment for her with a local NGO that performed HIV testing and accompanied her for the appointment and she was very grateful. She was later relieved and elated to learn she was HIV negative.

Building a narrative of the trauma

Sanele had experienced intrusive memories of the trauma prior to our eighth session and her intrusions took the form of nightmares that left her feeling afraid and distressed. I responded by educating her about PTSD and the mechanisms underlying the disorder. I explained that to address her intrusions she needed to speak about her ordeal in detail. Sanele now felt safe enough in therapy to speak about the rape and provided a verbal narrative of her ordeal. She reported that she had visited a shebeen one evening and the perpetrator approached her and attempted to befriend her. She did not know him and had not noticed him before at the shebeen. Later that night, he requested that she accompany him to fetch his brother who lived in a house nearby and she agreed. When they approached the house he pulled her inside the gate and asked her to accompany him to the bathroom located in the house and she felt confused and told him to go on his own. He then grabbed her and pulled her into the house and she then realised that it was an abandoned structure and that he may hurt her. As they entered the house, she pulled out the knife she kept under her shirt for protection and hid it behind her back. Once in the house, the perpetrator told her to remove her clothes and she brought out the knife but he caught her wrist and the knife fell from her grasp. He then starting hitting her and lifted her up and thrust her against a wall and she felt disoriented. The perpetrator subsequently brought out a knife and told her that he would kill her if she did not obey him and she then undressed and

after raping her he left. Sanele managed to walk back to the shebeen and her friends were shocked at her condition and took her to the hospital and then the police station. The perpetrator was subsequently arrested but released shortly thereafter on bail. However, a few weeks later he was again arrested and kept in police custody because he was found to be a serial rapist and murderer. He had perpetrated a number of these assaults after having been released from police custody.

After the retelling, Sanele appeared sad and forlorn and I asked her what she was feeling and she reported that she was "not feeling okay". She frequently used these words or "not fine" to describe negative emotional experiences in the assessment interviews. It was clear she did not have the vocabulary (in English or isiXhosa) to describe what she was experiencing and so I explained to her that people often felt sad and hurt following a severe trauma. She then reported that she felt sad and that thinking about the trauma left her yearning to contact her family for support. However, she feared that they would attribute the rape to her being a lesbian and blame her for the trauma. I learnt that 'corrective rapes' were prevalent in her community and that people often did not sympathise with the victim. However, Sanele refused to hide her sexual identity as many of her friends did and openly advertised her sexual orientation. I reflected on this increasing her vulnerability given the homophobia present in her community but she reported that she was determined to not hide herself from others.

Childhood trauma

I asked after her family and learnt that Sanele's father died shortly after her birth and her mother (Siboniso) severely abused alcohol. Sanele recalled that when she was three years old her mother started taking her to the shebeen so that she would not be home alone. At the time she had felt too afraid to object and worried that something might happen to her mother. For this reason, she tried to keep her mother safe by guiding her home from the shebeen late at night.

When she was eight years old, Sanele started living with her maternal grandmother (Nosine) in another town situated one hundred kilometres away because her mother could not support her financially. While she stayed with Nosine she was repeatedly raped by her mother's boyfriend who visited the town regularly as he had relatives in the area. The abuse persisted for four years and eventually stopped after her grandmother suddenly passed away from a heart attack. Sanele

then relocated to live with her older brother in another town. I determined that she suppressed her memories of these childhood rapes and as an adolescent she used alcohol to numb herself from the distress evoked by memories of the trauma. She did not currently experience any intrusions related to these episodes but she felt distressed whenever she thought about the abuse. She actively avoided visiting her mother so that she would not have any encounters with the perpetrator who was still her mother's boyfriend. Sanele wanted to disclose the rapes to her mother but feared that Siboniso would "stop loving" her and choose her boyfriend over her daughter. She did not have a close relationship with her brother and was extremely angry with him because he was currently serving a jail sentence for having raped a girl in his community. Sanele found it difficult to share her concerns with her friends because she did not trust them to care for and support her.

4.2.2. DIAGNOSIS

The diagnosis is based on close questioning in the assessment interviews as Sanele could not complete the self-report scales due to language barriers.

(i) PTSD

Sanele met diagnostic criteria for PTSD. She experienced intrusive memories related to her recent rape. These intrusions took the form of nightmares and flashbacks of the perpetrator's face and of the house in which the trauma occurred. These memories were triggered when she saw people who resembled the perpetrator, when she menstruated and when she approached a bathroom. Sanele experienced symptoms of hyper-arousal and felt overly alert, jumpy and easily startled when in her community. She actively avoided thinking and speaking about the trauma and used alcohol to avoid her trauma-related memories. She also avoided situations that reminded her of the rape (e.g. walking past the house in which the trauma occurred and interacting with men who resembled the perpetrator). Sanele first met diagnostic criteria for PTSD when she was eight years old as a result of her repeated rape by her mother's boyfriend. She had experienced intrusions related to these episodes of abuse and at the time used avoidance to cope. She avoided encounters with her mother's boyfriend and actively suppressed her memories of the trauma. In early adolescence, she resorted to abusing alcohol to numb her feelings and avoid trauma-related memories. She had also experienced symptoms of hyper-

arousal and felt easily startled and overly alert at the time. Currently, she did not experience intrusions related to her childhood abuse but she still actively avoided the perpetrator.

(ii) Major Depression (Recurrent, Moderate)

Sanele was suffering from depression at the time of her presentation. She believed that she was responsible for the trauma and could not turn to her family for support because they would blame her for the rape by attributing it to her being a lesbian. This left her feeling sad, alone and uncared for. Sanele started experiencing suicidal ideation after the trauma and frequently thought of killing herself. Sanele also had less of an appetite than before the trauma and had lost a significant amount of weight (6kgs). In addition, she lost interest in activities that she had previously enjoyed including spending time with her friends. Sanele's depressed mood was aggravated by the recent loss of her partner. She had been extremely fond of her girlfriend and believed she had found a loving and caring partner. It is possible that Sanele met criteria for major depression after her first romantic partner relocated and passed away shortly thereafter. At the time she had felt extremely sad and dejected. She also felt abandoned, alone and uncared for. However, she was not willing to speak about her emotional reactions during that time which made it difficult to form a clear diagnosis. Sanele had first experienced symptoms of depression and possibly met criteria for dysthymic disorder in late childhood following her repeated sexual abuse by her mother's boyfriend. Her depressed mood was exacerbated by her grandmother passing away. However, apart from feelings of profound sadness Sanele could not clearly recall her symptomatic reactions in childhood. This made it difficult to diagnose her condition at the time.

(iii) Substance Dependence (With physiological dependence)

Sanele abused alcohol for seven months after the trauma to help her cope with the distress evoked by the rape. She was aware of the adverse effects of alcohol on her health but continued to use the substance on a daily basis. She tried to limit the amount she drank but this led to her experiencing symptoms of withdrawal (e.g. nausea, headaches and hand tremors) and she found it difficult to focus on her work. Sanele occasionally consumed alcohol while at work to avoid trauma-related memories but her substance use interfered with the performance of her duties. After being reprimanded by her employer, she refrained from drinking while at work. Sanele spent more than half her monthly income (she earned R500 a month) buying alcohol and this

meant she had little left for food or other necessities. She first started abusing alcohol in adolescence to help her cope with her memories of childhood abuse.

(iv) *Borderline Personality Disorder*

Sanele met criteria for borderline personality disorder. She frantically tended to avoid any perceived abandonment and this was evident in her behaviour before and after I went on leave. She also tended to alternate between idealisation and devaluation in her relationship with me. This can be seen in her telephoning me after our first meeting to tell me she "loved" me and in her anger at me later in the assessment sessions for not meeting her needs. In addition, Sanele experienced marked difficulty regulating affective states and engaged in self-damaging behaviours to reduce her distress. This included not eating food, visiting the shebeen on her own late at night and consuming alcohol excessively. Furthermore, she experienced suicidal ideation and tended to be impulsive. This can be seen in the therapy narrative (*see T1-T4*) when she purchased battery acid with the intention of killing herself after she assumed that I intended to abandon her.

4.2.3. CASE FORMULATION

(i) Predisposing Factors

Sanele was raised in an extremely neglectful and abusive home environment. Her father died shortly after her birth and her mother (Siboniso) abused alcohol and was unable to appropriately care for and nurture her. Siboniso often took Sanele with her when she visited shebeens so that she would not be left home alone. As a child, Sanele experienced her mother as both a frightening and a helpless figure and felt uncertain whether she could approach her or depend on her for care and protection. She also worried that her mother's alcohol abuse would lead to her being physically injured and to prevent this she guided Siboniso home each night after her drinking sprees.

Sanele's early interactions with her mother led to her developing a disorganised style of attachment (*see section 1.3.3.(ii)*) that rendered her vulnerable to developing symptoms of complex PTSD. Her disorganised attachment style was evident in her behaviour in session. She wanted me to accompany her to the clinic to obtain medication and to the hospital to get her test results. However, when I explained that I would not be able to do so, she immediately

reacted by distancing herself and stating that she could cope on her own. Similarly, she was markedly distressed by my going on leave and unexpectedly arrived at my office on the day prior to my departure and expected me to see her. When I indicated that I could not, she angrily hung up the phone but contacted me early the next day to wish me well. Sanele's behaviour essentially reflected her uncertainty as to whether she could rely on me to be consistently available and responsive towards her.

The failure to develop an organised strategy for coping with distress leads to affective dysregulation and difficulties in using the social environment for emotional coping (*see section 1.3.3 (ii).*). Sanele resorted to alcohol abuse as a means of numbing her emotions and minimising her distress. Disorganised attachment relationships confer negative internal working models or maladaptive schemas. For Sanele these schemas involved: emotional deprivation; abandonment/instability; mistrust/abuse; defectiveness/shame and punitiveness. She attributed her mother's inability to nurture and care for her to mean she was deficient in some way and therefore unworthy of care (defectiveness/shame). She therefore behaved punitively towards herself whenever she fell short of her own expectations or was unable to achieve her goals. Siboniso's alcohol abuse and associated erratic behaviour and visits to the shebeen led to Sanele fearing that her mother could be harmed. As a result, she started doubting whether she could depend on others to continue to be available to her (abandonment/instability). Childhood neglect also contributed to Sanele believing she could not trust other people and others would hurt her if given the chance (mistrust/abuse).

When Sanele was eight years old she was sent to live with her elderly grandmother who provided her with care, attention and affection. However, during this time she was repeatedly raped by her mother's boyfriend. The abuse occurred during times when her grandmother was away and Sanele felt unable to disclose the rape because she feared it might cause her already frail grandmother further distress and she did not want to lose her caregiver. The abuse ceased after her grandmother suddenly passed away and she went to stay with her older brother. Sanele's experiences of repeated sexual abuse reinforced her negative core beliefs that she was deficient and unworthy of care and protection and that she could not rely on significant others to care for and protect her. Her grandmother's death reinforced her belief that she could not depend on others to be available to her and could lose the connections that she had established.

These latter assumptions were further intensified when Sanele was in late adolescence and her first romantic partner decided to relocate and subsequently ended their relationship. Her partner died two years later leaving Sanele feeling even more alone and abandoned. When Sanele was twenty-two years of age, she relocated to live with her grandfather who she experienced as kind, caring and supportive of her. However, he cast her out of the family home after she disclosed her sexual orientation and refused to have further contact with her. This further consolidated her assumptions that she was deficient and that others could not be relied upon to provide her with support and would hurt her. Sanele's disorganised attachment relationship and related difficulties in regulating affective states led to her resorting to maladaptive methods of coping, specifically alcohol abuse. She first started using alcohol in early adolescence to numb her distress in relation to her sexual abuse and to avoid-trauma related memories. She also used this strategy to cope following her revictimisation in adulthood.

(ii) Precipitating Factors

Sanele was raped seven months prior to her entry into therapy after having visited a shebeen late one night. At the time of the trauma she had believed that the perpetrator was going to kill her. She believed she was responsible for the rape because she had accompanied the perpetrator and punished herself by not eating anything for two weeks. She continued to starve herself for months after the trauma. In addition, the rape triggered her earlier memories of being sexually abused by her mother's boyfriend and this added to her distress. As a result, she started abusing alcohol to cope with her emotions but her symptoms did not subside and she eventually decided to seek help to cope with these reactions. Sanele's girlfriend unexpectedly passed away shortly before her entry into therapy and this sudden loss exacerbated her depressed mood.

(iii) Maintaining factors

Sanele's attachment style and associated early maladaptive schemas and coping strategies contributed to the maintenance of her symptoms. She believed she was responsible for the rape and that others would share this assumption and so she kept the trauma a secret. This prevented her from receiving care and support, disconfirming her negative assumptions and inhibited her from processing the trauma memory. To cope with the abuse, she resorted to self-punitive behaviours and alcohol abuse. She punished herself for the rape by not eating for two weeks and subsequently, whenever she encountered food, it evoked memories of the trauma and triggered

her self-blame. This further maintained her depressed mood. In addition, she used alcohol to numb her feelings and avoid trauma related memories and this contributed to the persistence of her PTSD. Furthermore, Sanele's attachment style inhibited her from disclosing the loss of her girlfriend. She did not feel that she could cope with her distress at the loss and therefore kept it a secret and avoided her emotions in relation to this trauma. This too maintained her depressed mood.

4.2.4. PRESENTATION OF TREATMENT PLAN

Sanele needed to be part of a long term therapy programme and I emphasised that she needed to stay in treatment until she was in a better space. I discussed the treatment plan with her and explained that it included the following focus areas and invited her to raise any concerns she had and to include any additional focus areas that she believed required attention.

- Fostering safety: It was important for Sanele to feel safe and secure within the context of therapy especially considering her attachment style. I explained that I was aware she often found it difficult to share her experiences and reassured her that I would remain with her throughout her treatment process. I emphasised that I believed as she became more accustomed to working with me, she would slowly come to realise that she could trust me. In addition, I reiterated that therapy was her space and she should feel free to use the session to share information she was comfortable revealing. I clarified that she was welcome to contact me when distressed but I wanted her to use our relationship as a space in which to share her problems and receive comfort and care. I explained that as she came to trust me, she would also feel more confident about sharing her life with supportive others in her environment. Sanele smiled and stared at the floor but did not comment on any of my remarks.
- PTSD: I explained to Sanele that she was suffering from PTSD and identified her symptomatic reactions (i.e. intrusions that included flashbacks and nightmares; avoidant behaviours and hyper-arousal) and described the treatment model (*discussed earlier).* I explained to Sanele that we would target her intrusions once our therapeutic relationship was more secure and she felt more able to trust me to care for and support her. She smiled at this and stared at the floor and it was clear she felt embarrassed. I emphasised that it took time for trust to develop and that she should not feel compelled to engage in anything she was not comfortable with. I reiterated that it was important that she gradually relinquish her avoidant strategies

particularly her alcohol abuse and instead use our relationship to share her distress and receive care and support. Sanele reported that she felt much calmer during and immediately after our sessions but she experienced difficulty coping with her distress in the interim period between sessions. This prompted her to use alcohol. I acknowledged this and explained that as we worked together in therapy she would gradually feel more able to cope with her distress on her own and would not need to resort to drinking alcohol. I proposed that we have two sessions a week so as to give her additional support but she reported that due to her work hours she could not devote more time to therapy.

- Social Support: I explained to Sanele that it was essential that she have supportive others outside of therapy and emphasised that this would give her additional resources to turn to when she was distressed. However, she reported that she simply did not trust other people and was not willing to share her concerns with them. I explained that in the course of therapy we would work towards addressing these beliefs and help her to gradually form more helpful relationships with others. Sanele reported that she wanted to re-establish connections with her family and I affirmed that we would work together to help her achieve this.
- Self-protection: I emphasised the importance of Sanele protecting herself while she was in therapy. I reiterated that this involved not engaging in any suicidal behaviour and limiting her visits to the shebeen. Sanele agreed not to engage in any suicidal gestures while in therapy but reported that she would find it difficult not to visit the shebeen. I encouraged her not to visit or leave the shebeen on her own and emphasised that intoxicated women were extremely vulnerable.
- Alcoholic Dependence: The local psychiatric hospital had an inpatient substance abuse programme and I explained this to Sanele. I emphasised that, when she was more secure in therapy, she could benefit from joining such a programme to help her regulate her alcohol use. Sanele was concerned her employer would not let her take leave to enter into such a programme and I explained that the unit was willing to contact employers to ensure that patients were given necessary leave.

4.2.5. THERAPY NARRATIVE

Sanele was seen for eight therapy sessions before she prematurely terminated.

Therapy sessions 01 – 04

Focus Area: PTSD; Crises management

Sanele was experiencing severe nightmares related to the trauma and this was interfering with her sleeping patterns. She would awake from these dreams feeling terrified and fearing the perpetrator was going to find her and kill her. As a result, she had started spending nights with a neighbour. An increase in flashbacks was also affecting her ability to work. These intrusions were triggered whenever a man, who resembled the perpetrator, approached her wanting to pay for parking and on a few occasions she had run away. Her employer had subsequently reprimanded her and she feared her flashbacks would affect her employment status. Sanele reported that she had started cutting herself with broken pieces of glass when at work as this served to distract her from emotional distress and allowed her to continue with her work.

Sanele's intrusions were severely affecting her functioning and I was very concerned about her use of harmful coping strategies. As such, I decided it was necessary to focus on processing her trauma memories. Sanele was more comfortable using isiXhosa to convey her experiences in session and it was clear it would be more helpful for her to use the language during a reliving. However, I was concerned about my fluency in isiXhosa and worried that I may miss important information and not respond as effectively. I explained this to Sanele and once again proposed to her the option of bringing in a translator. I emphasised that the individual I had in mind was a trained psychotherapist and part of the supervision group. She was familiar with the treatment model and worked with clients who had been exposed to trauma. After I explained this, Sanele immediately became upset. She reported that she had previously told me she did not trust other people and therefore could not understand my reasons for including someone else in her treatment. I reassured her I was aware of her concerns and explained that I did not intend to have the translator present indefinitely but only to aid with the reliving. I emphasised that the translator was a therapist and therefore bound by confidentially. However, Sanele then reported that it was best she end therapy. It was clear she experienced my actions as hurtful and I explained that I wanted to help her and would not compel her to engage in anything she was not comfortable with. Sanele appeared despondent and reported that she believed that my reasons for requesting a translator were because I was not seeing any change in her condition from my treatment efforts. She assumed that because of this I wanted to refer her. I reassured her that this was not the case and emphasised that I cared for her and intended to continue seeing her

and did not want to refer her to another person. I again reiterated that my reason for suggesting a translator was solely to address one aspect of the treatment and Sanele appeared relieved. She reported that she had believed I was leaving her and felt hopeless and suicidal and had went and purchased battery acid with the intention of drinking it and killing herself. It was clear Sanele did not feel secure enough in therapy and I decided against using a translator. I also postponed the reliving and instead, solely focused on developing a bond with her and ensuring she felt safe with me.

I consistently validated her needs and encouraged her to take the lead in session and she was gradually able to do this. She shared her experiences of neglect with her mother and tentatively started speaking about her girlfriend and her sense of sadness at the loss. However, she would not fully engage with her emotions and, if I prompted her further, she would dismiss the topic and report she was fine. I helped her cope with her intrusions by normalising her reactions. I encouraged her to engage in relaxing activities (e.g. socialising with her friends) and she established a tentative friendship with a neighbour who was an elderly woman and started spending time in her company. I advised her to spend nights with a friend rather than on her own and she agreed to this and found that her nightmares occurred less frequently when at her friend's place.

I saw Sanele for two months before I went on holiday for four weeks. I prepared her for this by regularly reminding her that I would be away and emphasising that I would return and we would continue our work together. Sanele reported that she was now certain that I would return and so was not distressed. She sent me three text messages in the first two weeks that I was away and mostly reported that she was coping well and looking forward to my return. I responded once a week and reassured her that I received her message and that we would work together to help her reach her goals.

Revictimisation

In the third week I was away, Sanele was brutally gang raped by four men who also severely physically assaulted her. She contacted me a week after the assault and reported that she had suffered severe injuries to her face and her eye and had been admitted to hospital for a week. I was horrified to hear that she had been assaulted again and advised her to visit the local

psychiatric hospital to receive counselling but she refused and insisted on waiting till I returned. I explained that she required care and support immediately and needed to take active steps to obtain help from available sources. She became silent and reported that she would contact me later and put the phone down. She subsequently text messaged me and reported that she was "fine" and would wait until I returned. I felt intensely frustrated and angry at her reluctance to obtain help even when it was available. I responded with an instant message and explained that she needed care and that I wanted her to speak to someone. I was relieved when I later learnt that she had spoken to a nurse whom she had befriended when I had taken her to the NGO for HIV testing and she had received some support and care.

Therapy sessions 05-06

<u>Crises management</u>

I met with Sanele after my return and found that she was in shock. She reported that she could not believe that she had been raped once again and did not understand how this could have happened to her. I validated her shock and empathised with her. Sanele also reported that she had contacted her mother shortly after her revictimisation and disclosed the gang rape. Siboniso had advised her to relocate and reside with her but because of her mother's boyfriend Sanele did not feel she could move in with her. I acknowledged her sense of discomfort and subsequently invited her to share the trauma with me but she reported that she did not feel able to speak about the trauma itself.

I asked her if she felt comfortable disclosing the circumstances surrounding the gang rape and she did. I learnt that on the night of the trauma she had been walking home from the shebeen and as she approached her flat she felt an object hit her ankles and she fell forward. She was seized by four men and taken to another neighbourhood. The perpetrators brutally physically assaulted her and this led to her losing consciousness before they raped her. She reported that she was relieved she could not clearly recall the rape. After regaining consciousness, she found that the perpetrators had stripped her of her clothing. She somehow managed to find her way to a friend's house and was taken to the hospital where she received medical care for slightly over a week.

I asked Sanele if she had reported the rape to the police and learnt that she had not disclosed the trauma to the attending doctor and since a rape test kit had not been used, she saw no point in reporting the assault to the police. I was horrified and asked after her reasons for not disclosing the gang rape and learnt that she had feared the doctor would react angrily and blame her for the rape as the previous doctor had done. As such, she had not received HIV testing and PEP and she feared she might have HIV. I felt helpless and exasperated and subsequently advised Sanele that, even without the evidence in a rape test kit, she could still report the rapes to the police. I encouraged her to do so but she then went silent and would not engage with me. It was clear that it was too early for her to consider such action and she first needed support and care. I therefore reassured her that I cared for and would help her to cope with the trauma. I emphasised that when she felt ready she could then report the case.

Sanele was very scared to remain in her current flat and I advised her that the area where she lived was unsafe and actively encouraged her to find a new place. After our sixth session, Sanele contacted me and asked to postpone treatment so that she could use the time to locate a new residence. She indicated that she would return to therapy after she found a new place to stay. I advised her that it was important she continue with treatment and she indicated that she realised this and would return.

Two weeks later, Sanele contacted me on a Sunday afternoon and stated that she had just seen me in town and greeted me but I had ignored her. She had concluded that I was upset and angry with her and to remedy this situation, she decided to return to therapy. I reassured her that I had not ignored her but had been with friends at the time and simply had not seen her. I then invited her to reschedule with me.

Therapy sessions 07-08

Crises Management

Sanele had not been able to find a new place to stay and reported that accommodation in a safer neighbourhood was more expensive (i.e. between R200 – R400) and she simply could not afford it. I was concerned for her and contacted the women's shelter but found they only took in children and adolescent girls. I advised Sanele to stay with a friend or a neighbour but she was not comfortable with this arrangement and reported that she would continue to search for a new

flat. I asked her how she was coping and found that she had resumed consuming alcohol excessively and was visiting the shebeen every evening. She had also started using cannabis because she found that the drug calmed her and allowed her to cope with her memories. However, it made her confused and disoriented and she found it difficult to focus on her work. In addition, Sanele had started punishing herself by not eating. She reported that she blamed herself for the trauma and believed she had been victimised because she had visited the shebeen and consumed alcohol and because she was a lesbian.

I explained that she was in no way to blame for the trauma and it was necessary that we focus on helping her recover. I emphasised that I was willing to support her but she also needed to take active steps to care for and protect herself. I explained that visiting the shebeen late in the evening and consuming alcohol and cannabis made her vulnerable and an easy target and she needed to cease these activities. Sanele smiled and would not look at me after I stated this and it was clear she was upset at my remarks. I reassured her that I cared for her and that my motives in telling her to cease these behaviours were because I did not want her to be hurt again. I proposed to Sanele that we meet twice a week for therapy to help her cope and she agreed to this.

Sanele was again experiencing inter-menstrual bleeding and she often felt physically weak. I actively encouraged her to visit the hospital or a clinic and receive treatment but she reported that she did not want to have to retell her story to the doctor. I explained that this was not necessary and that she only needed to alert the doctor to her having been raped and explain her condition. However, she remained unconvinced and refused. I again felt frustrated and exasperated and actively argued that she needed to take steps to care for herself. I emphasised that this not only entailed coming to therapy but also caring for herself outside of session. Sanele reported that she wanted to end our current session (T8) because she did not feel up to talking. I changed tack as I sensed she had interpreted my remarks as indicative of my disapproval of her behaviour and felt hurt. I reassured her that I understood that she was feeling distressed and hopeless and that I cared for her and wanted to help her. I invited her to continue sharing her concerns with me but she reported that she did want to speak about the rape. I explained that she could speak about anything she felt comfortable with and we did not necessarily have to talk about the rape immediately. However, she again reported that she did not want to talk and

promptly got up to leave. As she approached the door to my office she promised to keep her next appointment and then apologised and abruptly left.

I received a call from Sanele three days after our eighth session to tell me that she had been admitted to hospital for a week because she was unwell but she would not elaborate further. She undertook to contact me once she was discharged. I was doubtful that she was in hospital and this was confirmed when I saw her in the town the subsequent day. I tried to contact her a week later but she would not answer my calls. Six months later I received a text message from Sanele wishing me a Happy New Year and I responded with a similar message. I did not hear from her thereafter.

4.2.6. RESPONSE TO THERAPY

Sanele found it extremely challenging to engage with treatment for reasons that are comprehensively discussed below.

4.2.7. DISCUSSION

Sanele's interactions with her primary caregiver contributed to her developing a disorganised attachment style (*see 1.3.3. (ii)*) and this was reflected in her mixture of approach and avoidant behaviours in session. She contacted me after learning that she would have to appear in court and reported that she was "crying" but I "must not worry" and "should not call" her. Similarly, when I returned from a week long leave she refused to meet with me despite experiencing severe distress. Her behaviour reflected her ambivalence about whether she could rely on me to be available and responsive to her needs.

Disorganised attachment confers certain conflicting representations of self and caregiver. In the course of development, one of these representations displaces the others in the organisation of conscious experience and this allows the child to have some sense of mental integration (*see section 1.3.3. (ii)*). For Sanele, the representation that dominated was that of self as 'victim' and other as 'rescuer' and this was evident in her behaviour in therapy. She expected me to accompany her to the clinic to obtain the second course of the medication for her inter-menstrual bleeding (*see Medical Care)* and to the hospital to receive the results of her blood test

(see HIV Status) (other as 'rescuer'). She was then upset when I indicated that I would not be able to do so. She was also extremely upset with me for not being physically present and available to care for her *(other as 'rescuer')* after she fainted in court (self as 'victim') (*see section 4.2.1.)*. In addition, Sanele attempted to avoid eliciting reactions from others that would threaten these representations. She avoided visiting clinics because she did not want the nurses to treat her hurtfully. She refrained from disclosing that she had been gang raped to the attending doctor to avoid receiving negative reactions. Her avoidance essentially precluded other representations from coming to the fore (i.e. other as 'persecutor') and maintained a sense of internal coherence. After our sixth session, Sanele absented herself from therapy to use the time to search for alternative accommodation and returned to session after I failed to notice her in town (*see T5 – T6*). She interpreted my behaviour to mean that I was angry with her (other as 'persecutor') and she apologised and immediately scheduled a therapy session. Her behaviour was reflective of her need to reassert her representations of self as 'victim' and other as 'rescuer'.

When the attachment system is strongly activated, the dissociated set of representations come to the fore leading to the individual dissociating or resorting to maladaptive coping mechanisms in an attempt to achieve some form of internal coherence or equilibrium (*see section 1.3.3. (ii)*). In Sanele's case, evidence for the presence of these dissociated representations is evident in her dramatic shifts in session from casting me in the role of 'rescuer' one moment to 'persecutor' the next. For example, she expected me to care for her when she felt distressed after having fainted in court (other as 'rescuer') but she then became extremely angry with me for not being physically present and available to console her (other as 'persecutor'). Similarly, she expected me to help her resolve her intrusions (other as 'rescuer') but became upset when I proposed to bring in a translator to assist with the reliving. She interpreted this as indicating that I did not understand her needs and was rejecting her (other as 'persecutor') and she felt markedly distressed and resorted to maladaptive methods of coping (i.e. suicidal gestures).

In addition, Sanele consumed alcohol excessively as a means of regulating her distress. She first started using alcohol in early adolescence to cope with her memories of being sexually abused by her mother's boyfriend. She found that alcohol numbed her feelings and allowed her to avoid abuse specific memories and forget the trauma. Similarly, after her first sexual assault in adulthood, she again reverted to the use of alcohol and started cutting herself to numb her

feelings. In using alcohol, it is probable that Sanele attempted to displace the other representations of self and other that had come to the fore so as to retain her dominant representation of self and other and restore some form of mental coherence. Following the gang rape, Sanele started using cannabis and it is probable that this served a similar function to alcohol and allowed her to avoid her emotions and memories of the trauma and maintain a sense of integration.

Disorganised attachment and revictimisation

Sanele's disorganised attachment relationship conferred vulnerability to alexythymia (*see section 1.3.3. (ii)*). This situation was further exacerbated by her use of alcohol which further compromised her ability to recognise her emotional reactions. Sanele's alexythymia was reflected in her difficulties identifying emotional states and her limited emotional vocabulary. She used the terms "not feeling okay" or "not fine" to label and describe her negative emotional states. Her inability to identify her emotions placed her at risk for victimisation as was evident in the events surrounding the first assault. Sanele was befriended by the perpetrator for the first time on the night of the trauma and he requested that she accompany him to fetch his brother. She did not experience it as untoward that a stranger would insist that she accompany him on an errand late at night. It is probable that her alexythymia prevented her from experiencing internally generated danger signals (i.e. anticipatory anxiety), appraising the situation as potentially dangerous and realising that the perpetrator's behaviour was suspicious.

Her maladaptive strategies of consuming alcohol excessively further placed her at risk for victimisation. According to Briere (1992) and other theorists (Briere & Runtz, 1993; Messman-Moore & Long, 2003), individuals who experience a numbing of emotions as a result of alcohol or drug abuse are more vulnerable to victimisation because of their decreased awareness of their surroundings and potential sources of danger. Sanele's alcohol abuse and associated emotional numbing prevented her from being alert to her surroundings and this was evident in the events surrounding her gang rape. She was returning home from the shebeen that night and felt something strike her ankles and was then accosted by four men. Being intoxicated and emotionally numb probably prevented her from being alert to her environment and noticing the presence of the perpetrators.

Sanele's capacity for self-protection was low. She repeatedly visited the shebeen and consumed alcohol excessively despite my attempts to encourage her to protect herself. I repeatedly advised her that she was placing herself at risk and actively discouraged her from visiting the shebeen and drinking alcohol excessively (*see section 4.2.1. and T7 – T8*) but this did not deter her. Her inability to engage in self-protective behaviours was related to her difficulties regulating affective states and to her interpersonal schemas. Sanele saw alcohol as the only strategy available to her to regulate her distress outside of therapy and so consuming alcohol took precedence over her concerns for safety and self-protection. In addition, she believed that she was unworthy of care and protection and this compromised her ability to engage in self-protective behaviours. For example, she was unwilling to visit a clinic to obtain medical care and failed to inform the doctor that she had been gang raped. Furthermore, Sanele engaged in self-punitive behaviours by criticising herself and starving herself as punishment for having been victimised. Breitenbecher (2001) and Cloitre and Rosenberg (2006) hypothesis that exposing oneself to risk (e.g. Sanele visiting shebeens alone) is also motivated by self-punitiveness.

Early Termination

Sanele was brutally physically assaulted and gang raped in the period prior to our fifth session and this strongly activated her attachment needs. Her inability to cope with her distress led to her using alcohol and cannabis to numb her feelings and avoid trauma-related memories. She visited the shebeen every evening to obtain these drugs. In addition, her inter-menstrual bleeding returned and she did not seek medical care to deal with this. I used limited re-parenting and advised Sanele that I was willing to support her in therapy but she too had to take an active role in caring for and protecting herself. I explained that this involved discontinuing her daily visits to the shebeen, finding a new place of residence and seeking medical care. I actively encouraged her to take these steps. However, Sanele prematurely terminated therapy thereafter (*see T7- T8*). Her decision was related to two factors. The first involved her problematic representations of self and others. It is probable that Sanele believed that if she did not follow my advice, I would be angry with her (other as 'persecutor') and this threatened her internal representations and so, to maintain a sense of integration, she terminated from treatment. The second relates to her maladaptive schemas. It is probable that Sanele feared that, because I was seeing no progress in treating her and only more problems, I would abandon her and, to preclude this from occurring, she decided to terminate (*see T1-T4)*. Sanele also believed she was to blame

for the gang rape and her termination from therapy could also be related to her wanting to punish (self-punitiveness) herself because she believed she was unworthy of care and support.

CHAPTER 5: PTSD IN RESPONSE TO DRUG-FACILITATED SEXUAL ASSAULT (DFSA)

Three participants in the case series were exposed to DFSA namely, Anna, Emmy and Lori. Their case studies are provided below.

5.1. CASE 5: ANNA

Anna was a forty three year old, white woman who worked as a health care practitioner. She had lived in a major South African city before relocating to the University town with her two adolescent daughters. She relocated three months prior to our first meeting. Anna contacted me telephonically after having noticed a recruitment poster at a central location in the town. She was very abrupt during our conversation and I was taken aback by her aggressive tone. After introducing herself she demanded to know the "criteria" I was using in my "sample selection" so that she could determine whether she could participate. She reported that she had experienced a "date rape" twenty five years previously. In the conversation I had a distinct sense that Anna wanted to enter into therapy but was worried about being exploited and hurt. I invited her to meet with me and, due to my initial impressions, I emphasised that I would be willing to provide her with psychotherapy even if she did not meet criteria for the research. Two days later I met with Anna and experienced her as being quite adversarial. Upon entering my office, she immediately alluded to my relatively small office size and reflected on it being indicative of my being in a junior position. After I requested she complete the self-report scales, she looked at the questions and with much disdain asked if I had personally designed the questionnaires (i.e. BDI, BAI and PDS) as the grammar used was clearly sub-standard. It was apparent that Anna was threatened and anxious at the prospect of therapy. I sensed that she was harbouring considerable emotional pain and that her outward behaviour was an attempt to keep people at a distance so as not to be hurt further. As such, I responded in a factual way to these questions by explaining that I had not designed the questionnaires but they were valid measures. Towards the close of the screening interview, I explained to Anna that she did meet symptom criteria for PTSD and could be a candidate for the research project but I was concerned that she may feel exploited at having to participate. She immediately interjected and reported that this was not the case and that she wanted to be part of the research.

5.1.1. THE ASSESSMENT PHASE: RESULTS

The assessment interviews occurred over eleven sessions of ninety minutes each and Anna was seen twice a week during this process.

(i) Assessment interviews

A1: [BDI: 20; BAI: 33; PDS: 30] A6: [BDI: 22; BAI: 23; PDS: 25]

In the first assessment interview I found that Anna would fluctuate between being extremely candid about her experiences to completely avoiding further introspection. Her avoidance manifested in her: repeatedly changing the topic; interspersing her narratives with anecdotal stories; telling jokes and; asking numerous questions about the research project and my professional background. It was clear she was threatened by self-disclosure and so I reflected on the challenges inherent in speaking about deeply personal experiences in an unfamiliar context and with a stranger. Anna subsequently reported that she was generally a "closed person" and it was the first time she had spoken about her life and experiences in any detail. She appeared angry that I had noticed how difficult it was for her to be open and reported that based on her prior life experiences she had ample reason to be wary of other people. Anna then remarked that, irrespective of the discomfort associated with self-disclosure, she was determined to address her issues by participating in therapy. I empathised with her, acknowledged her concerns and encouraged her.

Anna was subsequently better able to engage with me but she often appeared markedly anxious and during these times she reverted to her avoidant behaviours. On many occasions I did not intervene to stop her from telling a joke or anecdotal story as it was clear she needed to achieve some distance from threatening material. Once she had told her joke or anecdote and appeared calmer I would then bring her back to the original topic that she had found challenging to share. Through this process I was able to foster a sense of safety.

Building a narrative of the trauma

I invited Anna to speak about the trauma that led to her decision to seek therapy and she was very forthcoming. After completing high school at the age of eighteen, she had visited a holiday resort to obtain some relief from her oppressive home environment. Anna's mother (Martha) was highly critical, controlling and punitive. For this reason, as a child and adolescent, Anna found

it extremely difficult to be in her mother's presence and tended to avoid her whenever she could. Her father (Jacob) was an uninvolved and neglectful parent who showed little interest in her life. I learnt that Anna had remained at the resort for two weeks and on the day prior to her departure she was invited to attend a party hosted by the resort. She had been anxious but also excited for the party and had wanted to socialise with others and decided to attend. While at the party she drank one soft drink, spent time on the dance floor and tried to interact with some of the people present. She was subsequently approached by an older man and recalled having been asked numerous questions by him including her age and whether she was alone at the function. Anna's next memory was of momentarily regaining consciousness and realising that she was being raped by this man in her hotel room. She had no memory of returning to her room or of how he had gained access to her room. During the assault Anna had felt disoriented, confused and physically paralysed and at one point she had experienced sexual arousal. Upon awaking the subsequent morning, she felt intensely nauseous and disorientated and found it challenging to stand up or even walk. She felt markedly confused as to exactly what had happened to her the previous night.

Anna report that her father arrived to collect her that day and upon seeing her physical condition, he laughed at her. He assumed that Anna's nausea and disorientation was the result of her having been intoxicated. I experienced Jacob's response as being highly insensitive and I asked Anna how she felt about the way her father reacted. However, she dismissed this question stating that her father was generally "uninvolved" when it came to their family and that he had responded in his usual way. I asked after her decision not to disclose the assault to her parents. Anna believed she would have been subjected to scorn and criticism from her mother and indifference from her father and this inhibited her from reporting the assault. She had two older siblings and I asked after her decision not to share the trauma with them and found that she had a distant relationship with both her brother and sister. Her sister (Adele) was nine years older than her and had left the family home at the age of eighteen due their mother's critical and controlling behaviour. Her older brother (Paul) had been their mother's favourite child and Anna had experienced him as being uncaring and hurtful during their childhood years and felt afraid to approach him.

I invited Anna to speak about how she coped in the days and weeks following the trauma. She appeared saddened and reported that she had no one to turn to at the time and had isolated herself in her room. She read countless books during that time in an attempt to avoid the trauma memory. Anna had also experienced symptoms of increased physiological arousal including feeling jumpy and easily startled and had considerable difficulty sleeping. However, her sleeping patterns improved a year after the rape. I subsequently explained to Anna that it was clear that her rape had been drug facilitated and she acknowledged this. She reported that in the months following the rape she had felt markedly confused as to what had happened to her because at the time she had not known that rape could be perpetrated by first administering a drug to the victim. However, in later years, she had researched her symptoms and learnt that they corresponded to the reactions encountered in victims subjected to drug facilitated rapes.

Following the retelling, I asked after Anna's experience of narrating the events that occurred the night of the trauma and she reported, in an angry yet dismissive tone, that she felt emotionally drained. It was clear Anna expected that I would respond harshly if she were to reveal her emotions and to counter this assumption I consistently acknowledged and validated her feelings. I advised her that it was important that she look after herself and suggested that she spend time engaging in relaxing activities and pampering herself. Anna looked at me quizzically after I suggested this and then tentatively disclosed that she did not know how to care for herself. I felt sad for her and explored the activities that she found relaxing and this involved having bubble baths and taking her dog on long walks. I subsequently encouraged her to engage in these activities and she later reported that she did so.

I closely questioned Anna about the circumstances that had prompted her to seek therapy. I learnt that her brother (Paul) had died in late 2006 following a long battle with cancer. Paul had been admitted in hospital for a period of eight months prior to his death. At the request of her parents, Anna had temporarily relocated from the city she had lived in to be near her family while her brother underwent medical treatment. She had ensured that he received the necessary medical care and had emotionally supported her parents and her brother's family through the period. After her brother's death, Anna had spent a year abroad as she believed that she needed time on her own. While abroad she had reflected on the experiences that had shaped her life and

the rape had featured prominently. As a result, she had decided that upon her return to the country she would seek professional help.

Trauma-related intrusions

Anna experienced two intrusive memories of the rape. The first involved an image of the perpetrator lying on top of her and raping her but she reported that this intrusion had ceased a year after the rape and had not recurred since. Her second intrusive memory involved an image of the party scene that had occurred prior to the rape and this intrusion persisted for twenty five years after the rape and continued to plague her. I subsequently explained to Anna the reasons for the persistence of intrusions in terms of the treatment model (i.e. they represent unprocessed parts of the trauma memory) and provided her with a rationale for reliving. Anna then, without any prompting, began visualising this intrusive memory and I subsequently asked after her thoughts and feelings. I found that this intrusion was associated with marked feelings of helplessness related to her being physically incapacitated by the perpetrator. It was also associated with secondary appraisals involving intense anger at her having been victimised and there having been no one to care for or support her in the aftermath of the trauma.

Crises Management

At the outset of our sixth assessment session, Anna dismissingly and with some humour reported that she had experienced a distressing flashback of the party scene. I closely questioned her about her experiences. Anna had visited a restaurant located near a popular beach resort and while lunching with two colleagues she had started to feel increasingly anxious. She subsequently realised that the interior of the restaurant bore a striking resemblance to the room in which the party had occurred the night she had been raped. She then experienced a flashback of the party scene and subsequently had a panic attack. In the days after this incident, she had relentlessly engaged with her work as a means of distracting herself from thinking about the rape. It was clear that the trauma memory had not been sufficiently processed. I psycho-educated her about the mechanisms underlying triggering and emphasised that it was necessary for us to facilitate the complete processing of the trauma memory through reliving. Anna reported that she understood the rationale for the approach and believed she could cope with a reliving.

I first invited Anna to draw a layout of the room in which the party had occurred and she was markedly surprised at the extent to which she could remember the interior of that room. I guided her to relive the night of the trauma from the moment she had entered the room in which the party had occurred. I closely questioned her about her thoughts and feelings during each stage of her ordeal. Anna's memory of the room was remarkably vivid and she coped extremely well with the reliving. I subsequently discussed the reliving with her and identified two secondary appraisals. The first involved Anna's assumption that the rape had affirmed her belief that she was not safe in social situations ("it put the stamp on any mistrust that I did have of social settings") and was associated with feelings of anger. The second involved her sense of sadness and disappointment that the rape had dampened her expectations of a better future. At the close of the session, Anna held the drawing she had constructed and looked at it for a few minutes. She then looked up at me with gratitude and thanked me and I was taken aback. It was clear she had wanted to confront the traumatic event for some time but had not believed she could tolerate doing so. It was also apparent that she was growing to trust me.

Return of the repressed

Anna appeared extremely angry when she arrived for our subsequent appointment and reported that the reliving had brought the reality of the rape to the fore and as a result she was experiencing marked feelings of anger, sadness and loss. I acknowledged her feelings and normalised her reactions by emphasising that it was the first time she had spoken about the rape in such detail and it was therefore expected she would feel vulnerable, hurt and angry. Anna affirmed that she had "buried" the rape for many years and the reality of the trauma had "hit her hard". I validated her experiences and encouraged her to share her sense of sadness and anger. Anna's sadness was related to her belief that the rape had shattered her expectations for a better future. I learnt that two months after the trauma she had enrolled at a local varsity and that attending college had been a cherished dream for hers since adolescence. She had believed that, by being away from the toxicity of her home environment, she would be able to establish a life for herself filled with friends, excitement and opportunity. However, the rape had severely dampened her spirits and left her feeling markedly depressed and despondent and she struggled to cope academically. In addition, she stopped menstruating for four months after the rape and this enhanced her anxieties as she feared she might be pregnant. Her menstrual cycle subsequently resumed but she still struggled with her academic work and dropped out of her

first year of studies much to the disapproval of her parents. Anna subsequently re-enrolled at another university but still found it extremely challenging to focus on her work as she was frequently plagued by thoughts of the rape. She found that she became intensely anxious in social situations and found it extremely difficult to form friendships. While at varsity, Anna met her partner and they became involved in a long term relationship and had two children. However, their relationship did not last and, after almost ten years together, Anna left her partner due to his controlling and abusive behaviour. I acknowledged the impact of the rape on her life and her expectations for her future. I also empathised and reflected on the losses engendered by the trauma and Anna became tearful and started sobbing.

Ann was also saddened and angry that she had been exploited at a young age and that there had been no one for her to turn to for support and care. I emphasised that it was a tragedy that she had been so alone at a time when she needed comfort and reassurance. In addition, she was angry at the perpetrator for rendering her helpless and exploiting her. I subsequently encouraged her to express her anger but she found it very challenging to engage with this task and so I did not push her.

Through close questioning I found that reliving and thinking about the rape had triggered Anna's memories of instances in which she had been victimised by her family, particularly by her mother and brother. I invited Anna to share these memories and empathised with her and reflected on her difficult childhood. I encouraged her to express her feelings of sadness and anger towards her mother and brother by using the empty chair technique. However, Anna found this extremely challenging and subsequently reported a reluctance to return to therapy. I responded by affirming that the task had been difficult and reassuring her that we would proceed at a pace that she was more comfortable with.

Anna felt extremely guilty and ashamed for having experienced sexual arousal during the rape. She believed that something was inherently wrong with her body for her to have reacted in that way. I addressed her guilt by explaining that this reaction represented her body's response to being stimulated in a particular area and was not indicative of her having gained any pleasure from the assault. I emphasised that she had been drugged prior to the assault and that any reactions she experienced were involuntary. Anna reported that years after the trauma she had

tentatively arrived at this same conclusion but that hearing it from someone else significantly validated her assumption and challenged her guilt and shame.

Enhancing social support

Anna was severely socially isolated and this was largely related to her social anxieties. She reported that she tended to keep people at "arms length" and this inhibited her forming friendships and she desperately wanted to establish meaningful relationships. She reported that her intrusion of the party scene was often triggered when she entered social settings and for this reason, she was reluctant to enter such contexts. Given the work on the trauma memory, I assumed that the intrusion had been processed and so encouraged Anna to participate in social events. This involved socialising with the people she was acquainted with on a more regular basis. I was aware that she had joined a local choir and met with them once a week to practice. I suggested that she socialise on a more frequent basis with the members of this group but she found this difficult. Anna attended their social functions and attempted to interact with people but experienced marked feelings of anxiety that led to her fleeing the social gathering. Her anxiety was not due to her experiencing intrusions but was related to her problematic cognitive appraisals when in these situations. Anna believed that she was not socially competent and would "stuff up" and say something inappropriate and other people would criticise or shame her.

5.1.2. DIAGNOSIS

On the basis of the information obtained from the assessment interviews and Anna's scores on the self-report scales (BDI: 20; BAI: 33; PDS: 30) she was diagnosed with the following:

(i) Post-Traumatic Stress Disorder

Anna first met diagnostic criteria for PTSD in the months after the trauma and her symptoms re-emerged in adulthood when she started reflecting on her life and her experiences of victimisation. In the aftermath of the trauma, she had experienced two intrusive memories of the rape but only one of these had persisted for twenty-five years after the trauma. This intrusion involved an image of the party scene that occurred prior to the rape and was triggered when Anna entered social settings. For this reason, she often avoided social contexts. She also experienced this intrusion whenever her patients shared their experiences of sexual victimisation with her. In addition, Anna felt jumpy and overly alert and had difficulty sleeping.

(ii) Major Depressive Disorder (Recurrent)

Anna was suffering from major depression at the time of her presentation. She experienced feelings of sadness and disappointment related to the negative impact of the rape on life. She felt guilty for the sexual arousal she had experienced during the assault and angry that she had been victimised by the perpetrator and that there had been no one for her to turn to for care and support. These symptoms of depression had been present for one month prior to her seeking therapeutic help. Anna had also met criteria for major depression in the period immediately following the rape. Her depression in relation to the rape had remitted slightly over the years after the trauma. However, she re-experienced symptoms of depression throughout her life in response to various adverse life circumstances.

(iii) Social Phobia

Anna met criteria for social phobia. She avoided visiting grocery stores, clothing stores and social gatherings because she feared that other people would scrutinise her. She feared that she would act in a way that embarrassed her. Whenever she was compelled to visit a shop or attend a social event, she experienced marked symptoms of anxiety and occasionally had panic attacks. Her social phobia often prevented her from obtaining goods that she needed on a regular bases (e.g. new clothing). In addition, it contributed to her being largely socially isolated. Anna first met criteria for social phobia in early adolescence.

The following diagnoses was added after the fourth therapy session as it was increasingly apparent that Anna's difficulties were better conceptualised as Avoidant Personality Disorder

(iv) Avoidant Personality Disorder

Anna met diagnostic criteria for avoidant personality disorder. She was guarded in her interactions with other people and this was related to her belief that, if she allowed others close to her, they would shame, criticise, belittle or control her. She therefore refrained from sharing her needs or feelings in interpersonal relationships. She also believed that she was not socially competent and would therefore behave in an embarrassing or humiliating way in interpersonal situations. These negative beliefs prevented her from establishing the meaningful relationships that she craved and left her feeling isolated and lonely.

5.1.3. CASE FORMULATION

(i) Predisposing factors

Anna was raised in an extremely punitive, critical and neglectful home environment and this led to her developing early maladaptive schemas involving: emotional deprivation; mistrust/ abuse; abandonment/instability; vulnerability to harm and; defectiveness/shame (Young et al., 2003). From early childhood onwards her mother (Martha) repeatedly criticised, shamed, belittled and ridiculed her. When Anna was four years of age her mother took her to a public swimming pool and at one point during the outing, Martha viciously and publicly accused Anna of looking unattractive in her bathing costume. Similar experiences of verbal and emotional abuse occurred throughout Anna's childhood. To preclude criticism and ridicule, Anna relinquished activities that she enjoyed, particularly drawing and painting, and avoided being in the vicinity of her mother and usually secluded herself in her bedroom. Anna's father (Jacob) spent most of his time at work and, when at home, he remained distant and was largely uninvolved in raising his children. As a child, Anna often tried to seek solace with her father but found that he would dismiss her or respond to her sarcastically and so she avoided seeking his attention and affection.

During her childhood years, Anna had sought companionship with her older brother (Paul) but she found that he would respond to her with little care or affection and often treated her aggressively, both verbally and physically. When Anna was five years of age, Paul encouraged her to climb up to the roof of their home. Anna, wanting to impress her brother, had complied but once on the roof she found that she did not know how to climb down. She subsequently pleaded with Paul to help her but he only found her distress amusing and simply walked away. At the time Anna had wanted to call to her mother for help but believed that this would be futile as her mother "would not hear her". She remained on the roof until late that evening and by that time cold and hunger prompted her to muster the courage to somehow come down from the roof. Paul's physical aggression often resulted in Anna being covered in bruises but Martha would always attribute these injuries to her daughter being a clumsy child. As a result, she would criticise Anna and not tend to her physical injuries. She would not reprimand Paul in any way and any misconduct on his part would be overlooked.

These adverse childhood experiences led to the creation of Anna's early maladaptive schemas which were subsequently strengthened by her negative experiences within her schooling

environment. In school, Anna was frequently ridiculed by her peers for her physical appearance as she was more physically developed than other students. She was frequently mocked by the female students in her class or subjected to inappropriate remarks from older male students. She was also singled out by teachers whenever she failed to master her academic work. For these reasons, Anna frequently absconded from school and refrained from developing friendships with other students.

Anna was raped at the age of eighteen and this trauma significantly reinforced her negative core beliefs. The rape had occurred following Anna's visit to a holiday resort where, despite her social anxieties, she had decided to socialise with others at a party and savour the experience of being away from her punitive home environment. However, she had been drugged and raped that night. The rape served to consolidate Anna's belief that she could not trust other people to care about her welfare or to respond to her with respect, warmth, compassion or empathy. It also confirmed her expectation that if she allowed other people into her life she would get hurt.

(ii) Precipitating Factors

Anna was exposed to a drug facilitated sexual assault at the age of eighteen after she attended a party. She experienced partial amnesia for the trauma and remembered momentarily waking up and seeing the perpetrator raping her. At the time of the trauma Anna had not been aware that rape could be perpetrated by first drugging the victim and her sense of confusion as to what had happened generated a sense of threat. This was exacerbated by her experiencing sexual arousal during the rape. She could not understand how her body could react in such a way and believed something was inherently wrong with her. She also felt extremely guilty for having experienced sexual arousal. These appraisals generated her PTSD reactions. The rape had occurred after Anna entered a social setting and this reaffirmed her existing assumption that social situations were dangerous and that other people could not be trusted. These appraisals contributed to the persistence of her symptoms.

(iii) Maintaining Factors

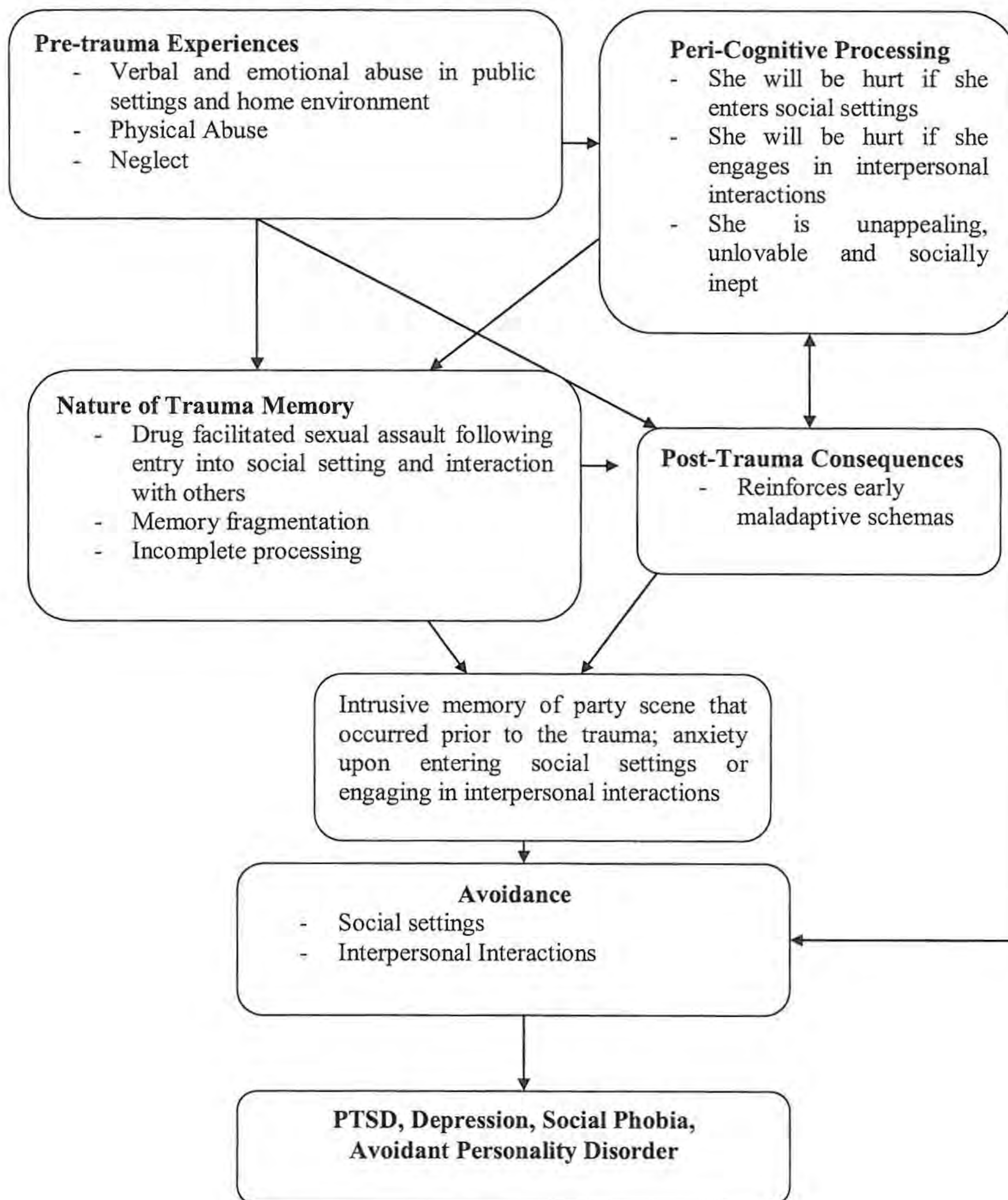
Anna's early maladaptive schemas and the avoidant strategies she adopted to cope with these negative core beliefs contributed to the creation and maintenance of her symptomatic reactions. Her schemas led to her believing that she could not trust other people to treat her with respect,

care, warmth or affection. She assumed that she was unlovable, socially awkward and undesirable in terms of her physical appearance. In addition, her schemas led to her expecting that she would be criticised, ridiculed or shamed if she established close relationships with other people. For these reasons, she was extremely wary of social situations and maintained mostly superficial connections with other people and this left her socially isolated and lonely.

The rape had occurred following her attempt to interact with others in a social setting and this lent further credence to her core belief that if she allowed other people into her life, she would be harmed. Anna enlisted her avoidant strategies to cope with the rape and she refrained from thinking about the trauma and suppressed her memories of the incident. She kept the rape a secret because she believed that she would either be accused of provoking the assault or her distress would be dismissed. Her avoidant strategies prevented her from emotionally processing the trauma and inhibited her from receiving needed social support.

To aid the case formulation, the clinical material is presented using an adapted version of Ehlers and Clark's (2000) diagrammatic formulation of their cognitive model of PTSD.

Figure 7: EHLERS AND CLARK (2000) COGNITIVE MODEL OF PTSD (Adapted)



5.1.4. PRESENTATION OF TREATMENT PLAN

Following the assessment sessions, I explained to Anna that it was necessary for us to discuss the treatment plan but this triggered her avoidant behaviours and she repeatedly changed the topic of conversation and started discussing arbitrary issues. I used direct empathic confrontation and reflected on her hesitance to review the treatment plan. Anna then appeared tearful and started crying. Through sobs she disclosed that she felt intimidated by the discussion of the focus areas for treatment as they brought home the reality of her issues. She also reported that she had been aware of the presence of these issues for many years and was angry that she had not addressed them earlier and was still being affected by them. I comforted and reassured her and emphasised that she had not had the opportunity to tackle these difficulties owing to her life circumstances but that once the opportunity arose she had taken the initiative to do so. Anna was subsequently calmer and we reviewed the treatment goals together.

Treatment involved addressing her PTSD symptoms, social phobia and unresolved grief. I identified Anna's PTSD reactions, reminded her of the treatment model and the techniques used to target symptoms. I explained to Anna the causative factors surrounding social phobia using the Clark and Wells (1995) model and she was very attentive during this process. She then requested that her social phobia be the first target of treatment as she wanted to address her social isolation. In addition, I explained to Anna that it appeared she had unresolved feelings of anger and sadness towards her mother and brother and that these aspects would need to be a focus of treatment. She appeared saddened at this and acknowledged that she needed to work on these areas. Anna requested that an additional focus area be incorporated into the treatment plan and this involved helping her to reclaim her artistic abilities. She had relinquished drawing and painting due to the critical and disparaging attitudes of her caregivers and wanted to reclaim these aspects of her identity.

5.1.5. THERAPY NARRATIVE

Anna was seen for thirty three sessions in total. The therapy narrative has been condensed and discussed in terms of the themes that formed the dominant focus of specific groups of sessions. The therapy sessions focusing on the application of schema therapy to target her avoidant

personality disorder are discussed individually as this approach led to the complete resolution of her symptomatic reactions.

Therapy sessions 01 – 04 [T3: BDI: 13; BAI: 36; PDS: 25]

Focus area: Social phobia

The first four sessions focused on targeting Anna's social phobia but her avoidant tendencies inhibited this process. I reminded her of the Clark and Wells (2005) model and explained the role of self-focused attention in maintaining anxiety reactions in social settings. I emphasised the necessity of identifying her thoughts in social situations and the emotions she experienced. However, I found that this triggered Anna's avoidant behaviour and she frequently diverted the focus towards discussing arbitrary issues and I had to repeatedly redirect her back to the original topic. I provided her with a document I had compiled (*see Appendix M*) explaining social phobia. The document contained a section in which Anna was invited to establish her goals with respect to her social phobia and detail her specific cognitive, behavioural and emotional reactions in social settings. However, Anna repeated neglected to review this document and I eventually decided to review it with her in session. She was markedly avoidant throughout this process. She also refrained from practicing paced breathing exercises that I explained would help to reduce her anxiety. In addition, she repeatedly avoided engaging in a behavioural experiment aimed at identifying her thoughts and feelings in social settings. I subsequently used direct empathic confrontation to address Anna's avoidance and explained that, to address her social phobia, it was critical to identify her cognitions. This led to her participating in the behavioural experiment and visiting two clothing stores. However, she only remained in each store for a few minutes (approximately five minutes) before rushing out. She experienced marked anxiety in both settings and, at one point, felt so nauseous that she was certain she would vomit if she did not leave the store.

I asked Anna if any visual images had come to mind when in the shops and found that she had an image of herself looking extremely fat with a pronounced stomach. This image prompted her to frequently pull down her shirt to ensure that it was covering her stomach. Through close questioning, Anna disclosed that her mother had once accused her of having a fat stomach when she was a child. Since that incident she believed that she was obese and unattractive and had a huge stomach. Anna was mildly overweight but she was not unattractive and did not have a

pronounced stomach. However, it was clear that the inaccurate image she had of herself was influenced by her childhood experiences and was deeply ingrained. Anna also disclosed that this image would frequently come to mind when she was interacting with other people and would cause her to feel very anxious and self-conscious and she would then flee the social setting. It was increasingly apparent from the history and severity of Anna's avoidant reactions that these behaviours were better conceptualised as avoidant personality disorder.

There was a five week break from therapy following our fourth session due to the Christmas holiday period.

Resuming Therapy

Following the holiday period, I contacted Anna to schedule an appointment with her and I experienced her as being dismissive. I had a sense that she did not want to attribute any significance to therapy because she feared being hurt and rejected in this setting.

Therapy session 05 [T05: BDI: 11; BAI: 16 PDS: 17]

Focus area: Re-viewing therapy goals

I used the fifth session to touch base with Anna and she was eager to tell me about her experiences during the holiday. I learnt that she had spent time with her parents and had not enjoyed the experience and was pleased that the holidays were over. I investigated her symptomatic reactions and found that she had not experienced markedly symptoms of social anxiety and this was largely related to her not having entered any social settings. She had mostly spent time at home with her family.

Anna disclosed that she had experienced a flashback of the perpetrator approximately a week before our meeting and the intrusion had left her feeling markedly distressed. She had coped by avoiding thoughts of the rape and situations that could potentially trigger flashbacks (e.g. social gatherings). I subsequently explained to Anna that it was important for us to target her PTSD symptoms as they were causing her marked distress and that we would leave addressing her social anxieties for later during the treatment process. She agreed to this as the intrusion had left her feeling distraught.

Therapy sessions 06-07

Focus area: PTSD

In the session I focused on addressing Anna's intrusions. The intrusion had been triggered during a consultation with a patient and while speaking with him she had felt increasingly anxious and had wanted to flee the room and had not understood her anxiety. Through close questioning, I established that her patient had borne a marked resemblance to the perpetrator in terms of his physical appearance. I subsequently explained to Anna that it was necessary for us to prevent triggering through then versus now differentiation. I emphasised that this involved reliving the trauma memory and then identifying the differences and similarities between the perpetrator and her patient. She subsequently agreed to this and I guided her to relive the trauma memory involving the party scene and prompted her to describe the features of the perpetrator.

Following the reliving, I discussed the differences between the perpetrator and the patient and Anna was able to identify the characteristics that differentiated these individuals. She emphasised that the perpetrator had a distinct Afrikaans accent and was dressed in a safari-suit and she believed he was a farmer. In contrast, her patient had a British accent, was dressed in modern clothing and was employed as a teacher. She was also able to appreciate that the rapist would currently be in his late sixties whereas her patient was a young man in his mid to late twenties.

I emphasised the necessity of differentiating between innocuous stimuli and those present at the time of the trauma so as to inhibit triggering of the intrusive memory. Anna then appeared surprised and reported that she had suddenly realised that her anxiety in certain social settings was due to the similarity between the men present in that setting and the perpetrator. She disclosed that she often felt anxious when near certain men but had simply attributed this to her social anxieties. However, she now realised that her anxiety had been due to triggering. She reported that simply understanding the mechanisms underlying this reaction was a significant relief. I subsequently advised Anna to pay careful attention to the similarities and differences between the men that she encountered in public settings and the perpetrator to further facilitate stimulus discrimination. I learnt that she was able to do this and it contributed to some reduction in her anxiety in public settings but she still remained socially anxious.

I explained to Anna the links between her social anxieties and the rape. I emphasised that due to the rape, social settings had become associated with a sense of threat. However, Anna reported that she was very uncertain as to whether it was the rape that had exacerbated her social anxieties or whether her social phobia was solely the result of her negative experiences with her family. I then educated Anna on the links between her negative experiences within her family and her anxieties in social settings and illuminated the role of the trauma in affirming the sense of threat that she already associated with social settings. This explanation resonated with her. I emphasised that we would target the sense of threat that she associated with social contexts in the course of her treatment process.

I addressed Anna's secondary appraisals of the trauma involving her belief that the rape had dampened her expectations of a better future. Through Socratic questioning I helped Anna to appreciate that despite the rape she had still managed to fulfil various life goals (e.g. fulfilling her goal of becoming a physiotherapist). I emphasised that the rape had been a significant setback for her but she had been courageous in attempting to reclaim her life. Anna then tearfully remarked that she had been essentially alone in her attempts to cope with the trauma and I affirmed this and emphasised her courage.

In the days following the reliving, Anna engaged in a number of avoidant behaviours to prevent herself from thinking about the rape. She voraciously read books (three novels a day), persistently watched television programmes and increased her working hours. Through close questioning I established that Anna's avoidance was related to her belief that if she thought about the rape she would become extremely angry at the perpetrator for victimising her and this would lead to her feeling intensely depressed and unable to function. I actively argued that not expressing her anger actually contributed to her feeling depressed but Anna vehemently maintained that accessing and expressing her anger was a pointless exercise. I invited her to share her concerns with me and she narrated an incident that occurred when she was an adolescent. Anna reported that when she was fifteen years old she had felt extremely angry at some situation and had decided to express her anger to her father. She vividly recalled that after doing so her father had simply laughed at her and his response had completely invalidated her feelings. I reflected on the possibility that Anna feared receiving a similar response in therapy. She quickly dismissed this but then tearfully reported that she did actually expect other people to

respond to her needs and feelings in the same way her parents and her brother had done. I acknowledged her fears and then actively argued that not all people would react in the same way as her family had done. Anna then reported that she was "logically aware of this" but it was clear that it did not resonate with her on an emotional level.

Therapy sessions 08-13 [T8: BDI: 12; BAI: 13; PDS: 10]

Focus area: Traumatic grief

Anna reported that she had increasingly started thinking about her brother and his hurtful behaviour towards her when they were children and this was leading to her feeling angry, sad and despondent. It was evident that the reliving had triggered her prior experiences of victimisation and I explained this and Anna acknowledged that this was a possibility. She had again engaged in avoidant behaviour to cope with her distressing emotions and so I invited her to share her concerns about accessing her feelings of anger and sadness. Anna believed that if she accessed her anger towards Paul this would mean accepting that she had been victimised as a child and she found this prospect markedly threatening. I asked what it meant to her if she had been victimised and she started to sob and I acknowledged her feelings of hurt and encouraged her. Through her sobs she reported that her brother had been her only companion during her childhood years and that if she acknowledged that he too had victimised her, this would imply that she had been completely alone in the world. I felt sad for Anna and empathised with her.

I had a sense that Paul's behaviour towards his sister when they were children was not malicious but the result of him having been in a neglectful family environment. I subsequently explained this to Anna and she started crying and reported that it was true that Paul had been neglected. I invited her to speak about this further and she recalled that when they were children Paul had frequently been taken to hospital as a child due to injuries (e.g. broken bones, severe cuts) that he had incurred while playing. However, apart from taking him to the hospital, their parents had never tended to Paul or deterred him from engaging in dangerous behaviours (e.g. jumping from the roof). Anna was clearly relieved after this discussion. It was apparent that she now fully appreciated that Paul's behaviour had never been checked by their parents and this had contributed to his aggression towards her.

I subsequently guided her to narrate her positive memories of her brother and she smiled through her tears and reported having enjoyed playing with him as a child and revelling in the games he devised. I asked Anna if she missed Paul and she wept for some time during session and I reflected on her sadness at his loss. After she was calmer I encouraged her to elaborate on the aspects that she missed about Paul and she indicated that she had cherished his spontaneity and courage and his non-judgemental attitude towards her. I invited Anna to speak about her brother's death and the impact of the loss on her life. She wept as she spoke about having watched her brother's physical health slowly deteriorate while he was in hospital and her sorrow at his loss. She also spoke of having loved and cared for him during that time.

In our thirteenth session, I proposed the empty chair technique to Anna as a means of voicing her anger towards Paul for his hurtful behaviours towards her when they were children. Although she was initially hesitant, she was able to engage with this work. It was clear that processing her grief at his death and understanding the reasons for his hurtful behaviour towards her strengthened Anna's inner resources and allowed her to engage with this work. In addition, my consistent validation of her needs and feelings allowed her to feel safe enough to express her anger. Using the technique, Anna was able to voice to Paul that he had hurt her through his insensitive behaviour and by not recognising or respecting her autonomy when they were children. I also guided her to voice to Paul how much he had meant to her and she was able to do so.

Therapy sessions 14-18

Focus area: Reclaiming her artistic abilities

Anna's feelings of anger and sadness in relation to her brother had abated significantly by our fourteen session and she reported that she believed she had grieved and made peace with him. It was clear that processing her grief had been emotionally taxing and so I proposed to Anna that we devote the next five sessions to her goal of reclaiming her artistic abilities. I believed that drawing would provide Anna with a needed interval to strengthen her inner resources before we moved on to addressing her schemas. I provided her with drawing materials and asked if she preferred to be alone when she drew and for the first two sessions, she requested that she be alone. I therefore left Anna for twenty minutes in my office and subsequently returned and discussed her drawings with her. Initially, she drew arbitrary pictures of animals and flowers and I

complimented her on these pictures. By the third session, Anna asked that I remain with her while she drew and it was clear she realised I would not respond to her drawings in a critical way and felt safe. She requested that I provide her with ideas for drawings and I suggested she draw images that captured phases of her life. This prompted Anna to draw pictures related to her childhood and I discussed each picture with her in terms of its content and implications for her life. One picture that stood out involved a three year old Anna attending her brother's birthday party. The picture was drawn in bright colours and contained an image of a very young child sitting on the grass in a far corner of the garden facing away from everyone. I discussed this picture with Anna but she reported that she could not remember what made this image stand out for her but the scene remained very vivid in her mind.

Therapy session 19 [T19: BDI: 14; BAI: 28; PDS: 12]

Focus area: Schema Therapy for Avoidant Personality Disorder

I used this session to review Anna's symptoms and prepare her for schema therapy. Anna had experienced an intrusive thought of the rape and this involved an image of the party scene. This intrusion had been triggered following a discussion with her daughter about the dangers of not returning home before dark. However, the memory had not elicited marked feelings of distress. Anna still experienced intense feelings of anxiety in social settings and her avoidance of such situations remained largely unchanged. She still found it difficult to establish close interpersonal relationships and it was clear that her early maladaptive schemas were contributing to the maintenance of these symptoms. I therefore proposed schema therapy to her.

I psycho-educated Anna about schemas and explained that repeated negative experiences contributed to the formation of certain problematic core beliefs. I emphasised that these core beliefs were often difficult to address because they were so deeply embedded. I explained that schema therapy offered a means of healing schemas through techniques such as imagery rescripting and empty chair work. Anna was extremely intrigued by this approach and reported that she was excited to engage with it. I requested that she complete the Young Schema Questionnaire-3 (YSQ-S3, Young et al., 2003) and emailed the questionnaire to her and, given her avoidant tendencies, I was surprised when she returned it to me the subsequent day. I analysed the results and found that Anna's dominant schemas were: mistrust/abuse; abandonment/instability; vulnerability to harm; emotional deprivation; and

defectiveness/shame. I subsequently discussed this with her and used Young et al. (2005) to explain the assumptions underlying each schema. I drew on repeated events in her childhood and adolescence to further illustrate how her schemas had developed and been strengthened. Anna then became tearful and started crying and reported that she had not realised how "far back these beliefs extended". She indicated that she was eager to engage with schema therapy to target her early maladaptive beliefs.

Therapy session 20

Focus area: Memory restructuring

At the outset of our session, I reminded Anna of the technique involved in memory rescripting and emphasised that we would evoke specific memories that had contributed to the development of her schemas. This would allow us to identify the salient emotions and cognitions associated with the memory and we would subsequently rescript the memory so as to weaken the schema. I proposed to Anna that we use her earliest memory involving the scene she had drawn of her three year old self attending her brother's birthday party. She agreed to this and then told me a joke and I sensed that she was anxious and was merely trying to lighten the mood. She subsequently engaged with the reliving and I was taken aback by the clarity with which she could remember the features of this memory. She described visual, auditory and tactile information as can be seen below in the segment from the transcript of the session.

> Anna: It's an incredibly strong textual memory as well...maybe because I was so close to the ground I don't know....
>
> Therapist: What are the textures you're feeling?
>
> Anna: The grass...and...a very lush grass and quite prickly...and err...the sky was a highveld sky...highveld skies are very dark blue almost an indigo blue....and the house... the wall of the house is a sort of a light peach colour erm....but I think I remember, I think I remember....erm....I think that was the first time I was conscious of almost being in a watcher mode... you know watching things from the outside, observing things...but not taking part...and not taking part because if I took part I would be clobbered or something nasty would happen ....
>
> Therapist: So there's a sense that if you participate something bad is going to happen so you're forced to stay on the outside
>
> Anna: Ja... and the knowledge that if something bad does happen it will always be my fault

Through reliving I established that this memory was associated with feelings of fear, rejection, isolation, anger, alienation and abandonment and some of these emotions are apparent in the segment above and below.

> Therapist: Is there anything else happening in that image...you said you're feeling isolated...very alone?
>
> Anna: Ja, everybody's running past and away from me...erm....I see lots of legs... that's a height scene so I see lots of legs...erm....and my mother's back is always towards me....erm...I seem to remember that I don't think she even checked on me once...even looked at me once during that whole birthday party...

Following the initial imaginal reliving, Anna was tearful and I comforted and reassured her. I then explained the salient emotions that I had identified and discussed the influence of this memory in the development of her schemas. Anna was able to recognise the connection between this negative childhood experience and her central EMS's (mistrust/abuse; abandonment/instability; vulnerability to harm). She pointed out to me that for these beliefs to have been present when she was three years old meant that they had to have originated at an even earlier stage in her life and I affirmed this.

I asked Anna what she believed her three year old child self had needed while attending her brother's birthday party. She tearfully disclosed that she had wanted to be included in the birthday party rather than being left on the side lines. I validated this and emphasised that it was extremely sad and hurtful that she had been so neglected and excluded. I then focused on rescripting the memory by incorporating Anna's needs into the scene. I explained to Anna that we would under-take another reliving in which she entered the scene as her adult-self. I emphasised that I would guide her to provide her child self with care and attention. However, Anna found this process very difficult because. Once she visualised entering the image as her adult self, she experienced intense feelings of anger that inhibited her from offering her child-self care and attention. It was also clear that Anna did not know how to care for her child self owing to her own experiences of neglect and deprivation. I therefore intervened during the rescripting and asked Anna if she could take her adult-self out of the image and if she could let me enter the scene and she was able to do this. I then focused on offering Anna's child-self the care, attention and validation that she had needed. I explained to Anna's child-self that it was not right that her

mother and brother had excluded her from the party and she too had a right to participate and enjoy herself.

I subsequently investigated Anna's experiences of the re-scripting and she reported that the imaginal reliving had generated feelings of anger and sadness for her. She cried and remarked that she had not realised the extent to which she had been neglected by her parents and bullied by her brother. I validated her experiences and comforted her. I emphasised that she had not deserved to be hurt or bullied and had needed love, understanding, care and warmth. Toward the close of the session, I explained to Anna that schema therapy was emotionally taxing and it was important she tend to her needs and devote time to care for herself. I later learnt that after our sessions Anna would spend time relaxing in her garden and would use this time to reflect on our session.

Therapy session 21

Anna had felt extremely tired in the days after our previous session and she attributed her exhaustion to the emotional intensity of the session and to a resurgence of her feelings of anger. She reported that the reliving had brought the extent of her childhood neglect to the fore and this left her feeling intensely angry but she was not avoiding this emotion. Instead, she was allowing herself to access this feeling and was surprised and pleased to find that this did not lead to her feeling depressed and unable to function. I was pleased for Anna and encouraged her.

Anna reported that she had started experiencing severe pain in her shoulder and she had not experienced this for a number of years. Her shoulder pain had first manifested twelve years previously in response to a severe injury she had sustained around the time her brother was first diagnosed with cancer. At that time she had sought medical treatment for the injury and it had subsequently healed. I asked Anna how she understood the re-emergence of this symptom and found that she associated shoulder pain with "carrying too much load". She believed that her shoulder pain was the result of her work in therapy and her attempting to release some of the load she had been carrying throughout her life. Anna had also experienced a recurrent, distressing dream since our previous session in which she witnessed her adolescent self running through a forest being chased by a non-descript dark black mass. I asked how she understood her dream and she reported that she believed that the dark mass was her adult-self who was forcing

her child and adolescent selves to confront issues that they had been avoiding. She regarded her dream as being positive despite the anxiety and fear that it generated.

I discussed the next memory rescripting work with Anna. This involved using the same memory of the party scene and re-scripting the image by confronting her brother for his bullying behaviour. Once Anna engaged with the memory, I noticed that her tone of voice and mannerisms resembled that of a young child and I felt very protective towards her.

In the segment below, the three year old Anna and I approach her brother Paul and confront him for his hurtful behaviour. At the beginning of the transcript, Anna is feeling scared and wants to hide behind me and I subsequently reassure her that she is safe and that I will protect her. Once we approach Paul, I explain to him that his behaviour towards his sister is inappropriate and hurtful. Anna subsequently reports that Paul would respond by merely ignoring me and by returning later and hurting her. I subsequently explain to Paul that Anna is safe and protected and that if he tries to harm her again, I will return and he will be confronted for his behaviour. Towards the close of the rescripting, I reassure Anna and take her hand and walk away with her.

> Therapist: ....shall we walk towards him together?
>
> Anna: I think my instinctive response would be to hide behind you
>
> Therapist: Okay, I know that you're scared but I'm here and it's going to be okay... Paul can't hurt you. Now I'd like you to come with me ....I take your hand slowly and we walk towards Paul.....he's standing in the distance and we approach him...and I say... Paul I'd like to talk to you....and he looks at me and he's a bit surprised ... he's surprised to see you there as well....and I say to Paul....Paul, I know that you said something to Anna that's made her scared...she's your sister and she does not deserve to be bullied...I know that you say things to hurt her... I know that you threaten her and I don't think that's right. She's your little sister and she deserves to be treated with care and respect....and you will not bully her
>
> Anna: I think he'd ignore you
>
> Therapist: How would he ignore me?
>
> Anna: Go on with what he's doing
>
> Therapist: Okay, and I say... Paul, I know that you're trying to ignore me but there's something that I'd like to say to you... I'd like you to stop what you're doing and pay attention to me...and Paul stops and he looks at me and he's a bit uncertain... and I say to him... you will not bully your sister...she's a little girl and she also needs to play and have

fun...that is not only your right....and she's also important and she also deserves to be treated with respect and you will not bully her, do you understand me...what would Paul do?

Anna: Honestly.... he'd say okay and then come back and get me later

Therapist: Uhm...okay...what would little Anna do now?

Anna: Erm...I... still be hiding behind you

Therapist: Uhm...and I continue to talk to Paul and I say....Anna is afraid of you and that's not the way it should be .... she should not be afraid of you and I know that you think that I'm only saying this now and when Anna is alone, you can come back and hurt her...but I'm going to come back too and I'm going to make sure that you don't hurt her...she is protected and she is safe and you will not continue to bully her ......What would he do?

Anna: I think he would probably acknowledge what you said....erm....but I don't know that it would make any permanent impression on him

Therapist: I'd like to continue talking to Paul....Paul, I'd like you to remember that Anna is protected and there are people who care for her and she will not be treated in a hurtful way and if you do try and hurt her again....I will be back...now Anna I know that you're a bit afraid but I want you to know that it's going to be okay...and if Paul ever tries to hurt you again....you need to tell me and we can deal with it together...you're safe now and you're protected and I know that you're feeling a bit afraid but it's going to be okay...what would you do?

Anna: I think ....feel relieved but I think.... also quite doubtful...

Therapist: Hmm ....I know that you're feeling as though you're not sure whether you can trust me, I know that...and it will take time before you realise that you can....but I'm here for you and we'll see this through together...so why don't we go back to the party now that we've spoken to Paul.. would you like to do that?

Anna: Uh huh

Therapist: And I take your hand and I walk back to the party with you....

Following the rescripting, Anna immediately cried and I empathised with her and offered her care and support. She then reported that she had started to increasingly realise what a powerful figure her brother had been in her childhood years. She expressed sadness that she had not had a loving and caring relationship with him and I validated this. I emphasised that her brother's behaviour towards her had been hurtful and unnecessary and it had occurred due to neglectful parenting practices and this resonated with her.

Therapy session 22

Anna reported that since our previous session her shoulder pain had completely ceased. It was clear that this memory was stored not only in a visual sense but also as a bodily experience and that, by confronting her brother, the schema had started to heal. I subsequently focused on confronting Anna's mother for her neglectful behaviour in a rescripting exercise. I used the same memory of the birthday scene to achieve this. Once in the scene I first commended Anna for her bravery during the confrontation with Paul and then asked her if I could approach her mother and do the same. Anna's child-self then informed me that she believed that confronting her mother would be a "battle" but that she was willing to let me try.

In the following segment below, I approach Martha and confront her for neglecting her daughter and failing as a parent. Anna reports that her mother would merely dismiss me and tell me that "it's none of [my] business". I subsequently explain to Martha that I care about Anna and am angry at the way she is being treated and that she needs to be a more responsible parent.

> Therapist: What would she say to that?
>
> Anna: There's no ways you would know that she's failed...and she never fails....and it's none of your business...
>
> Therapist: I'm making it my business....because I care about Anna, I care about what happens to her...and you are failing her even now....and each time you fail her, each time you neglect her, each time you hurt her, I will call you out on it....and I can see that you're angry...but that's nothing compared to how angry I am at the way you treat her....and if you try and hurt her after I've spoken to you...I will come back and I will call you out on it again.....now I'm going to take Anna and we're going to go and play...and you can think about the type of parent you want to be to your daughter....I realise that as a child you were neglected too but that doesn't give you the right to perpetuate that abuse....you need to be a mother to all your children...
>
> Therapist: And I take your hand Anna and I walk away with you and ....[continued]

The following segment illustrates Anna's growing sense of protection. In the scene, I kneel down next to Anna and reassure her and ask after her experiences and she reported that she feels "flabbergasted" and "happy". Anna also reports that she is doubtful that I can fulfil my promise to care for and protect her and I continue to reassure her. She then starts to experience a sense

of protection. At the end of the scene, I ask Anna if there is anything she would like to do and she reports that she wants to play in the garden and I incorporate this into the rescripting.

Therapist: ...when we're some distance away from your mother, I kneel down next to you and I say...Anna, I know that was very difficult for you...I know that your mom scares you and I know that I was angry with her right now too...and I realise that that could have been scary for you as well but I'm not angry with you....I see what's being done to you, I see how you're hurting....how you're being neglected and I don't want that for you....what would little Anna say?

Anna: ....she's.....flabbergasted

Therapist: I see you're looking very surprised at what just happened....you weren't expecting that and it's a shock that someone would say that to your mom...but I think that your mom is wrong in the things that she does to you...and it's time someone called her out on that....and I'm going to do that... each time your mom does something to hurt you, I'm going to call her out on it....because you need to be protected, you're a beautiful, bright little girl....and I'm here for you...and I'm going to make sure that you are cared for and you are protected....what would she say?

Anna: Uhmm....I think she's happy...but I think...she....wouldn't really believe that it would happen

Therapist: So little Anna is feeling happy at what just happened...but she's also feeling very doubtful

Anna: Uh huh

Therapist: That I can follow through on what I said....

Anna: Ja...

Therapist: I can see that you're quite happy with what happened. I think that you're happy that someone stood up for you...I think you're happy that somebody confronted your mother on the things that she doesn't give you...because I know that all children need love and care....and it's not right that you're not being given that... you're also feeling very uncertain...you're very doubtful...as to whether I will follow through in terms of protecting you....and caring for and defending you from your mother....and confronting her on her neglect....and it will take time before you feel able to trust me but I will be here....and each time your mother bullies you I will return and I will confront her on that....what do you feel?

Anna: I think....protection....a certain element of protection would creep in there...

Therapist: So you're feeling protected?

Anna: Ja....a little bit

Therapist: I know that you're feeling happy and more protected...and I'd like you to hold on to that feeling because I will follow through....and I will not allow you to be bullied like this...now what would you like to do, why don't we do something together....would you like to play... it's a birthday party and you're excited to be here...what would you like to do?

Anna: Play in the garden

Therapist: You'd like to go and play in the garden...shall we do that?

Anna: Uh huh

Therapist: And I take your hand and we both stroll together down to the garden....and I'd like you to slowly leave that image....and come back to the present

Following the latter rescripting, Anna once again cried and I offered her empathy and support. She then tearfully spoke of not being protected or defended as a child and I validated her experience. I emphasised that Anna's needs as a child were completely valid and it was a tragedy that her mother had treated her in such a critical and hurtful way.

Therapy session 23

Anna had experienced another recurrent dream but she could not recall the content of this dream. However, she recalled experiencing a sense of threat in the dream that she associated with "being suddenly pounced on". Through close questioning, I found that Anna related this experience to her sense of being unexpectedly verbally attacked by her mother during her childhood. I used her dream as a cue to the aspects that needed more attention in therapy.

I subsequently asked Anna how old she was in the dream and found that she was nine. I then guided her to review any memories that distinctly stood out for her during that time. Anna, after some reflection, reported that when she was nine years old her mother decided to make a dress for her and she had been extremely excited at the prospect of having a new dress. However, the dress her mother made was of a Victorian style with a long collar. It was not only inappropriate for the time and for Anna's age but was extremely uncomfortable and unattractive. Despite the dress being too tight, Martha had insisted that her daughter wear it out in public. Anna reported that she believed that this had been the moment she first realised that her needs and desires were not important to other people. She indicated that this incident had consolidated her earlier belief that her mother did not regard her as "pretty". This assumption had originally developed as

a result of the incident at the swimming pool when Anna was four years old. Her mother had told her that she had a "fat stomach" and should "pull [her] tummy in". I subsequently proposed to Anna that we re-script this latter memory and she agreed.

I guided Anna to relive the memory of her outing. From the reliving, I established that at one point during the outing Martha had called to her four year old daughter. She had then shouted, in front of other people at the pool, that Anna "had such a fat tummy" and that she "needs to keep it in because girls don't have fat tummies". These comments had made Anna feel hurt, ugly and embarrassed and she had subsequently left the swimming pool area and sat in a corner away from everyone. After the reliving, Anna became tearful and spoke of having felt deeply wounded by her mother's remarks. I validated this and expressed my horror at Anna's mother's behaviour towards her little girl and emphasised that it had been entirely unacceptable.

I then guided Anna to relive the memory from the point at which she had gone and sat in a corner. Once she connected with the memory, I asked after her thoughts and feelings and Anna reported having felt deeply wounded. With some astonishment she then remarked that she realised that she was feeling hurt because it was the first time that her mother had criticised her in front of a group of people. She believed that she had been made a spectacle of and felt deeply embarrassed.

I rescripted the memory by asking Anna to visualise my entry into the image. In the scene, I acknowledged her feelings of pain and her embarrassment. I then asked Anna how her child-self would respond to this and she reported that "little Anna would be crying". She then began to cry in session and I empathised with her pain. I asked her to imagine my holding her child-self and I then comforted and reassured her. I subsequently explained to little Anna that her mother's remarks had been due to her own issues and not due to anything being deficient with her. However, her child-self found it difficult to accept that her mother could be wrong. I actively argued that Martha's behaviour had been hurtful and inappropriate and that as a mother she should not have made such remarks towards her child. I emphasised that there was nothing wrong with her physical appearance and that her "tummy looked the way all little girl's tummies looked". I encouraged Anna to look at the other children in the scene and then emphasised that their bodies looked exactly the way hers did and that there was nothing wrong with her physical

appearance. I reiterated that her mother had been wrong in criticising her appearance. Anna then reported feeling more reassured and I asked her what she would like to do and found that she wanted to play in the pool.

I guided Anna to imagine that I was walking beside her towards the pool area and asked after her thoughts and feelings. She reported that she felt as if everyone was looking at her tummy and scrutinising her appearance. I explained to Anna's child-self that no one was looking at her tummy and encouraged her to look at the people around her (she had kept her head down in the scene) and notice that they were not focused on her. I reiterated that there was nothing wrong with her tummy and that I thought she had a "tummy that looked just like that of other children her age". I emphasised that it was only Anna's mother who believed that anything was wrong with her stomach and that this opinion was not shared by anyone else. I then asked how she was feeling and she reported that she felt better.

Following the re-scripting, Anna disclosed that while in her thirties she had taken up swimming as a physical activity but had always experienced panic attacks while in the changing rooms. She had not been able to understand this reaction but now she was able to connect her anxiety to this memory. I also connected the memory to Anna's fear of social settings and the sense of threat she experienced when in such settings and this markedly resonated with her. She reported that she now understood why she felt the need to always be on her guard when out in public.

Anna missed our subsequent appointment and I had felt ambivalent about contacting her as I was uncertain as to whether this would be intrusive. I therefore decided to wait until our next session and see if she made it before contacting her.

Therapy session 24 [BDI: 14; BAI: 21; PDS: 16]

Anna arrived fifteen minutes early for the session and was extremely apologetic for missing our previous appointment and reported that she had felt intensely sad after the previous re-scripting and since then she had spent a lot of time in her bedroom crying. I acknowledged that the rescripting sessions were harrowing and proposed to Anna that we pace the re-scripting in a way that allowed her sufficient time to recover. I suggested that we conduct a re-scripting every alternate session and Anna found this acceptable.

I investigated Anna's symptomatic reactions as I noted the increase on her self-report scores on the PDS. She reported that she had been experiencing distressing nightmares involving "chase scenes" that she believed were somehow connected to the rape. She reported experiencing a panic attack after visiting a hair salon that was triggered when she felt her neck being constrained by the apron placed around her by the hairdresser. I explained that being physically constricted could serve as a reminder of the trauma given her physical incapacitation at the time of the assault. However, Anna reported that she had no memory of the perpetrator choking her during the rape. I closely questioned Anna about her experiences of abuse with her brother and whether he had ever aggressively held her down by the neck. With some astonishment she reported that she recalled that as a child her brother had actually repeatedly tried to choke her. It was clear that her dreams were related to these memories and not to the rape and I emphasised this. Anna reported that this significantly helped her to understand some of her anxiety responses in social contexts. She indicated that her sense of being constricted might have also symbolised her inability to voice her needs with regard to her family. I invited her to speak about this further and she tearfully spoke of her brother having always been the one to be prioritised by her parents, especially her mother. I acknowledged her sense of having been neglected and hurt.

Towards the close of the session, I explained to Anna that I had been uncertain as to whether to contact her following her absence the previous week as I did not want to appear intrusive. I explained that I had been very worried about her and asked her if she felt comfortable contacting me in the event that she felt unable to make an appointment. Anna then cried and remarked that she was "so used to going it alone" and that it was a new experience for her to realise that someone else cared for and worried about her.

Therapy session 25 [BDI: 11; BAI: 7; PDS: 8]

I had realised, following the previous reliving, that Anna's mother displayed narcissistic traits and I decided to use the session to educate Anna about narcissistic personality disorder. I believed this would help her appreciate that Martha's hurtful behaviour towards her had not been due to her being deficient in any respect. I used the traits listed in the DSM-IV-TR (APA, 2000) and provided her with a book on the topic (Hotchkiss, 2003). The book contained a chapter on the impact of the narcissistic mother on their child's development and Anna was surprised to find

that the traits I listed accurately described her mother. I explained that at the root of narcissism was a deep fear of being shamed and Anna reported that she now recalled that her mother was acutely sensitive to any situation in which she could possibly be embarrassed. She recalled that Martha was also extremely hard on her children if they did or said anything that shamed her. I validated this and emphasised that her mother had been avoiding the possibility of her being shamed by being critical and demanding. Anna indicated that this gave her a new perspective on her mother's behaviour.

I was unexpectedly away for a week following this session and I apologised to Anna for the short notice. She was understanding and remarked that she would meet with me upon my return.

Therapy session 26 [BDI: 7; BAI: 7; PDS: 8]

I met with Anna following my return and reminded her that we had seven more sessions before having to terminate in terms of the treatment contract. Anna reported that she was comfortable with this arrangement and that she felt that she had obtained what she had needed from therapy.

I investigated her experiences of the re-scripting work we had done in earlier sessions and enquired as to how she felt continuing with this work. She reported that the re-scripting sessions left her emotional but she believed that it was highly beneficial in helping her understand the basis for her schemas and addressing these negative core beliefs. As such, she was eager to continue with this work. Anna had read the book on narcissism and it had provided her with significant insights into the factors that motivated her mother's behaviour. I emphasised to Anna that her mother's narcissism did not, however, justify her verbal and emotional abuse and she agreed with me. I then discussed the parts of the book that resonated with her. I found that Anna was increasingly beginning to realise that her mother's behaviour towards her had been reflective of her own issues rather than there being anything deficient with her. Towards the close of the session, Anna reported that she felt compassion for her mother and that she realised Martha had probably been subjected to painful experiences when she was younger and that this had contributed to her behaviour and I affirmed this.

Therapy session 27 [BDI: 6; BAI: 10; PDS: 11]

In this session, I proposed to Anna that we undertake a reliving involving a positive memory from her childhood. I explained that this would re-familiarise her with the process of reliving given that we had not undertaken this work for three weeks and she agreed to this. I guided her to reflect on her childhood and identify any positive memories that came to mind. After a few minutes, Anna reported that she had a vivid memory of playing in a vegetable garden as a child and having relished the experience and so I guided her to relive this memory. In the memory, Anna was four years old and she was sitting on the ground in the vegetable garden and playing with the soil while her mother was gardening near her. I found that the memory was associated with feelings of happiness, contentment and a sense of companionship. I subsequently discussed this memory with Anna and she reported that the memory brought her a sense of peace. I explained to her the concept of safe-space visualisation and advised her to use this memory to calm herself when she was distressed. Anna then reported that whenever she was intensely distressed she would go out onto her garden and lie on the ground and that this would immediately calm her. With some astonishment, she linked this to her memory of playing in the vegetable garden while having her mother beside her.

I proposed to Anna that we undertake a second rescripting of the memory of her being criticised by her mother during the outing to the swimming pool as this memory appeared to be critical in supporting her schemas. She reported that she was comfortable with this. I subsequently rescripted the memory by confronting Anna's mother for her hurtful behaviour. In the scene, I informed Martha that I had overhead her comments to Anna and regarded her remarks as unacceptable and irresponsible. I indicated to her that there was nothing physically wrong with her daughter and emphasised that Anna was a beautiful, intelligent and creative little girl. I also explained to Martha that it was a tragedy that she failed to appreciate her child. In the re-scripting, the four year old Anna had been shocked that someone could actually challenge her mother. She had also been pleased that someone had defended her and made her physical appearance entirely acceptable. Following the rescripting, Anna reported that she now appreciated that her mother's hurtful remarks towards her were not because there had been anything physically wrong with her. Instead, she realised that her mother's reaction had been based on her dissatisfaction with her own life and had nothing to do with her children and I reinforced this appraisal.

Therapy session 28 [BDI: 8; BAI: 8; PDS 6]

Anna had experienced severe migraines at least once a week since adolescence but since we initiated schema therapy, she reported that she had not experienced a single migraine. I asked her how she understood this. Anna reported that she was now more able to attend to daily tasks that she had previously avoided because it would mean interacting with people in a social context (e.g. paying her bills, grocery shopping). As a result, she was no longer weighed down or distressed by the knowledge that there were tasks that she needed to attend to and she believed that this had caused her migraines to cease.

Anna reported that she had been reflecting on therapy and she realised that her father had been largely absent from her therapy process. I validated this and emphasised that he had also been a distant figure in her life and this appeared to be reflected in therapy. I subsequently focused on discussing Anna's relationship with her father and the role he played in her life. I learnt that she had enjoyed her father's company during early childhood and he often allowed her to accompany him on errands and frequently invented stories to amuse her. However, when she was ten years old, her father grew distant from the family and she had not understood the reasons for this. His behaviour coincided with her menstruating for the first time and with her mother's increased punitive practices within the home but she did not know if these aspects had been influential in his decision. I subsequently reflected on how hurtful his behaviour had been for her as a child and Anna wept during the session.

Therapy session 29 [BDI: 6; BAI: 11; PDS: 7]

Anna reported another recurrent dream in which she was chased by a large man but there was no sense of threat associated with this image. I asked Anna if the man in her dream resembled her father and this resonated with her. She reported that her father was a mild mannered man and this explained the dream not being associated with a sense of threat. I reflected on the dream and suggested that it was apparent something was unresolved in respect of her relationship with her father. Anna affirmed this and reported that her father's complacency within the family was an issue that she had difficulty coming to terms with. She also reported that her father had always attributed any failure on her part to something being inherently wrong with her. He had never attempted to help her by determining if there was an external factor contributing to the problems she experienced. I asked after any specific memories that

stood out for her in this respect. Anna spoke of having struggled to cope academically following the rape and of her father having merely attributed her difficulties to her being inadequate. I explained the connection between these experiences and her schemas of defectiveness/shame and she was surprised and indicated that this explained her sense of being inadequate.

Therapy session 30

I focused on investigating the memories that Anna had of her father. A memory that distinctively stood out for her involved approaching her father when she was seventeen years old and informing him that she had begun smoking cigarettes. In disclosing this information, Anna had intended to gain her father's attention and to have him respond to her in a protective way by admonishing her for engaging in a harmful behaviour. Instead, he had reacted with disgust and disdain and this had left Anna feeling ashamed. I reflected on the association between this incident and her schemas of defectiveness/shame and this once again resonated with Anna. I suggested that we use this memory for our subsequent rescripting session and she agreed.

I explicitly hypothesised that Anna's father's withdrawal from her at the age ten may have been due to him wanting to afford her some privacy since she had begun menstruating. Anna reported that this could have been a distinct possibility as her father was extremely conservative and traditional. She remarked that he probably had not known how to help her cope with this.

Therapy session 31 [BDI: 5; BAI: 6; PDS: 7]

Anna was now having dreams involving "detoxing". She dreamt that she was detoxing the people that had harmed her and I reflected on this being indicative of her purging herself of prior negative experiences. This appealed to Anna and she reported that she was now feeling confident and good about herself. Her dreams were also reflective of her memories not only having been stored in a visual format but as bodily experiences. Dreaming of detoxing was essentially a means of purging her body of these stored toxic memories.

I guided Anna to relive the memory of her disclosure to her father about smoking cigarettes. From the reliving, I established that Anna had felt severely neglected at that point in her life and had desperately wanted to be "seen and recognised" by a significant other. I discussed this with her after the reliving and she reported that she had not realised that her intention in confronting

her father had been to gain attention and acknowledgement. She also reported that realising that her needs had been legitimate significantly challenged her sense of being inadequate and her feelings of shame. I focused on re-scripting the memory by inserting myself into the image and confronting Joseph for his neglectful behaviour. In the re-scripting Anna's adolescent-self had been shocked and pleased that someone had stood up for her and legitimised her experience of neglect. Following the re-scripting, Anna reported that she felt able to empathise with her father. She believed that his neglect had not been malicious but due to him having been faced with circumstances for which he did not have the skills to cope with.

Therapy session 32

I used this session to reflect on the changes that were occurring in Anna's life since the initiation of schema therapy. She reported that she was now dreaming of houses and I invited her share these dreams. Anna described the houses in her dreams as being open-planned, light, airy and receptive to the world. She believed her dreams were reflective of her newly found sense of stability and balance. She reported experiencing a sense of belonging that she had not felt before. Anna associated the houses in her dreams with a sense of transparency and attributed this to her "feeling less of a need to hide" herself. Anna had also started having sexual dreams and reported that these dreams were positive and she believed they were indicative of her increasing receptiveness to romantic relationships.

Anna had increasingly started spending time drawing. She mostly drew houses, people, buildings and flowers. She had even agreed to complete a drawing for a friend. I reflected on her increased sense of confidence and Anna indicated that she was feeling more "grown up" and able to care for and protect herself. She reported that she was feeling more assertive and able to stand her ground rather than run away from a situation. In addition, she no longer saw herself in a negative light and was spending more time tending to her needs. These included visiting shops and exploring the types of clothing she wanted to wear and pampering herself by purchasing cosmetic products and having bubble baths.

Therapy session 33 [BDI: 6; BAI: 5; PDS: 5]

Endings

For my final session with Anna, I focused on her experience of therapy and reviewed her progress. Anna reported that she was much more exuberant and confident about her future and her ability to cope with life challenges. She was more motivated to establish relationships with others and had started inviting people for coffee and luncheon dates and she believed that it was time she began dating. Anna was more comfortable visiting shops and attending social events and did not feel the urge to flee such settings. I reflected on her growth in therapy and expressed my confidence that she had reclaimed her life in many respects and she affirmed this. I invited Anna to contact me in the future if she experienced difficulties and she agreed to this.

Towards the close of our session, Anna invited me for a consultation at her practice. She reported that she wanted to give me something in return for helping her and I accepted her offer. The subsequent week I visited her practice which was situated in her home. After the consultation, Anna introduced me to her two daughters and showed me her garden. Before I left, I thanked her for sharing her home and family with me.

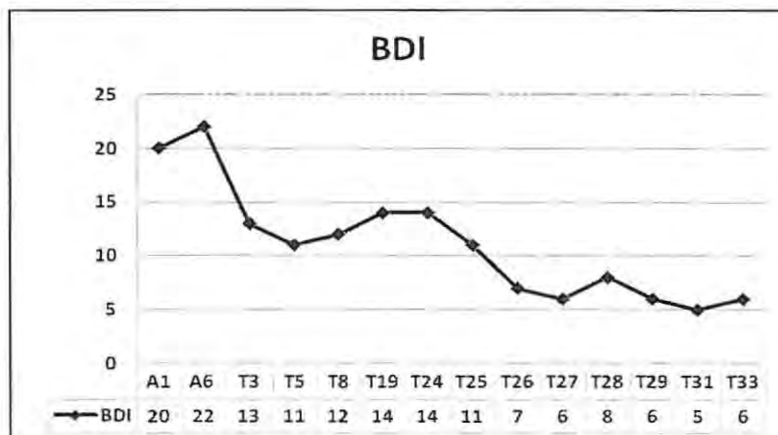
5.1.6. RESPONSE TO THERAPY

The scores from Anna's self-report scales indicate that there was significant improvement in her symptomatic reactions at the conclusion of therapy. I did not request that Anna complete self-report scales during the sessions in which she was grieving for her brother or during the time she was reclaiming her ability to draw (T8-T19) because I believed this would be intrusive and inappropriate. Responses on the self-report scales are displayed in figures 8 to 10.

(i) BDI

[Symptom scores: 1- 13 = Minimal; 14-19 = Mild; 20-28 = Moderate; 29-63 = Severe]

Figure 8: ANNA BDI SELF-REPORT SCORES

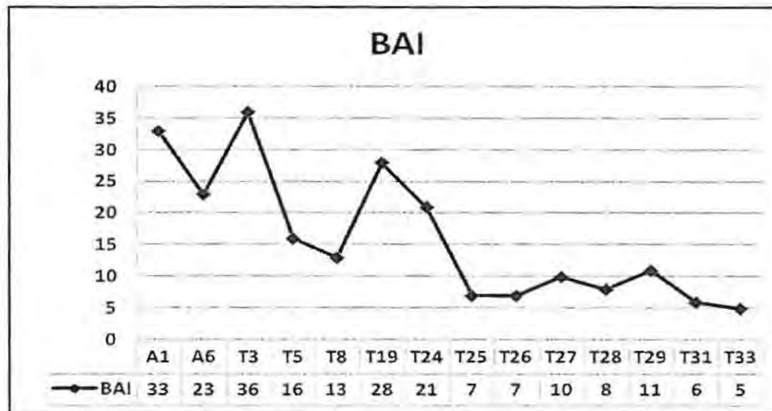


	A1	A6	T3	T5	T8	T19	T24	T25	T26	T27	T28	T29	T31	T33
BDI	20	22	13	11	12	14	14	11	7	6	8	6	5	6

(ii) BAI

[Symptom scores: 0-7 = Normal; 8-15 = Mild; 16-25 = Moderate; 26-63 = Severe]

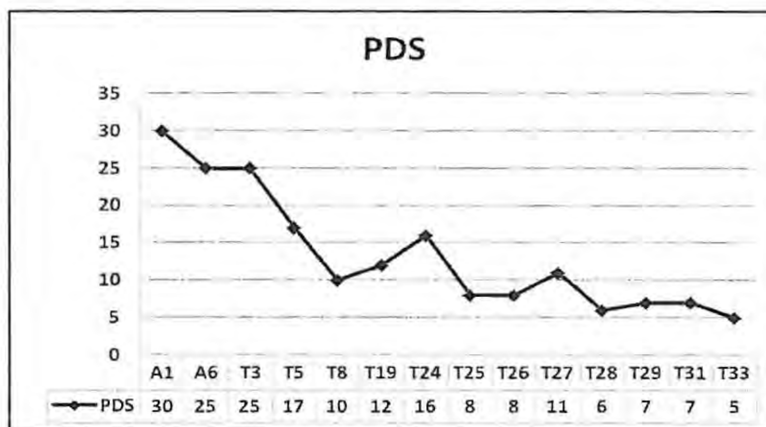
Figure 9: ANNA BAI SELF-REPORT SCORES



(iii) PDS

[Symptom scores: 1-10 = Mild; 11-20 = Moderate; 21-35 = Moderate/Severe; 36-51 = Severe]

Figure 10: ANNA PDS SELF-REPORT SCORES



At the outset of treatment Anna presented with clinically significant symptoms of depression (BDI: 20), anxiety (BAI: 33) and post-traumatic stress disorder (PDS: 30). There was a slight increase in her reported symptoms of depression (BDI: 22) by our sixth assessment session but her symptoms of anxiety and PTSD significantly decreased (BAI: 23; PDS: 25). The latter change is attributed to the interventions used in the first five sessions. These included: an intensive focus on stabilising Anna to ensure she felt safe and secure in the context of therapy; normalising her symptomatic reactions and; challenging her self-blame. These interventions helped Anna to

provide a detailed verbal narrative of the trauma and facilitated her engaging in imaginal reliving of one of the intrusive memories of the traumatic event. This intrusion involved an image of the perpetrator raping her (A4).

During the sixth assessment session, Anna reported experiencing an intrusive memory of the trauma after visiting a restaurant that bore similarities to the room in which the party had occurred the night of her rape. She was subsequently guided to relive the second and more prominent intrusion of the trauma. Although she coped well with this intervention, she required substantial stabilisation thereafter.

By the third therapy session, Anna's self report scores showed a decrease in her symptoms of depression (BDI: 13). The focus on stabilising her and prioritising her goals for therapy contributed to the reduction in her depressed mood. There was no change in her PTSD symptoms (PDS: 25). This is related to the links between her intrusive memory and her early experiences of victimisation within her family of origin. These links contributed to the persistence of her PTSD symptoms (*see section 5.1.7.*).There was a dramatic increase in her anxiety levels at this point (BAI: 36). This is attributable to Anna engaging in a behavioural experiment involving exposure to an avoided social situation as part of the treatment protocol for social phobia.

At the time therapy recommenced, Anna's self report scales indicated a reduction in all her symptoms (BDI: 11; BAI: 16; PDS: 17). The dramatic decrease in her reported symptoms is attributed to her not having been exposed to potential triggers. Anna had spent most of her time confined to her family home during the holiday period and had not frequented social settings. These settings generally served as triggers for her intrusions and social phobia. Targeting her PTSD symptoms formed the dominant focus of attention between the sixth and seventh therapy session. The interventions used included: psycho-education; imaginal reliving; 'then versus now' differentiation and; verbal challenging of her problematic secondary appraisals of the trauma. By the eighth therapy session, Anna no longer met criteria for PTSD (PDS: 10). Her symptoms of depression and anxiety were in the mild range (BDI: 12; BAI: 13). The therapeutic focus thereafter involved guiding Anna to process her grief at the loss of her brother (T08-T13) and helping her to reclaim her artistic abilities (T14-T18).

Schema therapy was used thereafter (T19–T32) to target the early maladaptive schemas maintaining her symptomatic reactions. At the outset of this process (T19) there was a slight increase in her symptoms of depression and PTSD (BDI: 14; PDS: 12) and a dramatic rise in her symptoms of anxiety (BAI: 28). These changes were the result of her having experienced an unwanted thought of the rape following a discussion with her daughter about the dangers of not returning home before night fall.

The first three sessions (T20-T22) were devoted to rescripting her earliest memory of being ostracised in a public setting. This memory involved her attending her brother's birthday party at the age of three and was associated with schemas of emotional deprivation, mistrust/abuse, abandonment and vulnerability to harm. Thereafter (T23), her memory of being criticised and shamed in public for the first time at the age of four was targeted for rescripting. This memory was significantly associated with schemas of mistrust/abuse and defectiveness/shame. Anna missed her appointment following the latter rescripting session owing to her feeling emotionally overwhelmed. Her self-report scores (T24) revealed that her depressive symptoms had remained unchanged (BDI: 14) and her anxiety levels had decreased marginally (BAI: 21). However, there was a significant increase in her PTSD symptoms (PDS: 16). This was the result of Anna experiencing distressing dreams involving "chase scenes" that she believed had a bearing on the rape. However, through close questioning, I uncovered that these dreams were related to her experiences of abuse with her brother and were not directly associated with the rape. This was a significant insight for her and there was a decline in her reported symptoms thereafter (T25: BDI: 11; BAI: 7: PDS: 8). These changes are attributed to Anna's increased insight into the factors underlying her anxiety responses in public settings.

The therapeutic focus (T25-26) subsequently involved psycho-educating Anna on narcissistic personality disorder (T26: BDI: 7; BAI; 8; PDS: 8). This was aimed at helping her to appreciate that her mother's abusive behaviour was reflective of her own issues and were not indicative of there having been anything deficient with Anna. Imagery rescripting was used to once again challenge the schemas associated with her memory of being criticised by her mother for the first time in front of a group of strangers (T27: BDI: 6; BAI: 10; PDS: 11). The absence of Anna's father from her therapy narrative was addressed and his role in her life and in the generation of her negative core beliefs was illuminated (T28: BDI: 8; BAI: 8; PDS 6; T29: BDI: 6; BAI: 11; PDS: 7). Imagery

rescripting was then used to challenge her schemas of emotional deprivation, abandonment and defectiveness/shame arising from her memory of her father responding to her with disgust and disdain (T31: BDI: 5; BAI: 6; PDS: 7). At the conclusion of therapy, Anna's symptoms of depression and anxiety were in the normal range and she no longer met criteria for PTSD (T32: BDI: 6; BAI: 5; PDS: 5). She reported that she felt "more grown up" and able to assert her needs and stand up for herself. She was able to engage with tasks that she had previous avoided (e.g. participating in social events and attending to work related tasks that involved interactions with others) due to the influence of her schemas. Anna indicated that she was more confident socially and believed it was time she began dating again.

5.1.7. DISCUSSION

The Self-Memory-System, self-coherence and the persistent of intrusive memories

Anna experienced one persistent intrusive memory of the traumatic event involving an image of the party scene that had occurred prior to her rape and this intrusion had persisted for twenty five years. To understand the persistence of this symptom, it is first necessary to consider the function of intrusive memories. Ehlers and Clark (2000) propose that intrusive memories serve the function of warning the individual of possible threats in the future and they therefore serve an adaptive function to some degree. In Anna's case, social situations and social interactions had become associated with a sense of threat for two reasons.

Firstly, from early childhood onwards, Anna had been subjected to repeated instances of verbal, emotional and physical abuse. Her mother had consistently criticised and belittled her in the home environment. These verbal attacks also occurred when Anna was in public settings with her mother. When Anna was four years old her mother accused her of looking fat in front of a group of strangers during an outing to a public swimming pool. At the time, Anna believed that she had been made a spectacle of and had felt deeply humiliated. During childhood and adolescence, her father had acted with indifference towards her and regularly invalidated her needs and feelings. He often laughed at her whenever she expressed her anger or dissatisfaction with specific situations that were affecting her. Anna's brother had been physically abusive towards her when she was a child and the injuries she incurred were always attributed to her having been clumsy. These aversive childhood experiences led to her developing early maladaptive schemas characterised by: emotional deprivation; mistrust/abuse; abandonment/instability; vulnerability

to harm and; defectiveness/shame. Her schemas led to her believing that she was inadequate, socially inept and unlovable and that she could not trust others to understand, care for or protect her. She also expected that she would be criticised, shamed or belittled in social settings and in the context of interpersonal relationships. These beliefs and the avoidant strategies she used to cope with her schemas formed the basis from which her social phobia and avoidant personality traits evolved.

Secondly, the rape occurred after her entry into a social context (i.e. a party) in which she had interacted with other people. In attending the party, Anna had wanted to initiate her goal of starting a new life for herself away from her toxic family environment and this included socialising with others and establishing friendships. However, at the party she had interacted with a stranger who subsequently drugged and raped her. The rape served to reinforce the existing link that social environments were potentially dangerous. As a result, whenever she entered social settings that bore similarities to the night of the party, she experienced an intrusive memory of the party scene. The intrusion served the function of warning her that she could be hurt in social contexts and exacerbated her avoidance of social settings in general.

Conway, Meares and Standart (2004) add to the warning signal hypothesis by proposing that intrusions function to maintain self-coherence. This idea is based on the model of autobiographical memory (*see section 1.4.2.)* called the Self-Memory System (SMS) (Conway & Pleydell-Pearce, 2000). The SMS is made up of the working self *(see section 1.4.2.*) and its knowledge base in long term autobiographical memory. According to Conway et al. (2004) the integration of episodic memories into the autobiographical memory knowledge base necessitates changes in these structures. However, to protect self-coherence, the SMS goal structure is highly resistant to change and only allows for gradual change.

On the basis of this theory, Conway et al. (2004) argue that one function of an intrusive image is to maintain a set of dysfunctional beliefs that in turn protect the goal system from the need for change. Intrusions therefore warn that a fundamental change is needed in the individual's goal system itself if the intrusive memory is to be integrated within the context of autobiographical memory. When applied to Anna's case, the intrusive memory served to maintain her negative core beliefs or early maladaptive schemas. The intrusion also warned that there needed to be a

fundamental change in these core beliefs for this memory to be integrated. Such a change would mean ensuring that the intrusion no longer corresponded with the goals of the working self (i.e. to protect her from social situations and interactions lest she get hurt).

Conway and Pleydell-Pearce's (2000) theory would explain why initial interventions aimed at targeting Anna's intrusion did not result in the resolution of this symptom. Essentially, these interventions did not fundamentally alter the negative core beliefs (e.g. "I will be criticised, belittled and shamed if I enter social situations") that were driving her intrusive memory and avoidance of social situations. As a result, the goals of the SMS system remained unchanged. To target her intrusion, it was first necessary to radically transform her long term self schemas and as a result the goals of her working self. This involved addressing the early maladaptive schemas that formed the basis of her conception of self, influenced her interactions with others and constituted the frame from which she interpreted experiences (Lee, 2006).

Imagery rescripting to target intrusive memories

In the cognitive-behavioural literature, memories of distressing life events have been shown to not only underlie PTSD but a variety of other disorders including depression, personality disorders, social phobia, agoraphobia and eating disorders (Arntz & Weertman, 1999; Wild, Hackmann, & Clark, 2007). These distressing memories have been found to correspond to certain negative, self-defining moments in the individual's life in which goals were threatened. The memories of these negative, self-defining moments are generally aversive to the individual and therefore lead to avoidant behaviour. This inhibits the processing of such memories into long term autobiographical memory structures. As such, like intrusions in PTSD, these distressing memories remain in episodic memory and are easily triggered by environmental cues. The individual then responds to the content of the memory as opposed to the current situation and this serves to maintain their symptomatic reactions (Conway et al., 2004).

In the Ehlers and Clark (2000) treatment protocol, imagery techniques (i.e. imaginal reliving and imaginal rescripting) are used to contextualise the traumatic event (i.e. as something that occurred in the past) and challenge the toxic meanings assigned to the worst moments of the trauma. Ehlers and Clark (2000) achieve this by inserting information that provides more realistic and less toxic appraisals. This facilitates the processing of the trauma memory within the context

of autobiographical memory and inhibits the ease with which it is triggered by environmental cues. The same theoretical principles underlie the rescripting of negative self-defining moments for other disorders. The aim is essentially to insert corrective information into the schematic representation that updates the memory (i.e. by providing information about what should have happened but did not) and challenges the meanings assigned to the distressing moment. This method has been used to treat a variety of conditions including: depression (Brewin et al., 2009); personality disorders (Arntz & Weertman, 1999); the sequelae of childhood sexual abuse (Smucker & Dancu, 1999); PTSD (Arntz, Tiesema, & Kindt, 2007; Hackmann et al., 2004); social phobia (Wild et al., 2007) and; agoraphobia (Day, Holmes, & Hackmann, 2004).

Transforming maladaptive schemas through imagery rescripting

The central goal of imagery rescripting is to change the meaning attached to past distressing memories that colour the individual's interpretation of current events. Wheatley et al. (2007) have pointed out that it is not necessary to rescript every memory that is associated with a particular schema. Instead, since specific distressing memories are thematically linked in a particular network, changing one highly emotionally charged memory will have repercussions for the entire network in terms of schema change. In Anna's case, three memories that supported her maladaptive schemas were identified and transformed. These memories had either come up during the course of her therapy process or were memories that were triggered from imaginally reliving an original distressing memory. The three memories were thematically linked and related to her core schemas.

Memory 1

The first memory involved Anna attending her brother's birthday party at the age of three. This memory was associated with schemas of emotional deprivation, mistrust/abuse, abandonment/instability and vulnerability to harm. The memory was intricately linked to the sense of threat she experienced as an adult when she entered social contexts. In the memory, the three year old Anna had remained on the sidelines at the birthday party because she feared that if she participated she would either be physically harmed by her brother or verbally reprimanded by her mother.

The memory was rescripted three times. The first rescripting involved my entering the scene and validating her needs and feelings. I explained to her child-self that she too had a right to participate in the festivities and that it was wrong of her mother and brother to keep her on the sidelines. The first rescripting led to Anna appreciating the extent to which she had been neglected and harmed as a child. As a result, she was able to access and express her feelings of anger (*see T21*) and this broke through patterns of helplessness. The second and third re-scripting involved my confronting Anna's brother and mother respectively for their abusive behaviour towards her. I expressed anger towards them for their treatment of Anna and, after each confrontation, I soothed and comforted Anna's child-self. I asked her child-self if there was anything she needed or would like to do and responded accordingly to her needs. Rescripting this memory led to Anna's maladaptive schemas being gradually replaced by a sense of safety and protection (*See T35*). In addition, it led to her experiencing a sense of agency in that I expressed anger on her behalf and confronted her abusers for their behaviour.

Memory 2

The second memory involved Anna being criticised in public for the first time by her mother when she was four years old. The memory was associated with schemas of defectiveness/shame. It was critically linked to her current social anxieties in that the negative self-image she had of herself in social contexts originated from the events represented in this memory. Furthermore, Anna believed this memory represented the originating point for her social anxieties because it represented the first time she had believed she was being scrutinised in a public context and had felt threatened.

In the memory, Anna's mother had accused her of having "a fat tummy" and had told her that girls did not possess this physical feature. Her critical remarks had left the four year old Anna feeling humiliated and believing that she was physical defective and unappealing. It had also led to her feeling highly self-conscious. In the memory, Anna had attempted to pull her bathing costume down so as to ensure that it hid her stomach from the scrutiny of others. In social situations, she performed this same behaviour of pulling down her shirt to ensure her stomach was hidden.

This memory was re-scripted twice. In both sessions, I extensively focused on normalising Anna's physical appearance so as to challenge her schemas of defectiveness/shame. I emphasised that "all little girls looked the way [she] did" and encouraged her to look around her and notice the appearance of the young girls in her vicinity. In the memory, Anna had believed that everyone around the swimming pool was staring at her and scrutinising her. I encouraged her to look around her while in the scene and to notice that no one was scrutinising her. Instead, the people around her were focused on other things.

I further challenged Anna's schemas of defectiveness/shame by explaining to her child-self that her mother's remarks were reflective of her own issues and not due to any deficiency on Anna's part. However, her child-self had difficulty reconciling this viewpoint and maintained that her mother was never wrong. As such, following the first rescripting, I extensively psycho-educated Anna on narcissistic personality disorder. I illuminated the parallels between her mother's behaviour and the traits that comprised the disorder. Anna then realised that her mother's behaviour had been due to her narcissistic traits and not due to anything being inherently wrong with her and she started feeling compassion for her mother. As a result of this intervention, in the second rescripting of this memory, Anna's child-self was more able to accept that she was not physically defective and that her mother's remarks were inaccurate. In the second rescripting session, I also focused on confronting Anna's mother for her hurtful behaviour and admonishing her for not appreciating her daughter. I subsequently reassured and soothed Anna's child-self.

Memory 3

The third memory chosen for rescripting was associated with schemas of abandonment/instability and defectiveness/shame. It involved a teenage Anna approaching her father to inform him that she had been smoking cigarettes. She had intended for her disclosure to lead to her father acting in a protective way towards her. Instead, he had responded with disgust and disdain and this had left Anna feeling ashamed, inadequate and unlovable.

Through imaginal reliving of this memory, Anna realised that her intention in disclosing her smoking to her father had actually been to obtain attention, recognition and affection at a time when she felt severely neglected and alone. This proved to be a significant insight for her in that

she released that her needs at the time had been completely valid. This realisation challenged her feelings of shame and her sense of being inadequate and unlovable.

In rescripting this memory, I challenged Anna's father for his hurtful remarks and conveyed to him that his daughter was feeling lonely and neglected. In the scene, Anna's adolescent-self had been surprised that someone would stand up for her and validate her needs. This addressed her schemas of abandonment and defectiveness/shame. Rescripting this memory also led to Anna appreciating that her father's response to her had not been malicious but had been the result of his helplessness when it came to tackling challenging issues. She then felt compassion for him.

Therapeutic effects of imagery rescripting

Through the use of imaginal reliving and imagery rescripting, Anna was able to come to new conclusions about her earlier negative experiences. She was able to appreciate that her childhood needs for attention, affection and companionship were completely legitimate and that she was deserving of love, warmth and care. She appreciated that her negative childhood experiences had implications not for herself but for other people (i.e. her mother and father). This led to her feeling compassion for her parents. In addition, imagery re-scripting allowed Anna to have the experience of being soothed, cared for and protected as a child. She was able to express childhood needs that she had suppressed and have these needs responded to.

By challenging the meanings she ascribed to earlier experiences, it was possible to change her long term self. Anna was essentially able to realise that her negative experiences represented an exception and not a life rule (Hackmann, 2005). This had implications for the intrusive memory in that it no longer fitted with the goal structure of the SMS system and as a result, the intrusion resolved. Imagery rescripting led to the creation of new, more positive goals that were reflected in the changes in Anna's life. She was able to care for herself and engage in behaviours that she had previously avoided due to the sense of threat associated with such activities. At the conclusion of therapy, Anna reported that she felt "more grown up" and able to assert her needs and stand up for herself.

5.2. CASE 6: EMMY

Emmy was a twenty-one year old, white woman from North America. She had been in South Africa for ten months as an exchange student before she decided to seek therapeutic help to cope with her trauma. Emmy had been raped in her home country two months prior to her transferring to South Africa. Her decision to temporarily relocate had been finalised prior to the trauma occurring.

5.2.1. THE ASSESSMENT PHASE: RESULTS

The assessment interviews comprised five sessions of sixty minutes duration each and Emmy was seen twice a week during this process.

(i) Assessment interviews

[A2: *BDI: 18; BAI; 14; PDS: 29]*

Building a narrative of the trauma

Emmy was very forthcoming regarding her experiences and reported that she had kept her trauma hidden for too long and was determined to confront her ordeal and heal from her wounds. I learnt that Emmy was very conservative and came from a religious family background. She reported that she had always cherished her virginity and regarded sexual intercourse as sacred and had intended to engage in sexual intimacies only when she was in a committed relationship. However, she had been raped in her home country approximately a year ago and the threat posed by this incident to her sense of self contributed to her using denial and suppression as a means of coping.

A few months after transferring as an exchange student, she met her boyfriend (Farai). Farai was also conservative and religious and had abstained from engaging in sexual activity due to his religious views. Emmy and Farai became involved in a committed relationship and following their first joint experience of sexual intercourse, Farai started to suspect that Emmy had not been a virgin as she had claimed. He shared his concerns with her and thereafter closely questioned her about the extent of her sexual intimacies in previous relationships. This triggered the trauma memory and Emmy subsequently disclosed the rape to him. Farai was very understanding and supportive and immediately encouraged her to seek professional help. He continued to be very

caring and supportive of Emmy while she was in therapy and requested that she keep him updated on how she was coping in session. I learnt that after each of our meetings, she would provide Farai with feedback on the content of our sessions and how she was coping and this enabled him to better care for her.

Emmy reported that she felt very close to her boyfriend and believed that she had someone to turn to when she was feeling distressed and so far away from her family. However, she was also worried that she was being too needy and therefore burdening Farai. She assumed that she should be more independent in her coping efforts. I explained to Emmy that she was going through a difficult period and was far away from her family and it was normal and expected that she would need care. Emmy appreciated this and indicated that she was still struggling to come to terms with what had occurred.

I learnt that she had not disclosed the assault to her family in North America. She believed that sharing the trauma with them telephonically would not be useful as there was little her parents and three siblings could do given the physical distance that separated them. However, she intended to disclose the trauma to them once she returned home.

I invited Emmy to share her story and she reported that her memories of that night were extremely vague. She attributed this to her having consumed alcohol excessively on the night and to her having suppressed her memories. I encouraged her to think back to that time and narrate the aspects she could remember and I closely questioned her about that night so as to facilitate further recall.

Emmy reported that she had been raped by an acquaintance after attending a party at her local varsity. She could not recall the events that had occurred the day of the party. However, she remembered arriving at the party by late afternoon, socialising with her friends and the perpetrator and consuming alcohol throughout that evening. She had no memory of leaving the party or of returning to the house she had shared with two other students. Her next memory was of entering her bedroom and feeling disoriented and extremely drowsy and seeing the perpetrator in her room. She felt very confused upon seeing him and had wondered what he was doing in her room and how he had entered the house. Emmy had one brief memory of the rape itself and this involved waking up and seeing the perpetrator on top of her and feeling confused

and unable to move her body. She reported having experienced her body as being "limp". Emmy's memories for the period after the trauma were slightly less fragmented. She reported that she had woken up the next morning feeling confused and disoriented and immediately upon waking she noticed the perpetrator discreetly attempting to leave her bedroom. She recalled that he appeared shocked upon noticing that she had awoken and rapidly left her room. Emmy then realised that she was completely naked and she experienced discomfort in her vaginal area and some bruising on her body.

Emmy's amnesia for the night of the rape, her sense of confusion and disorientation prior to the trauma and her paralysis during the rape led to my suspecting she had been drugged. However, before communicating this to Emmy, I re-examined her physiological reactions that night (as described above) and investigated her alcohol tolerance levels as well as her sleeping patterns to determine if my suspicions were accurate. I learnt that Emmy believed she had a "good" alcohol tolerance level and was able to remain awake and mobile even after she had consumed alcohol to the point of intoxication. Emmy had a ritual for nights when she drank alcohol in that once she returned home she would prepare a large meal for herself and drink large quantities of water before she went to bed. This ritual was aimed at preventing hangovers. On the night of the trauma, she had no memory of having engaged in any of these activities. I established that Emmy was a light sleeper and could easily be roused from sleep even after she had consumed alcohol. Based on this information and her physiological reactions that night, I concluded that she had been drugged and shared this with her. Emmy was shocked but immediately reported that she did not believe she had been subjected to a DFSA. Instead, she actively argued that the rape had occurred because she had consumed too much alcohol. She believed that if she had not been drunk at the time, the perpetrator would not have had the opportunity to hurt her.

Identifying problematic cognitive and behavioural coping strategies

It was apparent that self-blame was one of the strategies Emmy was using to cope with the trauma and that by blaming herself she was attempting to stave off increasing feelings of vulnerability and helplessness. I explained this to Emmy and it resonated with her. She reported that prior to the rape she had believed she was "invincible" and that her world was a safe place but these assumptions had been completely shattered by the trauma. She also reported that she knew she was trying to retain a sense of personal control by blaming herself. However, it was

clear that this strategy only enhanced her depressed mood and so to help her relinquish her self-blame I focused on rebuilding her conceptual world.

I first psycho-educated Emmy about schemas and explained that traumatic events challenged one's pre-existing assumptions about the self, world and other people. This led to Emmy reporting that she believed that her extremely positive assumptions merely reflected her "naivety" and it was clear she berated herself for holding such beliefs. I therefore normalised Emmy's experiences. I used guided discovery to help her appreciate that because she had been raised in a sheltered environment she had no reasons for suspecting that her world was not a safe place or that she was vulnerable to harm. I explained that the rape represented one instance in which she had been rendered unable to defend herself owing to the actions of another person. I emphasised that this incapacitation did not generalise to other areas of her life. I used guided discovery to help her identify instances in which she had coped courageously with difficult life circumstances. I explained that the rape did not imply that her world was entirely malevolent and guided her to identify her positive experiences with people in different parts of the world to emphasise this. These interventions helped Emmy to realise that her exposure to trauma did not imply she was a naïve person or that her world was a wholly dangerous place or that all people were untrustworthy and malevolent. Instead, she was able to appreciate that people were trustworthy but within limits and that she possessed weaknesses but was also a courageous person.

I addressed Emmy's self-blame by actively arguing that the perpetrator was entirely responsible for the assault. I explained that she had been unconscious during the assault and not a willing participant in a sexual intimacy. I also emphasised that the perpetrator had been aware that she was unconscious and had acted deliberately. This intervention led to Emmy acknowledging that she needed to re-evaluate her perspectives and by our fourth assessment session, she attributed complete responsibility for the assault to the perpetrator. In addition, she came to the conclusion that, although it was possible she had been drugged prior to the rape, she could not know this with absolute certainty. She had therefore decided that what was important was that she accepted that she had been raped and held the perpetrator accountable for the harm he had done to her. This involved taking legal action against him when she returned to her home

country. I subsequently advised Emmy to consult with the legal aid centre at her varsity when she returned to determine how best to proceed with her case.

Investigating post-trauma reactions

Since her disclosure to her boyfriend Emmy had started ruminating on the rape. Her rumination was predominantly related to thoughts of how she could have prevented the assault from occurring. From my knowledge of the treatment model, I was aware that rumination inhibited the processing of the traumatic event by preventing the individual from accepting that the trauma had occurred. I therefore reiterated that I was aware that the trauma had shattered her world and her expectations for the future and for this reason it was hard to accept her victimisation. This resonated with Emmy and I actively argued that for her to heal and move on with her life it was necessary for her to accept that she had been raped. By the end of the assessment process Emmy had stopped ruminating about the trauma.

While discussing the effects of the rape on her life Emmy alluded to berating herself for having been sexually intimate with an acquaintance she had met soon after her arrival in South Africa. I attempted to question her further about this issue but she had difficulty speaking about this incident. I decided not to probe further and to wait until she felt more secure in the therapeutic relationship.

I investigated Emmy's expectations in terms of her return home and to the site of the trauma. She believed that she had established a good support base in South Africa but feared she would feel alone and vulnerable when she returned to her home country. She was also threatened by the prospect of returning to the house in which the rape had occurred as she would have to continue residing in this house until she found alternative accommodation.

I determined that Emmy was experiencing symptoms of PTSD (*discussed under Diagnosis*). I psycho-educated her about PTSD, the nature of the treatment model and emphasised the interventions used. Emmy was markedly disconcerted when I explained the process of imaginal reliving and indicated that she did not feel ready to undertake this procedure. I acknowledged this and emphasised that we would only proceed with a reliving once she had accepted the trauma and felt more confident about her ability to cope.

5.2.2. DIAGNOSIS

On the basis of the assessment interviews and Emmy's scores on the self-report scales (PDS: 29; BDI: 18; BAI: 14) she was diagnosed with the following:

(i) Post-Traumatic Stress Disorder

Emmy met diagnostic criteria for PTSD. She experienced one intrusive memory of the rape that involved a visual image of the perpetrator lying on top of her and raping her. This intrusion was triggered by Emmy lying down on her bed at night. She experienced symptoms of hyper-arousal at night and was more vigilant and easily startled. Emmy had experienced these reactions in the weeks and months following the trauma. She had coped by suppressing her memories of the rape and ignoring her symptomatic reactions. These reactions diminished following her move to South Africa but intensified after her disclosure of the rape to her boyfriend (Farai) three weeks prior to her seeking therapy.

(ii) Major Depressive Disorder (Single episode, moderate)

Emmy met diagnostic criteria for major depression. These symptoms were precipitated by her disclosure of the rape to her boyfriend and did not occur in the immediate aftermath of the rape. Following her disclosure to Farai, she began to feel incredibly sad and dejected and would often cry. She had difficulty concentrating on her academic work and this troubled her as she had to prepare for her end of year exams. Emmy blamed herself for the rape and believed that the trauma would not have occurred if she had not been drinking. Her sense of responsibility for the assault and associated self-recrimination exacerbated her symptoms of depression. Emmy believed that the trauma had jeopardised her identity as a virgin and this further enhanced her feelings of sadness and dejection.

5.2.3. CASE FORMULATION

(i) Predisposing factors

Emmy was raised in a loving, caring and protected home environment. Her parents encouraged their children to be self-reliant but instilled in them the belief that they could turn to others when distressed. These experiences contributed to Emmy developing extremely positive assumptions about her capabilities and strengths, other people and the world. She believed she was

invulnerable to harm and capable of caring for and protecting herself and assumed that the world was a safe place and that other people were trustworthy. Emmy's family was very conservative and religious and her views on sexuality were shaped within this backdrop. She believed that being a virgin was sacred and that sexual intimacy was reserved for committed relationships. For this reason, in her romantic relationships, she strived to maintain her values by not allowing the relationship to develop into a sexual one. Emmy's belief system subsequently impacted on her responses to the trauma. She had been subjected to a drug facilitated sexual assault and the rape shattered her pre-existing meaning structures. This included her belief in personal invulnerability, the benevolence of other people and her identity as a virgin. To cope with this situation, Emmy kept the trauma a secret, avoided thinking about the rape and attempted to suppress her memories of the incident.

(ii) Precipitating factors

Two months after the assault, Emmy relocated to South Africa to be an exchange student. She subsequently met her boyfriend and established a long term relationship with him. Following their first joint experience of sexual intercourse, Emmy's boyfriend began to suspect that she had not been a virgin beforehand despite her telling him so and he shared his concerns. His close questioning about her prior sexual history triggered memories of the rape. This activated the sense of threat associated with the trauma in terms of its implications for her conceptual world and construction of self and generated her symptoms of PTSD and depression.

(iii) Maintaining factors

Emmy's avoidant behaviours contributed to the maintenance of her symptoms. She had attempted to cope by denying that the rape had occurred. She avoided thinking about the rape, suppressed her memories of the trauma and did not disclose the assault to anyone. These strategies prevented her from receiving social support, inhibited her from emotionally processing the traumatic event and contributed to the creation and maintenance of her symptomatic reactions.

5.2.4. PRESENTATION OF TREATMENT PLAN

At the time Emmy sought therapy, she had two more months in South Africa before having to return to her home country. She also had to prepare for her academic exams and would not be

able to come to therapy while writing her exams. As such, the treatment plan involved seeing her twice a week for at least eight to ten sessions.

I identified Emmy's PTSD reactions and reminded her of the mechanisms underlying the disorder and the treatment methods used. I explained that it was possible that trauma memories would be triggered upon her return to the house in which the rape occurred and for this reason it was necessary for us to prepare her for these reactions. Emmy was particularly concerned about this prospect and believed that triggering was a distinct possibility. She was also very worried about the absence of social support in her home environment. I explained that we would formulate a plan to ensure she was adequately supported when she returned home. I emphasised that the trauma had severely affected her belief systems and that part of our work would involve helping her reconstruct a more adaptive world view. She acknowledged this and indicated that she was determined to heal from the trauma.

5.2.5. THERAPY NARRATIVE

Emmy was seen for nine therapy sessions over a six week period. She had been unable to make two sessions owing to work commitments and ill health.

Therapy session 01

Focus area: Social support

Emmy was feeling anxious about the prospect of returning home and having no social support and, in accordance with the treatment plan, I focused on helping her devise a strategy to ensure she was supported. She had not seen her family for a year and believed that it would take time for her to readjust to being home before she felt able disclose the trauma to her parents and siblings. I therefore proposed that she share her story with her best friend within the first week of her arrival. I explained that this would ensure she was immediately supported while giving her time to reconnect with her parents and siblings. Emmy believed this would be a good approach and she decided she would disclose the assault to her family within the second week of her arrival home. I guided her to elaborate on how she would approach her friend and her family so as to prepare her for the disclosure. I investigated Emmy's expectations in terms of the responses she would receive from her friend and family. She believed that her significant others would be initially shocked and angry on her behalf but that after absorbing the news they would be

markedly supportive and caring and help her to prosecute the perpetrator. Following this intervention, Emmy reported that she felt very relieved that she had a plan of action that would ensure she was supported by her family at home.

Therapy session 02

Focus area: Social support

Emmy's anxieties about returning to North America had abated and she reported that she was feeling more confident about her return and was looking forward to being with her family. I subsequently focused on preparing her for the return to the house in which the rape had occurred by using imagery. She would have to resume living in this house within a month of her arrival home. I explained to Emmy that by imaginally reliving her return home she could afford herself a chance to familiarise herself with the emotions she could experience and not feel overwhelmed. I believed that imaginally reliving a less threatening memory would increase Emmy's tolerance when it came to reliving the trauma memory itself. Emmy was very motivated to undergo the reliving and believed she needed to fully prepare herself for her return. I therefore guided her to visualise returning to and entering the house. Through close questioning, I established that the sight of her room and specifically her bed elicited feelings of isolation, helplessness and fear.

Following the reliving, Emmy appeared distraught and disclosed that the imagery work had heightened her awareness of the trauma and she worried that she would not be able to cope when she returned to the house. I focused on stabilising her by normalising her reaction. I also emphasised that we were currently working to ensure that she would not be overly distraught when she returned. Emmy was much calmer after this. I focused on addressing her expectation that she would be alone and helpless. I guided Emmy to identify significant others within her home environment she could turn to and suggested that a family member accompany her on her return to the house. She believed this would be helpful and decided she would ask her father as she found his presence comforting. I proposed that we conduct another reliving that included her father in the imagery so that she could feel more supported and she agreed to this.

I guided Emmy to once again visualise returning to the site of the trauma but this time with her father at her side. She reported feeling calmer and more reassured during the exercise. I guided

her to imagine entering her bedroom and upon seeing her bed in the scene, Emmy reported having a "brief flash" of the rape. However, she did not feel overly distraught by this intrusion. It was clear that the presence of a supportive other in the image made the trauma memory less threatening. Following the reliving, Emmy was still calm and I focused on further enhancing her awareness that she had supportive others to turn to. I reviewed the resources that were available to her when she returned to the site of the trauma and helped her establish how she could go about accessing supportive others within the campus community. I decided to leave the discussion of the trigger for our next session as I believed it was important for Emmy to absorb the knowledge that she was not alone and had a solid support base at home.

Therapy session 03

Focus area: Re-building meaning structures

Emmy was now increasingly thinking about supportive others that she could turn to when she returned home and was feeling more excited about the prospect of returning. She reported that, because of the imaginal reliving, she felt less threatened by the trauma memory and was spending more time thinking about the rape. I emphasised that from the reliving, it was clear that the bed was a trigger and Emmy recalled that her intrusions had worsened whenever she had lain on the bed in which the rape occurred. While speaking about this, Emmy suddenly squirmed in her seat and made a facial expression that I equated with disgust. I reflected on this and she reported that she now remembered that she had felt disgusted at the sight of her bed and had cleaned all her bed linen following the rape. She reported that this emotion had re-emerged following the imaginal reliving and she now often felt disgusted when she thought about the rape.

I closely questioned her about this emotional reaction and learnt that Emmy believed the assailant was a disgusting person for having perpetrated a rape. She equated virginity with "purity" and assumed that by penetrating her, the perpetrator had compromised her experience of herself as pure. While speaking about her sense of disgust, Emmy became tearful and started crying. She reported that the perpetrator had deprived her of the opportunity to decide when and with whom she would "share [her] virginity". I empathised with her and focused on helping her grieve this aspect of her identity. I achieved this by guiding Emmy to share the meaning and value she had accorded her virginity and by reflecting on the pain associated with her loss. At the

close of the session, Emmy reported that she realised she could not reclaim this aspect of her identity but she still wanted to make the perpetrator accountable for the suffering he had caused her.

Therapy session 04 [BDI: 5; BAI: 9; PDS: 6]

Focus area: PTSD

Emmy had not experienced the visual intrusion since speaking about the trauma in detail in the assessment phase but was worried that the intrusion would be triggered when she returned to the site of the trauma. I believed this was a distinct possibility and proposed that we use reliving to address this reaction. Emmy was very motivated to engage with the task and indicated that she did not want to be troubled by this reaction when she returned. I reminded her of the procedure involved in reliving and guided her to visualise the intrusion and closely questioning her about her thoughts and feelings.

I established that Emmy had awoken the moment she had been sexually penetrated by the perpetrator and that this constituted a hotspot. It was associated with marked feelings of confusion as to what was occurring. Her confusion was reflected in her peri-traumatic appraisals ("what's going on, what's going on...I don't know what's going on...what's he doing?"). In the reliving, Emmy reported that her body felt "numb" but she could feel the pain of the perpetrator "being inside" her and this was associated with marked feelings of disgust. After the reliving, Emmy appeared badly shaken and reported that she felt anxious and very scared. I stabilised her through the use of safe space imagery. I guided Emmy to visualise walking along a forest trail that was situated close to her home accompanied by her best friend. She was much calmer after the exercise and I advised her to use the technique if she felt distraught outside of session. I decided to leave the discussion of the identified appraisals for our next session as this would allow sufficient time for Emmy to recover.

Therapy session 05

Focus area: PTSD

Emmy was distressed when she arrived for our fifth session because she had begun to experience kinesthetic sensations involving her body feeling "limp" and these reactions were reminiscent of what she had experienced during the rape. It was clear that the reliving had activated the trauma

memory and this had contributed to these reactions. Through close questioning, I established that this sensation was triggered whenever she lay down on her bed and was associated with marked feelings of disgust and contamination. Emmy had coped with this reaction by either going for a run or by using the safe-space visualisation exercise I had taught her in the previous session.

I intervened by first normalising her kinesthetic sensation. I explained that the sensation of her body being limp represented a kinesthetic intrusion owing to her having been physically paralysed during the assault. I explicitly hypothesised that Emmy's urge for physical activity after experiencing this intrusion was motivated by her need to affirm her agency given her helplessness during the assault. This resonated with her. I subsequently addressed her sense of disgust and contamination by actively arguing that the rape itself had been a disgusting act but she was not a disgusting person. I emphasised that she was still a good and worthwhile individual. I proposed to Emmy the technique of using healing imagery to help her feel cleansed. She was extremely eager to use this approach and reported that for her a healing force was the "Holy Spirit".

I guided Emmy to re-experience the sensation of her body being limp and the associated feelings of contamination and disgust. I then invited her to visualise her healing force and to incorporate this force into her body and allow it to cleanse her. Emmy, however, found this task difficult and appeared extremely frustrated and distraught during the procedure. I therefore stopped the exercise and reflected on this. Emmy reported that she was able to visualise the healing force but she found it challenging to incorporate the healing presence into her body. She indicated that she felt "blocked" in accessing the Holy Spirit and therefore "did not feel the cleansing". She also reported that, as a result of this blocking, she felt "locked" in her sense of contamination and powerless to release herself. I explicitly hypothesised that Emmy's sense of powerlessness in the imagery was related to her inability to protect her body during the assault. I proposed re-scripting the visual intrusion to challenge her sense of helplessness and powerlessness and she agreed to this process.

I guided her to imaginally relive the visual intrusion involving the perpetrator raping her. Once she connected with the trauma memory, I updated the appraisal involving her sense of

confusion. I asked Emmy what she knew now about what was happening to her then and she was able to realise that she was being raped. I subsequently guided her to visualise being released from her paralysis, pushing the perpetrator away from her, chasing him from her home and returning to a place of safety. However, after the re-scripting, Emmy appeared markedly perturbed and reported feeling intensely frightened. I found this reaction unexpected and invited her to share her thoughts with me. She reported that the reliving had triggered her memory of the incident in which she had been sexually intimate with an acquaintance (Todd) she had met shortly after arriving in the country. The re-scripted part of the imagery had borne a similarity to the way she had responded to Todd in that she had pushed him away from her but just before the point of intercourse. I established that Emmy had kept this incident a secret and had refrained from speaking about it in any detail owing to the intense feelings of shame that it generated. She had tried to suppress her memories of this incident but the re-scripting had triggered the reality of what had occurred. I then invited Emmy to share her experience with Todd.

Emmy reported that she had not intended to be sexually intimate with Todd but had "gone along" with his sexual advances. During their encountered she had experienced herself as being "passive" and had felt blocked in terms of voicing her intentions and needs and therefore had not insisted he use contraception. Their intimacies almost proceeded to the point of intercourse but Emmy had pushed Todd away from her before any genital contact occurred. Nevertheless, after the incident she had been frightened about whether she had contracted a sexually transmitted disease.

Emmy berated herself for this incident and reported that she "could not understand how [she] could have been so stupid". I empathised with her and explained that it was possible that the perpetrator's disregard for her welfare had caused her to question her worth and value and whether there had been any point in her cherishing her virginity. I explicitly hypothesised that the perpetrator's attitude had contributed to Emmy being indifferent when it came to her welfare and protection. This resonated with her and she cried. I consoled her and empathised with her feelings of sadness and loss. I linked her feeling of disgust and contamination to this incident with Todd and emphasised that because she had not had any genital contact with him she could not have contracted any diseases. I explained that the intimacy with Todd did not

define her as a person and that she was still worthwhile, good and valued. I emphasised that she had made a mistake but it was important she be able to forgive herself. I addressed her feelings of shame by asking Emmy if she would be able to forgive a friend in a similar situation and she affirmed that she would. I then emphasised that she needed to extend this same grace to herself. Emmy then reported that simply sharing this incident brought her much relief and she now realised that she needed to treat herself with more kindness.

Therapy session 06

Focus area: Crises intervention

Emmy appeared markedly distraught at the outset of the session and revealed that Farai had ended their relationship because he felt betrayed at her having been intimate with Todd. Farai and Todd were friends and he felt humiliated and betrayed because she had kept her intimacy a secret. Emmy felt acutely responsible for the break up and believed she had destroyed a worthwhile and rewarding relationship as a result of her behaviour and I empathised with her. I experienced Farai's attitude as being highly judgemental and moralistic and asked after his personal and relational history. I learnt that Farai was extremely conservative and had not been involved in any romantic relationships before Emmy. I explicitly hypothesised that his lack of exposure to romantic relationships led to him having unrealistic expectations when it came to Emmy's sexual history. This resonated with her and she reported that Farai constructed her as "lily white" and tended to place her on a "pedestal" rather than seeing her as human and subject to mistakes. I explained that her disclosure had shattered Farai's assumptions and this had probably contributed to the break-up and advised her to discuss this with him. I encouraged Emmy to fully express her feelings of shame and hurt at the incident with Todd and to explain to Farai the effects it had on her and she agreed to this.

Therapy session 07

Focus area: Social support

Emmy's mood had improved markedly since our last session and this was due to increased social support. Since the break-up with Farai, Emmy had been spending more time socialising with her female friends and had disclosed the rape to them. Her friends had been markedly supportive and had chastised her for not sharing the trauma with them earlier. They encouraged her to speak with them whenever she felt distressed. Emmy reported that during the course of

conversation with her friends, they had broached the topic of their prior sexual histories. She had subsequently learnt that many of her friends had engaged in sexual intimacies that caused them much embarrassment. She reported that this realisation contributed to her feeling less alone and that, since the conversation, she no longer experienced feelings of shame and disgust. Emmy had also approached Farai and had been extremely candid about her experiences with Todd and shared the extent of her shame and hurt. This led to Farai forgiving her for keeping the incident from him and they subsequently decided to renew their relationship. I was extremely pleased for Emmy and reflected on the changes she had effected by being open about the rape and its impact on her life.

Therapy session 08 [BDI: 3: BAI: 2; PDS: 3]

Focus area: Reflecting on gains

Emmy arrived for the session looking very cheerful and reported that she felt "lighter". I established that she had not had any visual or kinaesthetic flashbacks of the rape and she no longer experienced feelings of shame, disgust or contamination. I used the session to review her positive experiences during the year she spent in the country and her journey in coping with the trauma. I believed that reviewing her achievements would help Emmy appreciate how far she had come in reclaiming her life

Therapy session 09

Endings

For my final session with Emmy, I invited her to share her future plans. I also recapped her plan to disclose the trauma to her family and initiate legal action against the perpetrator. At the end of our session, Emmy tearfully thanked me for my role in her journey towards recovery.

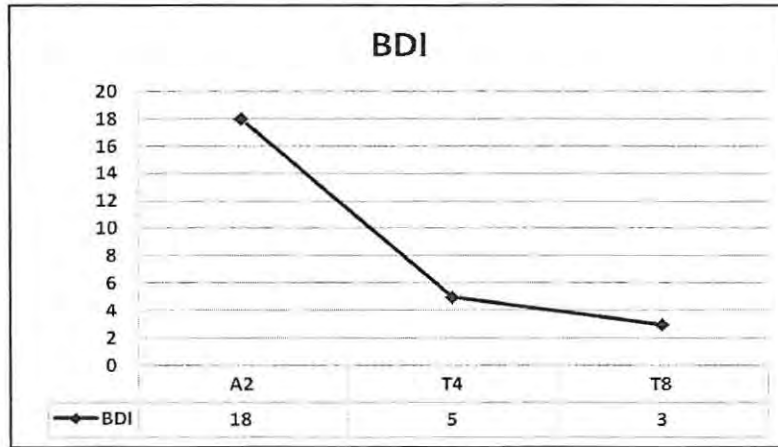
5.2.6. RESPONSE TO THERAPY

The self-report scales indicate that Emmy's symptomatic reactions improved markedly as therapy progressed. Responses on the self-report scales are displayed in figures 11 to 13.

(i) ***BDI***

[Symptom scores: 1- 13 = Minimal; 14-19 = Mild; 20-28 = Moderate; 29-63 = Severe]

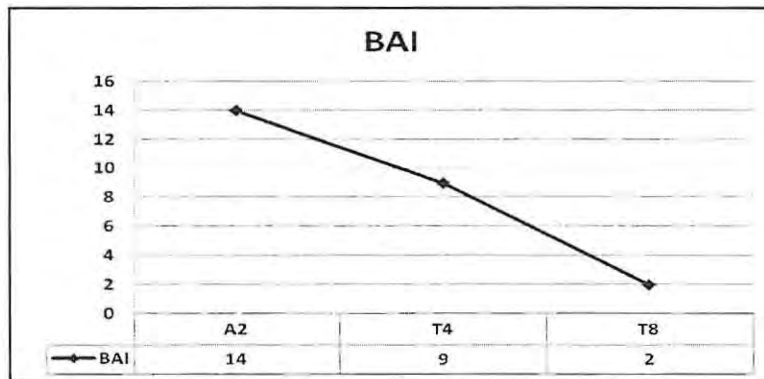
Figure 11: EMMY BDI SELF-REPORT SCORES



(ii) ***BAI***

[Symptom scores: 0-7 = Normal; 8-15 = Mild; 16-25 = Moderate; 26-63 = Severe]

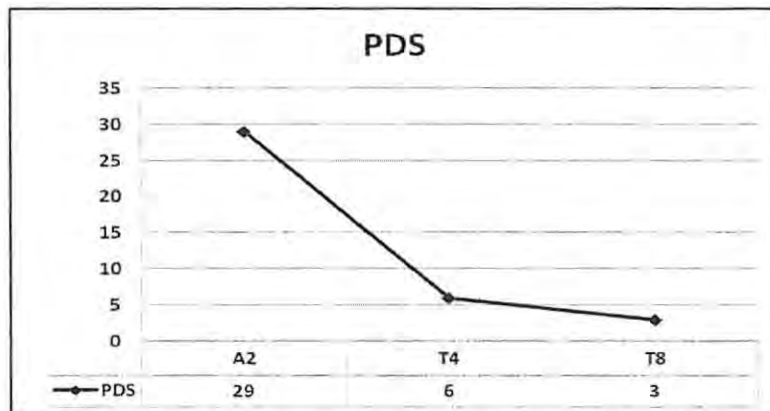
Figure 12: EMMY BAI SELF-REPORT SCORES



(iii) PDS

[Symptom scores: 1-10 = Mild; 11-20 = Moderate; 21-35 = Moderate/Severe; 36-51 = Severe]

Figure 13: EMMY PDS SELF-REPORT SCORES



At intake Emmy was suffering from clinically significant symptoms of depression (BDI: 18), anxiety (BDI: 14) and post-traumatic stress disorder (PDS: 29). Although Emmy's self-report scores at intake indicated that her depression and anxiety were in the mild range, these reactions were causing her significant distress and affecting her ability to function. The interventions used in the assessment stage and the first three therapy sessions led to a decline in Emmy's self-report symptoms. This included normalising her symptomatic reactions and addressing the impact of the trauma on her per-existing meaning structures and challenging her self blame. The therapeutic focus in the first four therapy sessions involved: targeting Emmy's maladaptive beliefs through verbal challenging and imaginal exposure; helping her grieve her sexual identity as a virgin and; using imaginal reliving to facilitate the processing of her visual intrusion. Her scores on the self-report scales declined markedly by our fourth session (BDI: 5; BAI: 9; PDS: 6). Emmy's symptoms of depression and anxiety were also in the mild range. Although she no longer met criteria for PTSD by our fifth session, she started experiencing distressing feelings of disgust and contamination. This reaction was not only related to the rape but to Emmy having been sexually intimate with an acquaintance she had met two months after the trauma. These symptoms were subsequently targeted and their resolution led to a further decline in self-report scores. By our eighth therapy session, Emmy's symptoms of depression (BDI: 3) and anxiety (BAI: 2) were in the normal range and she no longer met criteria for PTSD (PDS: 3).

5.2.7. DISCUSSION

A salient aspect of Emmy's case was the impact of the trauma on her construction of self as a virgin. Very few studies have investigated the distinctive psychological implications of rape in circumstances where the victim was a virgin. A very early study by Burgess and Holmstrom (1979) found that the period of recovery for rape victims who were virgins was similar to that of non-virgins. However, the study did not focus on nuanced understanding of the effects of rape in these circumstances.

The present case study reveals that certain additional negative appraisals of the trauma and its sequelae can arise when the victim was a virgin before the rape. Emmy believed that the rape had compromised her: sexual identity and experience of herself as "pure" and; ability to decide when and with whom she would first be sexually intimate. She believed these were aspects that she would never be able to reclaim and this enhanced the sense of threat associated with the rape and directly contributed to the persistence of her PTSD symptoms. As a result, a significant component of her treatment process involved affirming the impact of the rape on her sexual identity and helping her grieve this part of herself. Emmy believed that she had been contaminated by the perpetrator and this left her feeling disgusted. Studies (*see section 1.3.1. (iv)*) investigating the presence of mental pollution following exposure to sexual assault have found that women frequently experience a sense of contamination following rape. This was often related to the victim's belief that she had been tainted or sullied in some way by the assault. These negative appraisals, as is evident in Emmy's case, predicts PTSD. In treating Emmy's experience of contamination and disgust I used verbal cognitive restructuring, imagery rescripting, and healing imagery (Arbuthnott, Arbuthnott & Rossiter, 2002).

In using these approaches, I proceeded by first emphasising to Emmy that the rape was a disgusting act but she was not a disgusting person. Instead, she was still good, worthwhile and valued. Through healing imagery and rescripting, I uncovered a memory that was contributing to the persistence of her sense of contamination and disgust, namely her experience of being sexually intimate with an acquaintance two months after the rape. This incident had led to Emmy worrying that she might have contracted a sexually transmitted disease (STD) and therefore been contaminated. She also believed that she had compromised her standards by being sexually intimate with a stranger. I addressed these assumptions through verbal cognitive restructuring

and normalisation. Emmy was then able to realise that because there had been no genital contact, she could not possibly have contracted an STD. She also appreciated that the rape had affected her construction of herself and contributed to her behaving in ways that conflicted with her beliefs. As a result, she was able to forgive herself for not living up to her personal standards. Social support proved beneficial in enhancing treatment gains by further normalising Emmy's reactions and experiences in relation to the incident with her acquaintance.

5.3. CASE 7: LORI

Lori was a twenty-one year old, English speaking White woman studying at the university. She had been raped five months prior to my first meeting her. Lori disclosed the trauma to her step-father (Harold) and mother (Sue) three days prior to our first meeting. Her parents subsequently arranged a meeting with me to discuss Lori's referral for therapy. In the meeting, Harold and Sue were markedly distressed while Lori appeared less perturbed and assumed a forced cheerfulness whenever she spoke with me. I provided the family with psycho-educative information about the psychological impact of rape. I emphasised that sexual trauma often resulted in the victim developing PTSD reactions and experiencing severe difficulty coping with daily life. Sue then began to cry and Lori became tearful but when I turned to her she quickly smiled at me. It was apparent she was trying to hide her distress, possibly to protect her parents. I reassured the family that it was possible to recover from sexual trauma and I was willing to work with Lori to help her hear. However, Lori displayed some ambivalence about entering treatment. I explained that I predominantly worked with rape victims and was involved in a research project aimed at adapting a treatment model to suit the needs of South African victims of sexual trauma. I emphasised that as a result of my work I was very familiar with the difficulties experienced following rape and the process involved in recovery. Lori was subsequently keen to enter therapy and insisted that her treatment process go towards research that would benefit others.

5.3.1. THE ASSESSMENT PHASE: RESULTS

The assessment interviews comprised seven sessions of between sixty and ninety minutes duration and Lori was seen twice a week during this process.

(i) Assessment interviews

A2: [BDI: 33; BAI: 32; PDS: 38]

Lori appeared anxious and uncertain at the outset of our first meeting and I reassured her that we would work together to help her reclaim her life. I invited her to share her story with me but she was hesitant and reported that she experienced a marked sense of confusion and uncertainty as to what exactly had occurred the night of the trauma. I normalised this reaction and emphasised that it was usually difficult to remember an extremely harrowing experience and encouraged her to narrate the aspects she could recall.

Building a narrative of the trauma

Lori reported that she had been raped by a friend after having met him at a night club five months previously. He had bought her drinks throughout that evening and towards the close of the night he offered to accompany her home. Lori gratefully accepted his offer as she did not own a vehicle and had to walk seven kilometres to reach her house (which she shared with three other students). After arriving home, she made coffee for both herself and her friend and spent some time chatting to him. However, after a few minutes, she began to feel extremely drowsy and indicated to her friend that she was tired and needed sleep and he should see himself out. Lori then walked into her bedroom and changed into her pyjamas and this constituted her last memory of that night. She awoke the next morning feeling nauseous and disoriented and was shocked to find that she was only partially clothed. She experienced marked discomfort in her vaginal area and bruises on her body and this led to her realising that she had actually been raped. Lori found that she had no memory of the rape and felt extremely distressed and ashamed at her inability to remember and this deterred her from immediately reporting the assault.

In the weeks following the trauma, Lori began to feel increasingly responsible for the assault. She believed that by drinking alcohol and accepting drinks from the perpetrator she had rendered herself vulnerable and facilitated the rape. Lori assumed that she should have been able to "read his intentions" accurately and in not doing so she had allowed the rape to occur. In addition, she expected others to share her negative assumptions and this intensified her unwillingness to disclose the rape. Furthermore, Lori's parents were experiencing severe marital problems at the time and she had not wanted to "burden" them with her problems and for this reason, did not reach out to them.

Lori attributed her amnesia and other post-trauma physical reactions (i.e. nausea and disorientation) to her having consumed alcohol excessively but from her symptoms I suspected she had been drugged. I explained this to Lori and requested she guide me through the events that had preceded the assault once again. I carefully questioned her about her physiological reactions, thoughts and feelings in the hours that led up to the trauma. It was then clear to me that Lori had actually been drugged. She would not have been able to manage the seven kilometre walk home if she was severely inebriated and her actions upon arriving home (e.g. preparing coffee, having a conversation and changing into her pyjamas before entering bed) indicated that she was quite lucid. Lori was also a very light sleeper and awoke if she heard any noises in or around her house. In addition, she had never experienced such physical reactions (i.e. nausea and disorientation) on prior occasions when she had consumed alcohol excessively. I emphasised these aspects and psycho-educated her about DFSA and the physiological effects of the drugs used to perpetrate rape. Lori was shocked and exclaimed, "But that changes everything". It was clear that realising that the assault had been drug facilitated had caused her to question her self-blame. I reinforced this growing realisation by using Socratic questioning and asking Lori if she could identify the characteristics that would allow her to differentiate a potential rapist from a benign person. This helped her to further appreciate that she could not have gauged the perpetrators intentions and known that he wanted to harm her.

I asked after the circumstances that led to Lori ultimately disclosing the traumatic event. I learnt that she had felt intensely depressed after the trauma and her step-father noticed this and encouraged her to share her difficulties with him. She subsequently disclosed the rape and Harold had been extremely supportive and acted immediately to ensure she received necessary help. Lori reported that she had been surprised at the immediacy of his reactions (i.e. consulting with legal and medical professionals the day of her disclosure) and was extremely grateful to him for caring about her. She spoke of her step-father in a very positive way and reported that he treated her as his own child and had provided for her throughout her life and she had tremendous respect for him.

Investigating post-trauma reactions

I encouraged Lori to speak about her reactions since the trauma and found that she had initially tried to cope by suppressing her memories and denying that the rape occurred. However, she started feeling intensely depressed and dejected in the weeks and months following the rape and eventually found it difficult to simply get out of bed in the morning and attend to household chores. She felt unmotivated to attend her lectures and lacked the energy to participate in social activities. This included attending gym and spending time with her friends and she mostly isolated herself in her room.

Lori reported that she was concerned about the effects of her mood on other people, particularly her boyfriend (Khaya) who was a young Black man studying at university. She worried that she was "burdening" and "draining" him at a time when he needed to focus on his exams. In addition, she was concerned about being a burden to her friends who were constantly checking up on her and enquiring after her. It was evident Lori was not accustomed to letting people care for her and I reflected on this. She laughed and dismissingly remarked that she was usually "the strong one for everyone else" and did not "let others take care of" her. I tried to investigate these assumptions further but found this difficult as Lori tended to frequently change the focus of the conversation and speak in a rambling and frenetic way. I hypothesised that this was possible due to her not being accustomed to self-exploration but I later realised that she was actually very disconnected from her internal experiences. This first became apparent when I invited Lori to describe herself and she stared at me blankly. However, after much consideration, she reported that from the comments of other people she would describe herself as "bubbly", "outgoing" and having "a lot of personality". Through subsequent close questioning, I learnt that throughout her life Lori had looked after her younger brother, step-sister and tended to her parents and close friends. She tended to prioritise the needs of others over her own and it was clear that her focus on others contributed to her not being attuned to her own needs and experiences.

Lori believed that, if she was not able to care for others, she was being selfish and letting other people down. She was reluctant to share her needs with others because she assumed that they "would not be able to handle" the magnitude of her distress or would regard her difficulties as too great and abandon her. This latter assumption was aggravated by her recent disclosure to a friend (Abby) who subsequently avoided her. However, it was clear from her description of Abby

that she was a highly self-involved person and for this reason had not been able to offer support. I subsequently encouraged Lori to access supportive others by first explaining to her that it was important for her healing that she share her needs and feelings with people who cared for her. I used Socratic questioning to help her appreciate that Abby was highly self-involved and helped her to identify genuinely supportive others in her environment, including her boyfriend and a few female friends. Thereafter, Lori was relatively more willing to speak with Khaya about the rape but she later reported that she was increasingly "picking fights" with him to test how "far [she] could push him before he left". Lori disclosed the traumatic event to a close female friend (Alice) who responded with care and support. Alice expressed her anger at the perpetrator for harming Lori and emphasised that he was completely responsible for the assault. These responses significantly challenged Lori's self-blame and she reported that she now appreciated that drinking alcohol was not an invitation to be raped and the perpetrator was solely responsible for the trauma. She reported that since no one else blamed her for the rape, it would be unreasonable for her to hold on to her self-blame. Khaya and Alice deterred Lori from isolating herself and encouraged her to participate in social activities with them.

I found that Lori was extremely self-critical and this aggravated her mood. She frequently berated herself for "letting" the trauma affect her to such a degree and for allowing the perpetrator to "take so much away from her". She believed she should not be suffering from such a severe depression and, instead, should have coped effectively with her ordeal. It was apparent she did not appreciate that her symptoms were normal reactions to a severe trauma. I therefore psycho-educated her about the responses experienced by rape victims (e.g. depression and PTSD) and emphasised that she needed to be kinder to herself. Lori, however, continued to be self-critical and reported that she had experienced distressing situations before and had also suffered from bouts of depression but had always managed to pull herself together. She therefore could not understand why she could not do the same now. I invited her to speak about her prior experiences of feeling depressed and she was very forthcoming about her history but she spoke in a frenetic and rambling fashion and often without any affect. Her narrative was at times disorganised in that she tended to suddenly shift the focus from prior experiences to discussing her current functioning and then back again. I often found myself feeling confused and struggling to follow her story.

Prior depressive episodes and problematic coping strategies

Lori experienced a severe depressive episode when she was sixteen years old. She reported that she could not recall the events that precipitated the episode but remembered isolating herself in her room and only leaving the house to attend school. She had eventually managed to overcome her depression by taking small steps to re-engage in social activities. While speaking about her depressive episode, Lori casually reported that she had engaged in self-injurious behaviour at the time and frequently cut herself. She first started cutting at the age of thirteen and this was prompted by her feeling "numb" and wanting to "reaffirm [she] was alive". Thereafter, her cutting behaviour was precipitated by parental conflicts and her sense of feeling alone, helpless and powerless. Sue and Harold were experiencing problems with their marriage during Lori's adolescence and this contributed to frequent heated arguments in the home. In addition, Sue suffered from severe bouts of depression at the time and tended to isolate herself in her room or leave the family home without informing anyone of her whereabouts. Her behaviour left Lori feeling extremely distressed and she tried to comfort and reassure her mother but her efforts were merely rebuffed. Harold felt powerless to help his wife cope and frequently turned to his step-daughter for advice and support. Lori reported that at the time she felt she "needed to be there" for her parents and had to put her needs and feelings aside. It was clear she used cutting as a means of coping with her emotional distress.

Given the frequency of her self-harming behaviour, I asked Lori if her parents had ever noticed the cuts on her arms. She casually reported that her mother had stumbled upon her cutting when she was thirteen and had told her that her behaviour was "stupid" and she should stop it. Sue did not express any concern about her daughter's behaviour or try to determine why she was self-injuring. After this incident, Lori became secretive and only cut herself on parts of her body that would be hidden by clothing (e.g. her upper arms and legs). Lori reported that she had recently discovered that her younger sibling (Linda) was engaging in cutting behaviour and as a result, she had started visiting her home more often to support her step-sister. She encouraged Linda to share her problems and to spend more time outside the home and, as a result, Linda's cutting behaviours ceased. Lori reported that she was remarkably adept at helping other people with their problems but when it came to her own issues she found it difficult to cope.

Lori's most recent episode of self-injury occurred approximately four months previously and was precipitated by her parent's reactions to her inter-racial relationship. Lori had been dating Khaya for a few months before she decided to disclose this to her parents. Sue reacted with shock and anger and was extremely vocal in her disapproval of the relationship and insisted that Lori terminate her association with Khaya. She refused and Sue did not speak to her for two weeks. Harold also found it difficult to accept Lori's relationship and expressed his disappointment at her choice of partner but continued to remain in touch with her. Sue and Harold eventually decided to meet Khaya but the meeting was extremely awkward. Lori reported in a matter-of-fact way that she had felt intensely angry with her parents for not accepting her relationship. She indicated that Khaya was extremely supportive and made her feel valued and happy and she did not understand why her parents would want her to end a fulfilling relationship simple because her partner was of a different race.

I asked Lori about her parent's reactions to her previous romantic relationships. I learnt that she had been involved in one prior romantic relationship while in high school and this was also with a young man (Joshua) from a different racial background. The relationship began when she was fifteen years old and continued till she finished school but she did not disclose it to her parents due to their marital problems. Through close questioning, I learnt that Joshua had been repeatedly unfaithful to Lori and extremely manipulative. After learning of his infidelities, she had tried to end the relationship but Joshua threatened suicide and one night telephoned Lori and told her that he had overdosed on medication. She was panicked and immediately contacted his mother who rushed him to the hospital where he had his stomach pumped. After this incident, Lori renewed the relationship. She reported that at the time she had felt she had no one to turn to except Joshua and so was willing to tolerate his unfaithful behaviour. I empathised with her and reflected on her current relationship. I explained that her parent's difficulties accepting Khaya were possibly related to their having been raised in a different social and cultural context. She agreed with me but it was clear she harboured a great deal of anger towards her parents but was hesitant to recognise or acknowledge this emotion. I subsequently asked Lori how she dealt with negative emotions and found she usually hid her feelings from others and isolated herself when she felt distressed. She also tended to express her anger by breaking things in her room and by punching walls.

After discussing her self-injurious behaviours, Lori reverted to talking about her current depressed mood and her concerns that she was negatively affecting others. She then made a sudden reference to her biological father (Gregory) and his abandoning her when she was seven years old. While sharing her personal history, Lori had briefly disclosed that her father had relocated to a different province shortly after her mother remarried and that she had suddenly started thinking about this event. However, she had not discussed the impact of this experience in any detail. It was now increasingly clear from her narrative that this constituted a distressing event in her life. She avoided accessing her emotions in relation to this event and tended to laugh even when it was apparent she was deeply hurt by her father's behaviour. In addition, whenever I prompted her to engage with her feelings she deflected the conversation towards discussing her positive relational experiences with her mother. She spoke of her mother in a very positive way and it was evident that in doing so she was attempting to avoid her sense of anger, hurt and disappointment towards her father.

The following segment from the transcript of the session demonstrates an instance in which Lori made a sudden reference to her biological father. At the beginning of the transcript she speaks about her assumption that she would be disappointing other people if she was not able to tend to their needs but she does not engage with this in any depth. She then makes the reference to Gregory but avoids engaging with her feelings of anger and disappointment towards him by laughing and diverting the conversation towards discussing her positive view of her mother.

Lori: I know that people always consider me the strong one and the one they can go to. I just thought that if people thought that [I was having problems], I'd be letting them down....if I was struggling it would be a problem

Therapist: You're afraid that they [other people] would see you as a disappointment if you were not the strong one?

Lori: Ja

Therapist: If you were also human

Lori: [Laughs]... that's what my boyfriend always says that he does expect that I'm human

Therapist: You feel disappointed with yourself because things get to you?

Lori: Ja, I know what I felt when my dad left and I know what issues I have about that. I've never been able to resolve them but he won't talk about them. And I know what issues I have and how it's affected my relationships and I can see that my brother also has a lot of anger issues so ...

Therapist: And you're angry with your dad for leaving

Lori: Ja, my mom's right, I do deal with it like a seven year old [laughs], I am still angry. I mean he just moved. I mean he stayed in touch but I mean ....I had a best friend for my entire school career and he didn't meet her once and it's just little things like that

Therapist: And there's a sense of disappointment that he didn't act as your father in those moments

Lori: Ja, and I have so much respect for my mom because he made so many promises that he just didn't keep... So my mom always had to deal with us being disappointed

Therapist: And that's such a let down [father not keeping promises]

Lori: [interjected]And the way my mom has opened up to me....like before she would be like a parent and now it's more like a friend which I really respect her for

I later invited Lori to speak about her memories of her father but she reported that she had no memories of her early childhood and could barely recall her history up to the age of eleven. I learnt that her biological parents divorced when she was four years old due to her father's severe physical and emotional abuse of her mother. Lori had no memories of these episodes of abuse despite having been in the home during the times her father brutally assaulted her mother. She also did not recall if she had ever been subjected to abuse. I explained that it was extremely horrifying for a young child to witness their mother being harmed and emphasised that this could explain her amnesia. However, she disregarded my statement and continued to speak about having only vague recollections about her childhood and finding this very untoward. The only memory she could clearly recall was being involved in a train derailment at the age of five and feeling particularly worried about her father because she could not locate him immediately after the accident. Gregory had sustained severe injuries from the accident but eventually recovered.

Sue remarried a year and a half after the divorce and Lori reported that she could only vaguely recall the wedding but, from her mother's reports, she had been markedly distressed the first time she noticed Harold place his arm around Sue. Two years after Sue's marriage, Gregory decided to relocate to a different province and Lori reported that she remembered feeling abandoned and rejected by her father and was still troubled by his decision. She did not clearly recall the day of his departure but remembered attributing his decision to her not being "good enough". I encouraged Lori to speak about her feelings in relation to this incident but she continued her pattern of avoiding engaging with the topic by diverting the focus to discussing her

positive relational experiences with her mother and step-father. Throughout the remainder of the assessment interviews, Lori continued to make similar sudden references to her father abandoning her and she spoke about him in a globally negative way. She reported that he had failed as her parent and had never tried to establish a relationship with her or be involved her life. She indicated that she had little respect for him given his abusive behaviour towards her mother and found it unacceptable that he made demands on her time (e.g. insisting that she visit him during the holidays) and so she actively avoided him (e.g. she refused to call or visit him).

Lori suffered from a depressive episode when she was nineteen years old following the deaths of two close friends in separate, tragic car accidents. The deaths of her friends had occurred within months of each other and both accidents had occurred late at night. Lori had received the news of these deaths from her family shortly after each accident had occurred and had felt shocked and later sad and dejected. I asked her how she had coped with the losses but she was vague and alluded to having supported the families of the deceased and later recovering from her depression. She believed she had come to terms with her grief and was reluctant to discuss this further.

Since the rape, Lori had started feeling dissatisfied with her body weight and physical appearance and this was also contributing to her depressed mood. She reported that she had taken years to build up her self-esteem and self-confidence and now felt she had to start at the beginning. Through close questioning, I found that since the age of thirteen Lori had been extremely dissatisfied with her weight. At the time, her mother had taken her on a shopping trip and expressed shock that Lori required the same size clothing that she wore and insisted that it was time they did something about her weight. Sue subsequently cooked separate meals for her daughter and placed her on a series of restrictive diet programmes. Lori then started binge eating and was scolded by her mother for these episodes. As a result, she started eating in secret, usually when she felt emotionally distressed. I learnt that throughout Lori's life Sue had been extremely concerned about her own weight and followed a strict diet and exercise routine. I closely questioned Lori about her weight when she was an adolescent and she reported that she had seen pictures of herself and considered herself to be very thin at the time. She indicated that she binged throughout adolescence and while at varsity and these episodes were also

precipitated by her feeling distressed. However, she could not recall having engaged in any binge eating behaviours after the traumatic event.

Sleeping difficulties and "spacing out"

Following the rape, Lori experienced severe difficulties sleeping and was only able to sleep for two to three hours a night. This left her feeling tired during the day and she frequently took naps in the afternoon to ensure she was not completely exhausted. Through close questioning, I found that her sleeping difficulties were related to her PTSD symptoms. Lori experienced intrusive memories of the trauma that took the form of a kinesthetic flashback. This intrusion was usually triggered when she lay down on her bed and night and involved a sensation of a heavy weight bearing down on her (*see section 5.3.2. (i)*). She also experienced these symptoms when she visited the nightclub in which she had met the perpetrator the night of the trauma. Lori had started experiencing distressing dreams since the rape that involved themes of helplessness and powerlessness and she would wake up from these nightmares gasping for breath and crying. Her intrusion tended to occur immediately after these dreams and left her feeling intensely distressed. Lori experienced symptoms of hyper-arousal when alone in her room at night. She reported that she felt startled at any noise and at night would compulsively check the doors in her house to determine if they were locked. She tended to leave her room to determine the source of any noise she heard in or around the house. I normalised Lori's reactions and further psycho-educated her about PTSD symptoms. I explained that memories were not only stored in a visual format but also as bodily memories and her intrusion constituted a kinesthetic memory of the rape. I explained that her sense of being hyper-alert at night was due to the trauma having occurred in her room at night and the sense of threat that had come to be associated with that setting. I emphasised that once the trauma memory was processed, these symptoms would resolve and she would be better able to sleep at night. I decided against using imaginal reliving at this stage to aid treatment planning because Lori had only recently acknowledged that she had been raped and was severely depressed (BDI: 33) and I was concerned that the procedure would only exacerbate her distress.

Lori reported that since the trauma she frequently "spaced out" and would find herself in places she had no original intention of visiting (e.g. she would leave home to walk to campus and would instead find herself at a local shop with no idea how she arrived there). She also "spaced out"

during lectures and often could not remember anything about a lecture she attended and she found these reactions distressing. I explained that these symptoms were related to the trauma and would subside once she came to terms with what had occurred.

Physical injury and home visit

Lori contacted me on the day our sixth assessment session was scheduled and reported she had badly sprained her ankle and would not be able to make our appointment. She intended to see a doctor later that day but until the injury healed and she was able to walk again, she would not be able to make it to session. She reported that she was uncertain how long the injury would take to heal. From her remarks, it was evident Lori was trying to avoid therapy and I hypothesised that she was finding it threatening to focus on herself and was uncomfortable with the idea of being cared for and supported. However, I felt it was too early in our therapeutic relationship to reflect on this. I explained that I was concerned that delaying therapy would inhibit us from helping her recover from the rape and suggested that we meet in her home until the injury healed. After I stated this, Lori went silent for a brief moment and it was apparent she had not expected this response. She then quickly agreed to my proposal and we arranged to have our session later that afternoon.

While studying at varsity, Lori lived in a two-story house with three other students. Her room was located on the ground floor and was exceptionally tidy. I decided to use the opportunity of being in her home to identify any possible triggers. I asked Lori if there was anything in her home or her room that reminded her of the trauma but she was not aware of any triggers in her house. She reported that she had completely re-arranged her room to minimise any association with the rape. She had changed her curtains, bedding and wall decorations and there were no objects in her room that trigged the trauma memory. I asked after Lori's experience of being in the room and learnt that it had been her "sanctuary" but she now dreaded spending time alone in her room especially at night owing to her feelings of anxiety and trepidation. Despite this, she had decided to remain in the room as she believed it was important to reclaim her space. She would, however, be forced to relocate the subsequent year as her house mates were graduating and would not be returning.

Lori's sprained ankle healed rapidly and she was able to come to my office for our final assessment session two days later.

5.3.2. DIAGNOSIS

On the basis of the assessment interviews and Lori's scores on the self-report scales (PDS: 38; BDI: 33; BAI: 32), she was diagnosed with the following.

(i) Post-Traumatic Stress Disorder

Lori met diagnostic criteria for PTSD. She experienced one intrusive memory of the rape that took the form of a kinesthetic flashback. The intrusion involved a feeling of pressure on her chest that Lori described as a "heavy weight pressing down" on her. This sensation was accompanied by a feeling of being suffocated. Lori's intrusive memories were triggered whenever she lay down on her bed at night and after she experienced distressing dreams (not of the traumatic event). The intrusion was also triggered when she visited the night club where she had met the perpetrator the night of the rape. Lori experienced heightened physiological arousal and was overly alert when alone in her home at night. She would awake at the sound of any noise and would repeatedly leave her room to ascertain the source of a sound she heard and to check that all the doors in her home were locked. These symptoms of re-experiencing, hyper-vigilance and distressing dreams significantly impacted on her sleeping patterns and due to insufficient sleep she often felt exhausted and unable to concentrate on her academic work during the day. Lori suppressed her memories of the night of the trauma and avoided speaking about the rape. She avoided attending night clubs so as not to be reminded of the trauma. She experienced these symptoms of PTSD for approximately five months prior to our consultation.

(ii) Major Depressive Disorder (Recurrent, moderate)

Lori met criteria for major depression (BDI: 33). She experienced feelings of profound sadness and a sense of dejection following the rape and frequently isolated herself in her room and cried. She believed she was to blame for the trauma and this left her feeling guilty and ashamed and aggravated her low mood. She relinquished participating in activities that she had previous enjoyed including socialising with friends and participating in physical activity. In addition, she experienced a lack of energy and motivation and found it difficult to attend to daily tasks. Lori had experienced episodes of major depression throughout adolescence and had felt intensely

dejected and sad during these times. Her prior depressive episodes were precipitated by her feeling alone and by her parents experiencing severe marital conflicts. She had also experienced an episode of major depression following the loss of two of her friends when she was nineteen years old.

(iii) Insomnia related to PTSD

Lori was experiencing significant difficulties falling asleep and staying asleep since the traumatic event and was only able to sleep for two to three hours a night. Her sleeping difficulties left her feeling tired during the and negatively affected her academic work. Her sleep problems were directly linked to her PTSD and were present for five months after the traumatic event.

(iv) Dissociative Features

Lori displayed dissociate symptoms in that she had no clear memories prior to the age of eleven but she did not meet criteria for any dissociative disorder. She expressed distress about her inability to recall childhood events but this did not significantly interfere with her functioning. It is probable that the sudden changes in her life arising from her mother's remarrying and her father's abandonment and the emotional adjustment associated with these experiences were overwhelming and contributed to her dissociating during childhood. By the time Lori was twelve years old, her step-father's presence in her life was consolidated and the associated sense of stability might have inhibited her from dissociating. In addition, by that time, her coping mechanisms involving compulsive-caring had become more consolidated and this might have prevented her from having dissociative episodes.

The following diagnosis was added after the third therapy session as it became increasingly evident that Lori showed features of Borderline Personality Disorder (BPD).

(v) Borderline Traits

Lori had symptoms of BPD but did not meet full criteria for the disorder. She was involved in intense, unstable relationships prior to the traumatic event. This included her first romantic relationship in high school with Joshua and her friendships with Ruby and Carla (*see T2*) which began the year she joined varsity. Lori displayed an intense fear of being abandoned and interpreted the rejecting behaviour of others to imply that she was unworthy and not "good

enough". Despite her fears of abandonment, she behaved in ways that had the potential to elicit rejecting responses from others (e.g. engaging in testing behaviours with Khaya). She also tended to idolise or completely devalue other people as can be seen in the differences in her attitude towards her mother and step-father when compared to her biological father. Furthermore, she had difficulty controlling her feelings of anger and engaged in self-harming behaviours including self-mutilation and binge eating.

5.3.3. CASE FORMULATION

(i) Predisposing factors

Lori's experiences with her parents contributed to her developing a disorganised pattern of attachment (*see section 1.3.3. (ii)*) that had implications for her subsequent capacity to cope with distressing events. Her mother (Sue) was severely neglected by her own parents and repeatedly physically abused and raped by her father throughout childhood and adolescence and she eventually ran away from home to escape the abuse. A number of researchers (Lyons-Ruth et al., 2005; Madigan, Morgan, & Pederson, 2006; Schuengel, Bakermans-Kranenburg, van Ijzendoorn, & Blom, 1999) have found that mothers with histories of maltreatment by caregivers tend to behave in ways that frighten their own children leading to disorganisation of the attachment behavioural system. These authors argue that such disorganisation occurs because the child's attachment behaviour activates memories of the caregiver's prior experiences of abuse leading to their reacting in an erratic or disoriented manner. Such reactions are frightening for the child and places them in a paradoxical situation in which their source of comfort and reassurance also becomes a figure of threat. They subsequently fail to learn a coherent strategy for minimising distress and instead use a chaotic mixture of approach-avoidant behaviours. For Sue, her prior memories of abuse were not only triggered by Lori's attachment behaviours but by her exposure to domestic violence in the context of her marital relationship. Sue married Gregory shortly after running away from home but the marriage was characterised by high levels of negative conflict. Exposure to domestic violence most likely triggered Sue's memories of being physical abused by her father and contributed to her behaving in a frightened way towards her child.

Lori's disorganised attachment style was further aggravated by her witnessing domestic violence. She was in the home during the times her father attacked her mother and in all likelihood witnessed or heard these instances of abuse and might have been subjected to abuse.

Witnessing an attachment figure being harmed by another caregiver and unable to protect herself produces extreme feelings of confusion, fear and helplessness in the child. It contributes to the child doubting the extent to which they can rely on caregivers to protect them from harm (van Ijzendoorn & Bakermans-Kranenburg, 2009). Lori could not turn to either her mother or father for comfort and reassurance because they not only represented figures of safety and reassurance but sources of extreme threat and this disorganised her attachment system.

The disorganisation of the attachment behavioural leads to affect dysregulation (*see section 1.3.3. (ii)*). In Lori's case, this was evident in her amnesia for her childhood experiences prior to the age of twelve. It is probable that these memory deficits were related to her experience of being with a frightened caregiver and to the sudden change in her family structure (i.e. mother's remarrying and father's abandonment). Lori's difficulties with affect regulation were also evident in her self-harming and binge-eating behaviours in adolescence and adulthood. These episodes were precipitated by her feeling extremely emotionally distressed, alone and unable to cope. In addition, her approach-avoidant tendencies and difficulties with affect regulation were reflected in her behaviour in session. She was extremely willing to speak about her distressing experiences but assumed a casual, matter-of-fact approach throughout her narrative and actively avoided engaging with her emotions. She displayed hesitance in coming to therapy after our fifth appointment but once I reassured her and showed interest in her wellbeing, she agreed to a home visit and subsequently resumed coming to session (*see A5* and *A6*).

Lori's internal working model or schemas of self and others were significantly affected by her early exposure to interpersonal trauma and her subsequent repeated negative experiences with her caregivers. Lori developed early maladaptive schemas involving: defectiveness/shame; emotional deprivation; abandonment instability; mistrust/abuse; punitiveness and; subjugation. She interpreted her caregivers' inability to adequately care for and protect her to mean she was inherently deficient and unworthy of support and protection (defectiveness/shame). She expected that she could not rely on others to be consistently available to meet her needs (abandonment/instability; emotional deprivation) and if she expressed her feelings and concerns, she would be hurt, rejected and abandoned (mistrust/abuse). As a result of these assumptions, Lori avoided expressing herself to others and suppressed her needs and feelings (subjugation) and maintained an overly cheerful, bright demeanour when interacting with other people

(overcompensation). She engaged in compulsive-caregiving behaviours and excessively focused on supporting and caring for other people so as to feel needed and valued (over-compensation). Whenever she was unable to adequately meet the needs of others or fell short of her own expectations, she was extremely self-critical (punitiveness).

Lori's early maladaptive schemas were reinforced by her father's unexpected decision to relocate to a different province when she was seven years old. Thereafter, his involvement in her life was limited to an occasional phone call. He often told Lori he would spend time with her during school holidays but always failed to follow through on these promises. Gregory's behaviour reinforced Lori's belief that she was inherently deficient and unworthy of attention, affection and support and that she could not rely on others to adequately meet her needs. When Lori was thirteen years old, Sue expressed dissatisfaction with her daughter's weight and subsequently placed her on a series of diet programmes. This further intensified Lori's assumption that she was deficient and unacceptable.

(ii) Precipitating factors

Lori was subjected to DFSA five months prior to her entry into therapy and experienced complete amnesia for the rape itself. Her inability to remember the trauma generated feelings of shame, confusion and uncertainty and contributed to the development her PTSD symptoms. Lori's appraisals in the weeks following the rape reinforced the sense of threat she associated with the traumatic event. She believed she was responsible for the rape because she had consumed too much alcohol and accepted drinks from the perpetrators. She also believed that she should have been able to gauge the perpetrators intensions and expected that others would share her opinion that she was to blame.

(iii) Maintaining factors

Lori's symptoms of depression and PTSD were maintained by her avoidant behaviours. She believed she could not turn to others and had to cope with the trauma on her own. As a result, she suppressed her memories, isolated herself from others and kept the rape a secret. However, this inhibited her from receiving care and support. It prevented her from disconfirming her maladaptive assumptions that she was to blame for the rape and that other people would hold

her accountable for what had occurred. In addition, her avoidance prevented her from being able to process the traumatic event.

5.3.4. PRESENTATION OF TREATMENT PLAN

It was clear Lori needed to be seen as part of a long term therapy programme but I was aware she was extremely threatened by being in therapy and had only entered treatment at the encouragement of her family and solely to address the effects of the rape. I therefore decided against suggesting long-term therapy until the therapeutic relationship was stronger and instead focused on her treatment goals which involved resolving her PTSD symptoms. I identified Lori's PTSD reactions and reminded her of the mechanisms underlying PTSD and explained the treatment model. Lori was particularly concerned about her kinesthetic intrusions, nightmares and related sleeping difficulties. She reported that she did not want these symptoms to further jeopardise her academic work and her ability to prepare for her upcoming exams. I reassured her we would work towards resolving these reactions.

5.3.5. THERAPY NARRATIVE

Lori was seen for four therapy sessions of ninety minutes each once a week. She missed her fifth appointment and attempts to contact her thereafter were unsuccessful. I subsequently reached her mother and a few days later, Lori contacted me and reported she wanted to halt therapy for six weeks and resume treatment in the New Year. She was seen for one session thereafter and due to symptom resolution she decided she did not need to continue with therapy.

Therapy session 01 [BDI: 18; BAI: 12; PDS: 20]

<u>Focus area: PTSD</u>

Lori was still experiencing sleeping difficulties by our first session and reported that she was often not able to sleep for days at a time and this left her feeling exhausted. I reminded her that these sleeping problems were linked to her intrusions and her room being associated with a sense of threat. I emphasised that once this link was broken, her anxiety would lessen and she would be able to get a decent night's rest. However, Lori was very hesitant to engage with reliving and reported that she was worried that "nothing would come back". It seemed she assumed the exercise was meant to help her recall the trauma and so I explained that the procedure was

aimed at updating existing memories and not necessarily at facilitating the retrieval of memories. However, Lori still remained ambivalent and reported that she had "rehashed and rehashed" the events that had occurred the night of the trauma and believed that nothing would come from her reliving the trauma memory. It was clear that she found the prospect of reliving threatening and was avoiding the procedure and I focused on motivating her. I explained that reliving was potentially harrowing but I believed she was resilient and could cope with the exercise. I emphasised that once the memory was processed she would no longer be plagued by this unpleasant reaction and could resume her life. Lori was then more willing to undertake the procedure.

I guided her to relive the sensations that constituted the intrusion and her rate of breathing increased the moment she connected with the trauma memory. Her face became flushed and she appeared frightened and I found the change in her physiological reactions unsettling. I asked after her thoughts and feelings and she was able to give me an indication of her experiences. At one point during the reliving Lori began to cry and, from my knowledge of the treatment model, I was aware that such a reaction was indicative of a hotspot and so I prompted Lori to describe her experiences. From her responses, I identified two peri-traumatic appraisals. The first appraisal involved a sense of confusion ("I don't know what's going on....I want it to stop and I don't know what it is") while the second appraisal involved her not being able to wake up ("I can't wake up") and not understanding the reason for this.

Lori was unsettled after the exercise and I focused on helping her to calm herself by using deep breathing exercises. I emphasised that the trauma was over and she was in a safe place. Once she was calmer, I explained that I had identified two appraisals that were maintaining her intrusion. The first appraisal was associated with a sense of confusion and I linked this to her being drugged and rendered unconscious and therefore being unable to fully comprehend what was being done to her and this resonated with Lori. I reflected on the second appraisal and invited Lori to share her thoughts and feelings on not having woken up during the trauma. She believed she should have woken up during the rape and in not doing so she had colluded in the assault and this generated feelings of shame and a sense of self-blame. I addressed her negative assumption by reiterating the physiological effects of the drugs used to perpetrate rape. I used Socratic

questioning to help Lori appreciate that her not waking up was not an intentional decision but the result of her having been drugged and purposefully rendered unconscious by another person.

I engaged Lori in a second reliving and guided her to insert corrective information to update the memory. She was able to attribute the physical weight bearing down on her to the perpetrator being on top of her and raping her. She was also able to attribute her inability to wake up to her having been drugged by the perpetrator beforehand. Following the exercise, I once again helped Lori to relax by emphasising that she was in a safe place and that the trauma was in the past.

Therapy session 02

Focus area: PTSD

Lori appeared dejected when she arrived for session and confirmed that she had been feeling "down" since our last meeting. I attempted to investigate her cognitions during the times she felt depressed but she reported that she could not clearly recall her thoughts and it was just that "everything was getting to her". I reflected on the reliving and suggested it was possible that the exercise made the trauma more apparent and this was causing her to feel down. Lori, however, dismissed this and reported that she had been drained by the exercise but had coped well. I established, through close questioning, that she had not experienced any intrusions since our previous session but was still plagued by distressing dreams that left her feeling anxious and weary of going to sleep.

Lori had experienced four distressing dreams. The first involved witnessing a close friend commit suicide by hurling herself from a cliff edge and feeling paralysed and unable to move or stop her friend. The second dream involved Lori being pregnant and not realising this and drinking alcohol excessively and later worrying that she had terribly harmed her child. The third dream involved being in a stationary car with her step-father and sister and witnessing another car speed past and collide with a group of protestors standing in the road. In the dream Lori had protectively covered her sister's eyes to prevent her from witnessing the horror but she watched the scene and felt helpless to stop the car and horrified at the collision. The fourth dream entailed being in a night club and witnessing a man being brutally assaulted and not being able to stop the assault. The night club in her dream resembled the one in which she had met the perpetrator the night of the rape. I established that each of her dreams evoked a sense of horror and helplessness.

There were also themes of violence and death in three of her dreams and I explicitly hypothesised that there could be a link between her dreams and her prior experiences of loss. I requested that Lori remind me of the losses she had suffered in her life and the time period in which each of these traumas had occurred. It became clear that it was the anniversary of the deaths of her two friends and I emphasised that it was possible that these losses were being reflected in her dreams. This resonated with her and she reported that she had received news of the deaths late at night and for the previous week she had started leaving her phone under her pillow in anticipation of receiving a distressing phone call. I emphasised that the trauma was in the past and proposed to Lori that she switch her phone off at night as it was clear that her anticipatory anxiety was contributing to her sleeping problems. However, she reported that she wanted to be available to any of her friends in the event that they experienced problems. I actively argued that her friends had other resources they could use if they were unable to reach her and that her needs were also a priority but she repeatedly countered my arguments. Lori emphasised that she would be very disappointed if she was not available to support her friends. I experienced a sense of frustration and helplessness at her self-sacrificial behaviour and unwillingness to give any significance to her needs. I later hypothesised that by focusing on her friends Lori may have been trying to avoid any emotional distress she experienced at night as a result of the trauma.

I used dream restructuring to address the sense of helplessness Lori experienced in her nightmares. She was less threatened by the prospect of dream restructuring and I guided her to relive the first of her nightmares involving the suicide of her close friend (Ruby) as this represented her most distressing dream. In the restructured dream I guided Lori to visualise being released from her paralysis and walking towards Ruby and offering her comfort and support and guiding her away from the cliff edge. She then visualised holding Ruby's hand and walking away from the cliff. After the procedure, Lori reported that she felt extremely relieved and surprised that she had been able to move and walk as she had felt completely paralysed in the nightmare.

I explored her relationship with Ruby and found that Lori once again spoke in a frenetic, rambling and disorganised way and I often struggled to follow her narrative. I was unsettled by the extent to which she had engaged in self-sacrificial behaviour to support her friend but Lori did not

regard her caregiving behaviour as excessive. I learnt that Ruby came from a dysfunctional family background and suffered from bulimia and engaged in self-injurious behaviour and for two years Lori had gone out of her way to help her cope with these difficulties. There were distinct similarities between Ruby's experiences with her family and Lori's relationship with her parents. I hypothesised that Lori identified with Ruby and in trying to help her, she might have been indirectly attempting to tend to her own wounds and achieve some form of mastery over unresolved experiences.

In the following segment from the transcript for the session, Lori deflects the conversation away from discussing her tendency to excessively focus on the needs of others by speaking about Ruby. She discloses, for the first time, that Ruby is from an Arab country and that her sister has been engaging in sexual activity which is prohibited in terms of the religious codes of that country. As a result, Ruby's mother has been forced to relocate the family to protect her daughter from local authorities. The segment also demonstrates Lori's tendency to speak in a rambling and disorganised way. In addition, it highlights the similarities between Ruby's experiences with her family and Lori's relationship with her parents.

> <u>Therapist</u>: But it also feels like you've taken a lot of responsibility for caring for her [Ruby] and you worry about her more than say her parents do
>
> <u>Lori</u>: (pause)....no...it's just like....well because.... it's just that she lives in an Arab country and whatever and it's illegal to have sex outside of marriage and they found out her younger sister was and that caused drama and mom's not happy... like her mom has to relocate the family again and her little sister's unhappy with all the tension at home and everything and she's going home to all of that....which isn't good and her parents are very caught up in their own things...they don't really worry about her much....they cut her off half the time for no apparent reason and just like she's experienced true friendship and like here and now she's got to go back to that

Despite Lori's efforts, Ruby's condition did not improve and she eventually started distancing herself from Lori and avoiding her. Lori alluded to feeling angry with Ruby but would not fully engage with these feelings despite my attempts to encourage her to do so.

The next segment from the transcript demonstrates Lori's difficulties engaging with her feelings of anger and her tendency to deflect the conversation away from threatening emotions.

> Lori: Ja, if I knew what made her suddenly decide she didn't want to help herself anymore, maybe I could understand but I do have some anger at the moment because she was doing it and she was doing so much better and [laughs]now she just stopped
>
> Therapist: Tell me about that anger?
>
> Lori: [stares blankly at therapist]
>
> Therapist: You're angry at her
>
> Lori: Ja... I am angry at her....I mean we've....well I mean I've invested a lot we've been friends for a while....we were friends since the first few weeks of our first year together....and...I've always been there for her and I've always made sure she's okay and we just got really close and we've always done everything together....in first year and just...

Lori attributed Ruby's failure to recover to her being inadequate and not a "good enough" friend. I hypothesised that by blaming herself Lori was attempting to avoid acknowledging her helplessness and vulnerability and this was connected to her experiences with her father. I reflected on the links between her sense of not being "good enough" for Ruby to improve and her experience of not being "good enough" for her father to have stayed. However, Lori ignored my comment and simply continued to speak about her relationship with Ruby and with another friend (Carla). She reported that she had been very close to Carla and they had also "done everything together" but after some time Carla grew distance and avoided Lori and she did not understand the reasons underlying her friend's behaviour. Through close questioning, it became clear that Lori had played a care-giving role in this relationship as well. I explicitly hypothesised that some of her friends might have been using her to fulfil their own needs and once these were met and they no longer needed her, they grew distant. This resonated with Lori and she reported that she often felt like a "doormat" in relationships but she believed she needed to be there to tend to others and so was willing to look past their hurtful behaviour. Lori was extremely unwilling to recognise or acknowledge that some of her friends' behaviours were unacceptable and abusive of her friendship. Instead, she actively argued that irrespective of their behaviour, she needed to be a "loyal friend". I later hypothesised that it was possible that Lori's friends

might have experienced her behaviour as controlling and therefore distanced themselves. However, I did not suggest this to her as I did not believe it was the appropriate time to do so.

Towards the close of the session, I reflected on Lori's tendency to excessively focus on others at the expense of her own needs, feelings and desires. She casually reported that she was not accustomed to focusing on herself and was largely unaware of her needs, feelings or aspirations. She then reverted to talking about her friends but I redirected the conversation and closely questioned her about her difficulties with self-exploration. This eventually prompted Lori to tentatively disclose that she believed that, if she focused on herself, she would discover that all her negative assumptions about herself were true. She feared this would lead to her feeling deeply disappointed and emotionally distressed and unable to cope. I explained that it was very threatening to change ingrained beliefs and patterns of behaviour because they provided a sense of grounding and security and a means of negotiating relationships. I emphasised that her beliefs were destructive in that they prevented her from receiving care and support and from forming meaningful relationships with others. Lori remarked that she was increasingly becoming aware of the existence of these negative beliefs and the extent to which they impacted on her life but she would not elaborate on this further.

Therapy session 03

Illness

Lori was ill with a cold and coughed severely and so our third session was shorter than usual. I used the session to investigate the changes in Lori's symptomatic reactions. I learnt she had not experienced any kinesthetic intrusions for the preceding two weeks and her symptoms of hyper-arousal had decreased. She reported that her compulsive checking of the doors in her home had markedly reduced and she now only checked all the doors in her home once before she entered her room at night and then once more before she went to bed. She had previously been checking these doors countless times during the course of the night. Lori reported that she no longer felt compelled to ascertain the source of each noise she heard in the house at night. Despite these improvements, she was still finding it difficult to sleep but this was partially related to her severe cough which kept her up at night.

Lori reported that she was feeling increasingly dissatisfied with her weight. I established that she was within the normal weight range for her age and height (she was twenty one years old and weighed seventy kilograms and was approximately five foot eight in height) but she still felt unattractive and ugly. I reflected on her experiences with her mother and this having negatively affecting her perceptions of her physical appearance. Lori then remarked in a frustrated tone that her mother's comments had made her feel inadequate. She reported that she would never be "good enough" for her mother no matter how much she weighed and was not certain exactly what her mother required from her. This was the first instance in which Lori acknowledged being dissatisfied with her relationship with Sue. I reflected on her sense of rejection and hurt at not being acceptable to her mother and Lori acknowledged this but then quickly diverted the focus back to discussing her concerns with her weight. She reviewed her experiences of feeling dissatisfied with her appearance in adolescence and binge-eating but shied away from discussing her mother's role in the evolution of these difficulties.

Therapy session 04

Focus areas: Sleep disturbances; Feelings of anger and helplessness

Lori's health had improved only slightly by our fourth session and as a result, she had decided to return home for a week long break to recuperate from her illness. She had not experienced any intrusive memories or nightmares but was still having trouble sleeping and appeared extremely exhausted. I closely questioned her about the content of her cognitions when she was lying down on her bed at night. Her thoughts largely revolved around the possibility of an intruder entering her home and harming her. This cognition generated significant anxiety and kept her overly alert at night and I decided to reality test the probability of her fears being realised. I closely questioned Lori about the security features in and around her home and she realised that she actually lived in a very secure area and that the likelihood of an intruder entering her home was minimal. Her neighboured was protected by security guards and her home had burglar bars on all windows and an effective locking system on each door. Lori also locked the door to her room at night and she lived in a house with other students and was rarely alone at night. In addition, her home had not been the subject of robberies or forced entries.

I explicitly hypothesised that Lori's continued difficulties sleeping were related to the trauma and the sense of threat still associated with her room and with going to sleep at night. I explained it

was possible that the trauma memory was insufficiently processed but Lori then changed the topic and it was apparent she was threatened by the prospect of reliving. I reassured her and explained that I was aware that the initial reliving had been harrowing. I emphasised that we would only undertake the procedure once her health improved and she was in a better position to tolerate such an exercise.

Lori reported that she had seen the perpetrator in town but these sightings no longer generated feelings of shame. Instead, she felt increasingly angry towards him and was uncertain how to go about expressing her anger in constructive ways. I proposed letter writing but, because the perpetrator had immobilised her, Lori believed she needed a physical method of releasing her anger towards him. She believed this would allow her to feel more physically empowered. I therefore suggested boxing and she found this idea useful and decided she would use the punching bag at the local gym as a means of venting her anger. I suggested she imagine the punching bag was the perpetrator and she laughed and reported that she believed it would be useful. Through close questioning, I found that Lori's anger was also related to her sense of helplessness when it came to making the perpetrator legally accountable for his actions. Lori and her parents had consulted an attorney after her disclosure and were informed that, due to her amnesia and the time lapse between the assault and her disclosure, she would not be able to successfully prosecute the rapist. I sought Lori's consent to contact a prominent public prosecutor in the town to determine if there were any legal recourse available to her and she agreed to this.

Just before the close of the session, Lori reported that "after therapy [she] was going to cheer up a friend". I enquired further and learnt that her friend (Margaret) had been feeling depressed and Lori had been tending to her for the past two weeks but Margaret's mood had not improved. Lori displayed a sense of anger when she spoke of her friend and it was apparent she was starting to feel frustrated with constantly having to care for and serve others especially when she was experiencing difficulties. However, since it was the close of the session, there was not enough time to explore this further.

I arranged to meet with Lori following her trip home but she did not keep the appointment and my attempts to reach her proved unsuccessful. I eventually reached her mother who informed

me that Lori had only stayed home for a short period and was at varsity. I learnt from Sue that her relationship with Lori had become increasingly strained because of her daughter's inter-racial relationship. Sue reported that she had been raised in a different world and was struggling to accept her daughter's choice of partner. I empathised with her and explained that Lori had been making progress in therapy and I was concerned about her not keeping her appointment. Sue, however, was not surprised at Lori's behaviour and indicated that her daughter experienced difficulty accepting help. She ended our conversation by advising me that I "could only help someone if they wanted to be helped". A few days after my contact with Sue, I received a brief text message from Lori. She apologised for not contacting me earlier and reported that she wanted to discontinue therapy until the New Year and would contact me thereafter to reschedule. I thanked her for getting in touch with me and invited her to return to see me.

I did not hear from Lori once the academic year resumed in 2009 but two months later I noticed her in the Department. She appeared surprised to see me and embarrassed and quickly approached me and requested that we meet. It was clear she had not intended to contact me and felt compelled to do so by our unexpected meeting.

Therapy session 05 [BDI: 5; BAI: 9; PDS: 5]

Endings

I subsequently met with Lori and as with our first meeting she assumed a forced cheerfulness while interacting with me. She reported that she had relocated and was living alone in a flat and was much happier and in a better space. I asked after her decision to discontinue therapy and she was very vague and alluded to her having felt better and wanting to exclusively focus on her exams at the time. I enquired after her mood and her PTSD symptoms and found that her depression had lifted completely and her PTSD had resolved. In addition, her sleeping habits had returned to normal following her relocation. As a result of these improvements, Lori reported that she had achieved her main treatment goal of reclaiming her life from the trauma and believed she no longer needed to be in therapy. I invited her to contact me if she experienced any difficulties in the future and emphasised I would be willing to work with her.

I explained to Lori that I had contacted a public prosecutor and been advised that she would be able to submit an affidavit to the police detailing the rape and this would serve as evidence in the

event the perpetrator committed a similar offence. Lori was shocked to hear this news as she believed no action could be taken against the rapist. She reported that she intended to compile the affidavit and submit it to the authorities as soon as possible as this would help her achieve closure. I attempted to contact Lori a week later to determine if she had followed through on this but could not reach her.

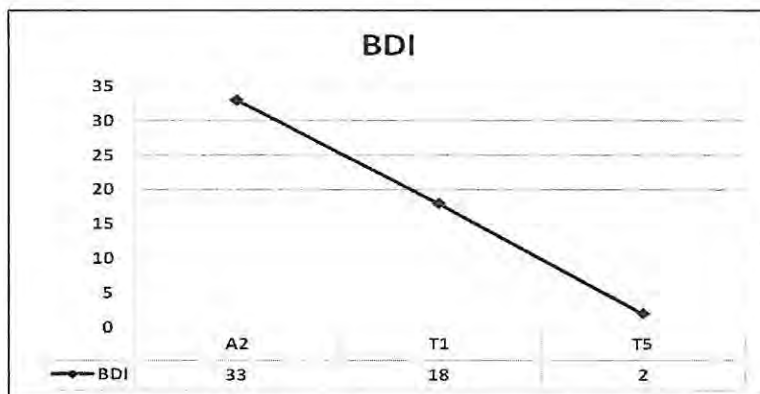
5.3.6. RESPONSE TO THERAPY

According to the self-report scales Lori was better after therapy than before treatment. Lori's scores on the inventories are presented in Figures 14 to 16 below.

(i) BDI

[Symptom scores: 1- 13 = Minimal; 14-19 = Mild; 20-28 = Moderate; 29-63 = Severe]

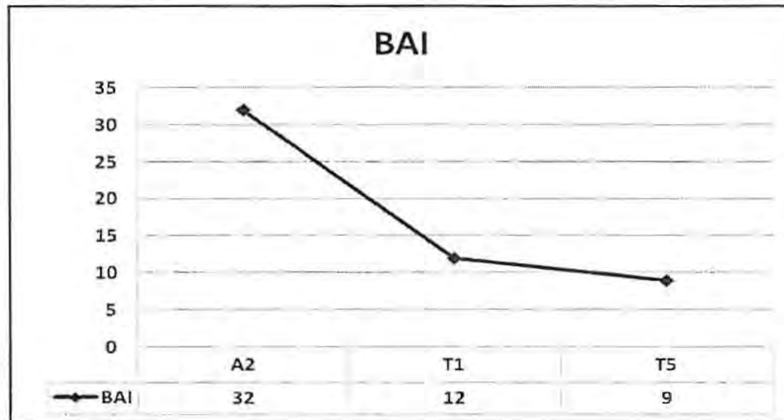
Figure 14: LORI BDI SELF-REPORT SCORES



(ii) BAI

[Symptom scores: 0-7 = Normal; 8-15 = Mild; 16-25 = Moderate; 26-63 = Severe]

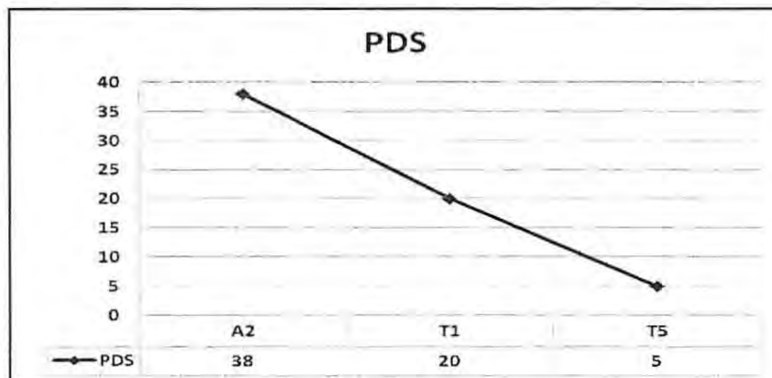
Figure 15: LORI BAI SELF-REPORT SCORES



(iii) PDS

[Symptom scores: 1-10 = Mild; 11-20 = Moderate; 21-35 = Moderate/Severe; 36-51 = Severe]

Figure 16: LORI PDS SELF-REPORT SCORES



The results indicate that at intake Lori was suffering from clinically significant symptoms of depression and anxiety (BDI: 33; BAI: 32) and post-traumatic stress disorder (PDS: 38). There were significant reductions in her scores on all three scales during the course of treatment. Crises intervention during the assessment phase which involved: psycho-education and normalising symptomatic reactions; mobilising social support and; challenging problematic beliefs (e.g. self-blame) led to a dramatic decline in her self-reports of symptoms (BDI: 18; BAI: 12; PDS: 20). The subsequent therapeutic focus was on targeting her PTSD symptoms of re-experiencing. Through close questioning in the second, third and fourth therapy sessions, it was established that Lori no

longer experienced intrusive memories of the rape and her symptoms of hyper-arousal had significantly decreased from when she first started therapy. She no longer compulsively checked all the doors in her house throughout the course of the night but, instead, only twice. She also stopped getting out of bed throughout the night to determine the source of any noises she heard. Her residual symptoms of hyper-arousal, however, continued to interfere with her sleeping patterns. I did not ask Lori to complete the self-report scales in session during this time because she was ill and I did not feel it was appropriate. I used close questioning, instead, to obtain information about her symptoms. Lori halted therapy following our fourth session and six weeks later her scores on the self-report scales revealed that her presenting symptoms had completely resolved (BDI: 5; BAI: 9; PDS: 5). The resolution of her symptoms of hyper-arousal and anxiety were partially attributable to her change of residence. The absence of triggers led to her no longer experiencing the sense of threat that came with being in the room in which the trauma occurred.

5.3.7. DISCUSSION

Unresolved attachment and hostile-helpless states of mind

Lori's early experiences with her primary caregivers contributed to her developing a disorganised style of attachment (*see section 1.3.3. (ii) and 5.3.3.*). The adult equivalent of childhood disorganisation has been described as unresolved attachment and is reflected in the presence of a hostile-helpless state of mind in relation to early attachment figures (Lyons-Ruth, Bronfman, & Atwood, 1999; Lyons-Ruth, 2003; Lyons-Ruth, Melnick, Patrick, & Hobson 2007). The term hostile-helpless state of mind describes the mental or psychological organisation of an individual that is characterised by "explicit contradictory but un-integrated emotional evaluations of a central caregiver" (Lyons-Ruth., et al 2005, p. 16). Lyons-Ruth et al. (2005) examined the narratives of adults to identify the features that reflected a hostile-helpless state of mind. The indicators they identified included: global devaluation of a caregiver; laughter while relating painful experiences; having a special sense of unworthiness (e.g. generalised negative self-descriptions, feelings of being undeserving of positive attention); evidence of controlling behaviour in childhood and; evidence of ruptured attachments (e.g. deliberately cutting ties with a caregiver). In addition, these researchers found that the discourses of individuals with a hostile-helpless state of mind showed: lapses in reasoning (i.e. parts of their narrative appeared

disorganised); had a matter-of-fact quality; conveyed an attitude of resilience or toughness in the face of adverse events and; had a distinct absence of involved anger.

Lori displayed signs of having a hostile-helpless state of mind in relation to her early caregivers. She described her biological father in globally negative terms and explicitly spoke about his physical abuse of her mother. However, she still firmly believed that had he remained in her life, she and her family would have been better for it. She spoke about her mother in a very positive way but described her as being hurtful and rejecting and did not notice or correct the contradiction inherent in these impressions. In addition, Lori's discourse reflected a hostile-helpless state of mind in that she: narrated her negative experiences with attachment figures in a casual or matter-of-fact way (*see section 5.3.1. (i)*); displayed a sense of having been tough or resilient in adverse circumstances; laughed while speaking about painful experiences and; showed an absence of involved anger. Furthermore, she held on to a sense of being unworthy (i.e. "not good enough") and attributed her various experiences of rejection to her inadequacy. Furthermore, Lori showed signs of a ruptured relationship in that she severed ties with her father and refused to visit him during holiday periods. According to Lyons-Ruth et al. (2007), the presence of these features suggests that the individual has not been able to engage in sufficient self-reflection to bring conflicting and contradictory impressions to a conscious level and achieve a more balanced or coherent evaluation of attachment figures. In Lori's case, such insufficient self-reflection was motivated by her need to keep threatening attachment related needs, feelings and experiences out of awareness and maintain self-coherence.

Adoption of representational and behavioural coping strategy to achieve self-coherence

Lori's exposure to domestic violence and maternal frightened behaviour led to her adopting a representation of self as 'rescuer' and other as 'victim' and assuming a controlling-caregiving strategy towards others. In the absence of reparative experiences, the chosen behavioural coping strategy of a disorganised child becomes consolidated (Lyons-Ruth et al., 2007). In Lori's case, this was reflected in her life long pattern of disavowing her own needs and caring for others. In adolescence she looked after her brother and step-sister and tended to the needs of her parents and boyfriend. In adulthood, she continued to assume the same role and compulsively cared for her parents, siblings and friends (*see T3* and *T4*).

According to Liotti (1999, 2004), the interpersonal coping strategies of previously disorganised children fail when the individual is subsequently exposed to events that strongly activate the attachment system. This can lead to the dissociated set of meaning structures (i.e. self and other as 'rescuer'; 'persecutor' and 'victim') coming to the fore and can lead to the individual resorting to maladaptive coping mechanisms (e.g. alcohol abuse, self-mutilation) in an attempt to achieve some form of internal coherence or equilibrium. Lori's controlling-caregiving strategy failed in adolescence when her mother (Sue) and step-father (Harold) experienced severe marital conflicts and there were heated arguments in the home. This experience possibly activated Lori's prior memories of her traumatic early attachment experiences and led to her feeling distraught and she initially tried to cope with the distress evoked by caring for her parents. However, her mother rebuffed her efforts while her advice to her step-father did little to resolve the conflicts in the home. This situation left Lori feeling intensely distressed, alone and unable to regulate her emotions and to maintain some form of internal coherence she resorted to self-harming behaviours including binge-eating and cutting.

Lori was exposed to DFSA in adulthood and this trauma strongly activated her attachment system. She attempted to cope by suppressing her memories of the trauma and denying that the rape occurred. She enlisted controlling-caregiving strategies in that she kept the trauma a secret and in doing so believed she was protecting others (e.g. her boyfriend and parents) at a time when they were experiencing stressors in their lives. However, these attempts at coping eventually proved unsuccessful and Lori disclosed the trauma to her step-father. Her parents subsequently encouraged her to enter therapy but this conflicted with her internal working models (i.e. self as 'rescuer'; other as 'victim') and contributed to her initial ambivalence about seeking treatment. Lori subsequently agreed to enter therapy provided she could be part of the research project. In insisting to have her treatment process go towards research aimed at helping others recover from trauma, she was essentially trying to retain her internal representations of self and other and her sense of self-coherence. However, the therapeutic relationship subsequently strongly activated her disorganised and dissociated internal working models of self and others.

This was first evident in her reports that she had suddenly started thinking about her father's abandonment of her when she was seven years old. As a child, this incident directly challenged

Lori's fragile organisational system because her father had shown little regard for her needs (self as 'victim') and simply left (other as 'persecutor'). To maintain self-coherence, she construed the event as indicating that she was inadequate and had she tried harder or done more (self as 'rescuer') her father would have not felt the need to leave (other as 'victim'). However, as her attachment needs became activated in session, the other representations once again came to the fore. This was evident in her devaluing her father (self as 'victim'; other as 'persecutor') and feeling threatened by this representation and glossing over it by referring to her admiration for her mother. Lori clearly identified with her mother and in doing so was able to maintain her dominant internal representations. However, in the third therapy session, she started to reflect on her mother's hurtful behaviour but then diverted the conversation and avoided any reference to this issue because it was too threatening for her to construe her mother in a negative light.

The presence of the dissociated self-states was also evident in her dreams in which she was repeatedly represented as being helpless in the face of adverse interpersonal events (*see T2*). Lori found these dreams markedly threatening and feared going to sleep lest she have more nightmares. The sense of threat she associated with her nightmares was not only related to their content but to their implications for her sense of self-coherence.

<u>Disorganised attachment and early termination</u>

Lori's disorganised attachment style and related difficulties integrating conflicting representations of self and others contributed to her termination. For her, being in therapy represented the first instance in which she was afforded the opportunity to express her needs, feelings and experiences and have them received, validated and reflected back to her. Despite this being momentarily gratifying, it strongly conflicted with her internal representations or schemas. Lori believed that to maintain relationships she needed to disavow her own needs and tend to others (self as rescuer; schema: subjugation) or face the possibility of being abandoned by helpless and overwhelmed caregivers (other as victim; schema: abandonment/instability). Her subsequent inability to resolve this paradox led to her retreating from session. This was first apparent during the assessment process (*see A5*) when Lori used her sprained ankle as a reason not to come to session. It was evident when she missed her fifth therapy session and thereafter requested that therapy be halted for six weeks. Towards the fourth therapy session, Lori had become increasingly aware of her unconscious motivations and their influence on her behaviour

(*see T2*) and had started feeling dissatisfied with her role in relationships (*see T4*). She was starting to realise that, for her to lead a fulfilling life, she would need to completely revaluate her pre-existing assumptions and ways of being in the world. However, such a drastic change was very threatening and so she retreated from therapy. Lori felt compelled to come for one last session (*see* T5) and due to the resolution of her PTSD symptoms, she decided to discontinue treatment. Despite Lori's recovery from PTSD, her unresolved attachment status and the related "disconnection between [her] outward behaviour and cognitions on the one side, and [her] interpersonal needs and feelings on the other" (Liotti, 1999, p. 308) would continue to make "any adaptive cognitive regulation of impulses and emotions, and satisfactory engagement in relationships" extremely challenging (Liotti, 1999, p. 308).

THE CASE SERIES: COMPARATIVE SUMMATIVE PICTURE

The case studies that formed the basis of this research project have been comprehensively described and a comparative summative picture of the seven cases is provided below. In the subsequent section, the results of cross-comparisons are presented. A cross-case comparison of the distinct aspects of the DFSA case series is first presented and subsequently contrasted with the most current literature available on the treatment of this population group. Following this, the results of the cross-case comparison of all seven cases is provided and the client-related and contextual aspects influencing treatment delivery and outcome are comprehensively described.

Table 2: The case series - Comparative summative picture

Client	Age	Type of trauma	Time since most recent trauma	Diagnoses	PD	No. Assessment sessions	No. Treatment Sessions	Treatment status at termination	Initial Self-reports			Final Self-reports		
									PDS	BDI	BAI	PDS	BDI	BAI
Zinhle	19	Single incident	9 years	PTSD; MDD (SE, moderate)	None	4	5	Complete	24	17	21	0	0	0
Lulama	16	Single incident	5 months	PTSD; MDD (SE)	None	5	6	Incomplete	N/A	N/A	N/A	N/A	N/A	N/A
Khuselwa	17	Multiple incident	3 months	PTSD; Dysthymic Disorder	BPC	8	12	Incomplete	26	28	15	15	40	?
Sanele	23	Multiple incident	7 months	PTSD; MDD (R); Substance abuse	BPD	10	7	Incomplete	N/A	N/A	N/A	N/A	N/A	N/A
Anna	43	Single incident	25 years	PTSD; MDD (R); social phobia	APD	11	33	Complete	30	20	33	5	6	5
Emmy	21	Single incident	1 year	PTSD; MDD (SE)	None	5	9	Complete	29	18	14	3	3	2
Lori	21	Single incident	5 months	PTSD; MDD (R)	BPC	7	4	Complete	38	33	32	5	5	9

DATA INTERPRETATION

CHAPTER 6: THE DFSA CASE SERIES

6.1. IMPLICATIONS FOR ASSESSMENT AND TREATMENT

This section focuses on supporting and expanding the existing knowledge base on the treatment of DFSA using the Ehlers and Clark (2000) model. Gauntlett-Gilbert et al. (2004) provide the most recent literature available on the psychological impact of DFSA and the clinical implications of treating this population group using cognitive treatment approaches. In their clinical work these authors have relied on the Ehlers and Clark (2000) cognitive model to guide treatment and have found the model to be particularly useful in addressing the psychological sequelae associated with DFSA. They delineate three issues that are salient to this population group and that have implications for treatment. These include memory disturbances, issues of safety and security and the effects of the responses of significant others. The relevance of these issues to the three cases of DFSA that form part of the case series are discussed below and the utility of the treatment model in addressing these factors are also described.

6.1.1. MEMORY DISTURBANCES

The memory disturbances encountered in DFSA are amnesia and symptoms of intrusive re-experiencing and are discussed separately below.

(i) Amnesia

Amnesia in DFSA is characterised by a partial or complete absence of memory for events leading up to the trauma and for the trauma itself. Although this memory disturbance is highly prevalent among victims of drug facilitated assaults, this reaction is not distinct to DFSA. Instead, it is also encountered among victims of non-drug facilitated sexual assaults (Bletzer & Koss, 2006) and following exposure to a variety of other traumatic events. This includes motor vehicle accidents (Creamer, O' Donnell, & Pattison, 2004; Bryant & Harvey, 1999; Mayou, Black, & Bryant, 2000), combat related trauma (Brown, van der Hart, & Graafland, 1999) and concentration camp experiences (Merckelbach, Dekkers, Wessel, & Roefs, 2003). For the purposes of this section, the focus will be on memory disturbances related to sexual trauma.

Amnesia in cases of non-drug facilitated sexual assaults is particularly prevalent among adult survivors of childhood sexual abuse (CSA) (Draucker & Martsoff, 2006; Sanderson, 2006). The causal factors underlying amnesia in these cases, as in other non-drug related sexual assaults, are argued to be the result of dissociation (Terr, 1994; Van der Hart & Nijenhuis, 2001), repression (Loftus, Polonsky, & Thompson-Fullilove, 1994; McNally, Clancy, Barrett, & Parker, 2004; Barnier, Levin, & Maher, 2004) and emotional numbing which impedes the elaboration of the trauma memory and results in more fragmented recall (Mechanic, Resick, & Griffin, 1998). Despite the presence of amnesia in victims of non-drug related sexual assaults, in DFSA this memory disturbance is distinct for two reasons. Firstly, unlike in non-DFSA cases, amnesia is deliberately induced by the perpetrator through the administration of an illicit drug that renders the victim unconscious. It is not the result of psychological mechanisms. Secondly, due to the effects of the drug, the memory disturbance in DFSA is markedly more pronounced than that experienced following a non-DFSA. In a non-DFSA, the victim is fully conscious for the event and is therefore able to remember what had occurred even if only in a fragmented manner. In contrast, a victim of DFSA often has no memory of being sexually assaulted. Often the only reason they suspect having been harmed is because they regained consciousness wearing little or no clothing or because they experienced unexplainable injuries such as discomfort in their vaginal area or bruising on parts of their body (Elliot, 2008; Zorza, 2001).

Lori experienced complete amnesia for the rape itself. She was a college student and had been drugged and raped by a friend in her home after visiting a night club. Upon regaining conscious, she noticed that she was partially clothed and felt marked discomfort in her vaginal area and had bruising on her body. This led to her realising that something untoward had happened to her during the course of that night. Similar accounts to that of Lori's are provided in the literature. Elliot (2008) describes the case of an eighteen year old college student who was drugged and then raped after attending a party. She was found by her friends lying in a room with her clothing markedly dishevelled. After regaining consciousness, the student realised that she experienced marked discomfort in her vaginal area. She was also aware that she had only consumed a small amount of alcohol and these factors led to her suspecting she had been raped.

Emmy and Anna experienced partial amnesia for their rape. However, they still had very little memory as to what exactly transpired during the assault. Emmy, like Lori, was a college student

and had been raped in her home by an acquaintance after attending a party at her local campus. She could recall the events preceding the trauma but had no memory of how she returned home or how the perpetrator came to be in her room. She had one memory of the rape itself which involved an image of the perpetrator raping her and this was reflected in her intrusive memory of the trauma. Upon regaining consciousness, Emmy witnessed the perpetrator discreetly attempting to leave her room. She felt markedly confused and disoriented and then realised that she was completely naked. As with Lori, she experienced some discomfort in her vaginal area and bruising on her body. She had no distinct memory of what exactly occurred that night but her symptoms lead to her realising she had been raped.

Anna had been raped in her hotel room after attending a party at a holiday resort. She was befriended by the perpetrator and could vividly recall the events that had transpired prior to the trauma. However, she had no memory of returning to her room or of how the perpetrator gained access to this room. Anna had one memory of the assault itself which involved an image of the perpetrator raping her and, as with Emmy, it was reflected in her intrusive memory of the rape. After regaining consciousness, Anna experienced severe disorientation, nausea and had marked difficulty with physical mobility. These symptoms, in conjunction with her amnesia, led to her initially feeling extremely confused as to what exactly had happened to her. In the years following the trauma, Anna researched her symptoms and realised that they corresponded to those experienced by a victim of DFSA.

a) The Effects of Amnesia: Confusion, uncertainty and a preoccupation with the trauma memory

Gauntlett-Gilbert et al. (2004) argue that one of the salient effects of amnesia in DFSA is that it results in the victim experiencing a marked sense of confusion and uncertainty surrounding the traumatic event. Once again, this reaction is not unique to DFSA and is frequently encountered by victims of non-DFSA who experience fragmented recall of their trauma (Bletzer & Koss, 2006). However, in DFSA, one of the distinct effects of amnesia-related confusion and uncertainty is that it serves as a significant additional deterrent to disclosure. This occurs for three reasons. Firstly, the victim's marked sense of confusion as to what exactly occurred before and during the traumatic event can lead to their worrying about whether they invited or provoked the assault. Secondly, it can lead to the victim questioning whether their experience can be classified as rape especially since they have no memory of actually being subjected to a sexual assault. Thirdly, it

can result in the victim expecting that others may doubt the validity of their experience or not believe their story (Hall & Moore, 2008; Pechke, Squiller, & Bollen, 1997; Zorza, 2001). According to Gauntlett-Gilbert et al. (2004), another salient effect of amnesia in DFSA is the victim's preoccupation with trying to recall the trauma. This can result in the ruminative replaying of the trauma memory in an attempt to fill in missing information. In non-DFSA, in contrast, rumination is predominantly focused on why the assault happened or how it could have been prevented or alleviated rather than on triggering memories (Ehlers et al., 1999; Michael et al., 2007).

As in the cases described by Gauntlett-Gilbert et al. (2004), Lori's amnesia led to her experiencing marked feelings of confusion and uncertainty as to what had happened to her. This contributed to her initial reluctance to disclose the rape and led to her repeatedly reviewing the trauma memory in an attempt to trigger memories of the rape itself. Her inability to acquire new memories only engendered further distress and frustration. Lori's sense of confusion and uncertainty surrounding the traumatic event featured in her two peri-traumatic appraisals of the trauma. Her first peri-traumatic appraisal ("I don't know what's going on....I want it to stop and I don't know what it is") of the rape reflected her sense of confusion as to what was happening to her during the trauma. Her second appraisal involved her not being able to wake up ("I can't wake up") and not understanding the reason for this. These appraisals were related to her intrusive memory of the rape which took the form of a kinesthetic flashback (*see section (ii)*).

Emmy's partial amnesia for her rape led to a sense of uncertainty and confusion about what had happened to her the night of the trauma. However, it did not lead to her reluctance to disclose the rape. Instead, Emmy's unwillingness to disclose the trauma was related to her need to preserve her positive assumptive world which had been shattered by the trauma. Emmy's sense of confusion and uncertainty, like Lori's, was reflected in her peri-traumatic appraisals ("what's going on, what's going on...I don't know what's going on...what's he doing?") of the rape. These appraisals were related to her visual intrusion of the trauma. Emmy ruminated on the traumatic event. However, in contrast to the experiences of Gauntlett-Gilbert et al. (2004) with their clinical cases, Emmy's rumination was not focused on trying to trigger memories of the rape. Instead, it was similar to that found in cases of non-drug facilitated assault and was focused on how she could have prevented or alleviated the traumatic event.

Anna experienced partial amnesia for the rape and initially felt markedly confused as to what exactly had occurred to her. However, as in Emmy's case, her sense of confusion did not contribute to her unwillingness to disclose the trauma. Instead, her expectation that others would respond negatively and accuse her of having provoked the assault contributed to her reluctance to speak about the rape. Anna did not display a preoccupation with the trauma memory and did not ruminate on the rape.

b) Clinical implications

Gauntlett-Gilbert et al. (2004), drawing on the principles of the Ehlers and Clark (2000) model, advise on the necessity of addressing a victims' negative appraisals of their amnesia to facilitate recovery from DFSA. On the basis of their clinical work, they report that a frequently encountered maladaptive belief that maintains symptoms is the victim's assumption that they need to recall the trauma in order to recover. This assumption did not feature in the case series. Instead, the only problematic appraisal related to amnesia that arose involved the assumption that this reaction was induced by excessive voluntary alcohol consumption rather than due to the effects of having been administered an illicit drug and this fuelled self-blame. A key factor maintaining this negative assumption involved a lack of awareness of DFSA and the effects of the drugs used to perpetrate rape.

Lori had limited knowledge of DFSA and the nature and physiological effects of the drugs used to perpetrate this crime. She had voluntarily consumed alcohol prior to the rape and had accepted drinks from the perpetrator. Lori attributed her amnesia and other physical symptoms to the effects of her having drank too much alcohol and this fed into her self-blame. She believed that she had colluded in the assault by being unconsciousness and not defending herself from the perpetrator. Similarly, Emmy had little knowledge of the effects of DFSA drugs. She had voluntarily consumed alcohol prior to the assault and believed that this was the causal factor underlying her amnesia and other physiological reactions. She assumed that, if she had not been drinking that night, the rape would not have occurred. Anna had not consumed any alcohol prior to her assault. However, she also experienced uncertainty as to the causal factors underlying her amnesia because at the time she had no knowledge of DFSA. It was only through her subsequent research into her symptoms that she was able to conclude that her amnesia and other symptoms were due to the effects of an illicit drug.

The circumstances surrounding Lori's and Emmy's assaults are not uncommon. The majority of DFSA (and a significant portion of non-DFSA) occur against the backdrop of recreational alcohol or other drug use. Hindmarch, ElSohly, Gambles and Salamone (2001), on the basis of their analysis of two-thousand and three urine samples of alleged victims of DFSA, found that alcohol (alone or in combination with other drugs) was present in 67% of the cases. Scott-Ham and Burton (2005) analysed 1014 cases of alleged DFSA and found that in 46% of these cases victims had consumed alcohol (either alone or with an illicit/and or medicinal drug) prior to the assault. Hurley, Parker and Wells (2006) in their study found that in 77% of alleged DFSA cases, the victim had consumed alcohol prior to the assault. Excessive alcohol consumption can cause symptoms similar to those produced by the drugs used to perpetrate DFSA. These include blackouts (i.e. periods in which the individual is unconscious), disorientation, confusion, nausea and difficulties with physical mobility. The effects of DFSA drugs are also enhanced when combined with alcohol. In addition, public awareness surrounding DFSA and the physiological effects of the drugs used to perpetrate this crime is limited. For this reason, victims of DFSA who voluntarily consume alcohol before the assault are more likely to attribute their amnesia and other physical symptoms to the effects of alcohol consumption. This can have the effect of intensifying self-blame in that the victim may believe that they facilitated their rape (Hensley, 2002; Nicoletti, 2009; Romeo, 2004).

Psycho-education surrounding the sequelae associated with trauma forms a central focus of the Ehlers and Clark (2000) model as it helps to normalise symptoms and challenge maladaptive appraisals. Gauntlett-Gilbert et al. (2004) successfully used this approach to challenge the negative appraisals associated with amnesia among victims of DFSA in their clinical work. In the case series, psycho-education surrounding DFSA and the nature and effects of the drugs used to perpetrate rape proved beneficial in helping Lori to realise that her rape had been drug facilitated. Psycho-education was also useful in validating Anna's belief that she was a victim of DFSA. However, as can be seen in Emmy's assessment sessions, psycho-education was not sufficient to target her problematic appraisals. This was because the idea that her rape had been drug facilitated challenged her sense of personal control and belief in the benevolence of other people. As such, in addition to psycho-education, other methods needed to be used to help her relinquish her self-blame. The methods used were drawn from the Ehlers and Clark (2000) cognitive model and can be seen in Emmy's assessment sessions (*see section 5.2.1. (i)*)

The similarities in the physiological reactions associated with excessive alcohol consumption and the symptoms produced by DFSA drugs have implications for clinical assessment. If the victim had been drinking alcohol before the assault, the clinician may assume, like the victim, that symptoms were produced by alcohol intoxication. This can negatively impact the identification of victims of DFSA and the identification and prosecution of perpetrators. For this reason, if sexual abuse has occurred against the backdrop of alcohol consumption and the victim presents with amnesia, the clinician needs to thoroughly assess for DFSA. An awareness of the types of drugs used to perpetrate rape and the physiological symptoms associated with DFSA drugs is an essential first step in being able to identify a victim of this crime. Secondly, closely questioning the victim about their physiological reactions prior to, during and after the rape can provide the clinician with crucial information that can allow them to determine if a rape was drug facilitated. This process can be seen in both Emmy's and Lori's assessment interviews.

(ii) Intrusive re-experiencing

Intrusive re-experiencing is frequently found following exposure to a range of traumatic events and forms part of the clinical picture of PTSD. The phenomenon has been extensively investigated in relation to a wide variety of traumatic events including motor vehicle accidents, sexual assault and among adult survivors of childhood sexual abuse (Ehlers et al., 2002; Hackmann et al., 2004). In all these cases intrusions have been shown to be predominantly visual in nature and correspond to the worst moments of the trauma or the moments signalling that the traumatic event was about to happen or that the meaning of the event was about to become more threatening. However, relatively little is known about the nature and content of intrusive memories in cases of DFSA and whether they differ from those encountered following exposure to non-DFSA. Gauntlett-Gilbert et al. (2004), on the basis of their clinical work, found that intrusions in DFSA were mostly visual in nature and that these intrusions were reflective of the parts of the traumatic event that the victim was able to recall. They also found intrusions characterised by affect without recollection (i.e. emotions and physiological sensations associated with the traumatic event without a memory of the event itself) (Ehlers & Clark, 2000). In the present case series, affect without recollection did not feature but visual intrusions were common. In addition, kinesthetic intrusions were encountered. The content of these intrusive memories was found to be essentially similar to that found following exposure to non-DFSA and other traumatic events. This is further discussed below.

Visual intrusions were prevalent for Emmy and Anna but not for Lori. Emmy experienced one visual intrusion of the rape that involved an image of the perpetrator lying on top of her and raping her. The content of this visual intrusion reflected the moment in which she had momentarily regained consciousness during the assault. Anna experienced two trauma related visual intrusions. One of her visual intrusions was identical to Emmy's in that its content reflected the moment in which she had temporarily regained consciousness during the rape. It involved an image of the perpetrator lying on top of her and raping her. Anna's second visual intrusion involved the moments preceding the traumatic event. She had attended a party prior to her rape and had been accosted by the perpetrator while at this party. Her second intrusion involved an image of this party scene. The visual intrusions in the DFSA case series corresponded to those found by Gauntlett-Gilbert et al. (2004) in that they were reflective of the moments of the trauma for which the victim was conscious and able to recall what had occurred in that moment. Lori had been unconscious for the trauma and therefore experienced no visual intrusions related to the rape.

The content of the visual intrusions in the case series corresponded to those in non-DFSA cases in that they either represented the moment in which the meaning of the event became more threatening or the moments that preceded the traumatic event. Emmy's visual intrusion comprised the moment in which the perpetrator had penetrated her and this had profound implications for her sense of identity as a virgin. Anna's visual intrusion was associated with a sense of helplessness and this was a highly threatening state for her as can be seen in session six to seven in her treatment process. Her second visual intrusion of the party scene reflected the moments preceding the traumatic event and the moment when the meaning of the trauma became more threatening because it served to validate the sense of threat she already associated with social settings. This can be seen in the assessment sessions (*see section 5.1.1. (i)*).

A form of re-experiencing encountered in the case series and that has not been described by Gauntlett-Gilbert et al. (2004) involved kinesthetic intrusions of the traumatic event (i.e. intrusions involving bodily sensations originally experienced at the time of the trauma). Lori experienced one kinesthetic intrusion of the rape that involved a feeling of pressure on her chest that she described as a "heavy weight pressing down" on her. This sensation was accompanied by a feeling of being suffocated and was triggered whenever she lay down on her bed at night.

Emmy also experienced one kinesthetic intrusion. It involved the sensation of her body feeling "limp" and, as with Lori, it was triggered when she lay down on her bed. Intrusions involving bodily sensations are not distinct to DFSA but are commonly reported following exposure to other traumatic events including non-DFSA. In their study Ehlers et al. (2002) found that adult survivors of CSA endorsed experiencing intrusions characterised by bodily sensations. Michael et al. (2004), in a study involving victims of a variety of traumatic events, including sexual assault, also found that intrusions characterised by bodily sensations were commonly experienced. However, relatively little has been written about the prevalence and content of kinesthetic intrusions and whether these intrusions are amenable to the same treatment approach as that prescribed for visual intrusions.

In terms of the case series, the content of the kinesthetic intrusions encountered were similar to that of visual intrusions in that they corresponded to the moment with the greatest emotional impact and were associated with certain negative peri-traumatic appraisals. Lori's kinesthetic intrusion was associated with peri-traumatic appraisals that reflected her sense of absolute confusion as to what was being done to her and her sense of panic as to why she could not wake up. This can be seen in her first therapy session. Similarly, Emmy's kinesthetic intrusion was associated with a profound sense of disgust and contamination associated with the perpetrator penetrating her and compromising her experience of herself as "pure". This can be seen in the fifth therapy session in her treatment process. These intrusions were found to be responsive to the same treatment strategies as those used to target visual intrusions. This is further discussed in the section below.

a) Clinical implications

Gauntlett-Gilbert et al. (2004) have found the Ehlers and Clark (2000) cognitive model to be particularly useful in addressing intrusive re-experiencing following DFSA. In terms of their clinical cases, they have found that exposure can be carried out to trauma memory fragments or other sensory impressions that constitute the victim's emotional 'hotspots'. However, they do not specify the nature of such exposure work (i.e. whether it involves imaginal reliving or, for example, having the victim write out a narrative of the trauma memory). In addition, these authors indicate that victims with complete amnesia for the trauma will not be amenable to exposure due to the absence of a trauma memory. Gauntlett-Gilbert et al. (2004) therefore

advise that, in such cases, alterations in negative appraisals and maladaptive coping strategies are sufficient in targeting problematic reactions. The present case series corroborates certain of these findings.

Imaginal exposure (i.e. imaginal reliving and cognitive restructuring within reliving) was used to target Lori's kinesthetic intrusion. The procedure was applied in the same manner as when targeting visual intrusions and led to the complete resolution of this reaction as can be seen in Lori's first therapy session. Imaginal reliving was also used in Emmy's case to identify the peri-traumatic appraisals maintaining her kinesthetic intrusion. These negative appraisals were subsequently targeted through verbal challenging and imagery rescripting incorporating the use of a healing image. This can be seen in session five of her treatment process. However, these interventions did not completely resolve Emmy's symptoms because the cognitive factors maintaining her intrusion went beyond those related to the trauma itself. They included her negative appraisals of her behaviour in the post-trauma period. Emmy had been sexually intimate with an acquaintance two months after the rape. She believed that she had compromised her moral code and had been disgusted at her behaviour. In addition, she feared having contracted a sexually transmitted disease as a result of her actions. The meanings that she assigned to this incident maintained the sense of current threat associated with her kinesthetic intrusion.

Ehlers and Clark (2000) and Ehlers et al. (2004) as well as other theorists (Hackmann, 2005; Lee, 2006) have pointed out that in certain cases intrusions persist because of the affective links between this memory and other negative life experiences. As such, for symptoms to resolve these links need to be uncovered and their role in maintaining the trauma-related intrusion need to be addressed. In Emmy's case uncovering this link was complicated by her use of suppression as a coping strategy. She had originally coped with the trauma by suppressing her memories of the rape and denying that the trauma had ever occurred to preserve her pre-existing conceptual world. Her decision to be sexually intimate with her acquaintance was indirectly related to the rape as can been in therapy session five. For this reason, she also suppressed this memory to avoid having to face the reality of her victimisation and therefore only vaguely alluded to this incident in the assessment interviews. Its significance in maintaining her intrusion only became apparent when imagery rescripting, aimed at addressing her sense of helplessness during the assault, inadvertently triggered this memory.

The role of avoidant coping strategies (e.g. rumination, distraction, behavioural avoidance, etc) in maintaining intrusive symptoms forms a central component of the Ehlers and Clark (2000) treatment model. Thought suppression in particular has been found to be a highly prevalent avoidant coping strategy following exposure to negative experiences due to its temporary positive effects on mood. However, thought suppression delays recovery because the cognitive costs associated with this strategy compromises the quality of cognitive processing. This occurs because it prevents the individual from evaluating their experience and drawing new meanings from it. For this reason, in cases where the individual displays a tendency to suppress trauma-related material, the clinician needs to be particularly attuned to the role of such suppression in maintaining symptomatic reactions such as intrusive memories (Beever & Scott, 2001; Geraerts & McNally, 2008; Geraerts et al., 2008; Shepherd & Beck, 1999).

Imaginal reliving and cognitive restructuring within reliving successfully resolved Emmy's visual intrusion by updating this trauma memory as can be seen in session four of her treatment process. Anna's intrusive memories required additional interventions not included in the treatment package. Her visual intrusion of the rape had ceased a year after the trauma and had not recurred in the twenty-five years since. However, the sense of helplessness inherent in this intrusion and the secondary appraisals related to this memory remained active. They were initially addressed by encouraging Anna to express her anger at the perpetrator. Guided discovery was also used to help Anna realise that she was not an inherently helpless person. However, as can be seen in session six and seven of her treatment process, these interventions were insufficient to fully resolve her reactions. To target her second visual intrusion involving the image of the party scene, imaginal reliving and 'then versus now' differentiation were repeatedly used. However, this intrusion did not completely resolve. As in Emmy's case, these symptoms persisted due to the thematic and affective links between her appraisals of the trauma and her other negative experiences. For Anna, these negative experiences were from her early childhood. She had been repeatedly subjected to severe neglect as well as verbal, emotional and physical abuse from a very early age and this led to her developing early maladaptive schemas. The meanings she subsequently ascribed to her rape were intrinsically linked to these early experiences and this contributed to the persistence of her symptomatic reactions.

Ehlers and Clark (2000) appreciate that the meanings that individuals ascribe to traumatic events are influenced by their pre-existing beliefs and that these beliefs may need to be modified for more adaptive meanings to be assigned to the traumatic event and for symptoms to resolve. However, they do not claim to comprehensively address the implications of an individual's pre-existing beliefs for treatment. A number of other theorists (Hackmann, 2005; Lee, 2006) have extensively studied the links between an individual's early maladaptive schemas and persistent PTSD. Lee (2006) describes the case of a rape victim who was repeatedly raped at the age of eighteen and sought treatment twenty-two years after her attack. A significant factor in the persistence of her PTSD symptoms was the correspondence between the meanings she ascribed to the rape and her fundamental core beliefs that she was unworthy and unacceptable. Lee (2006) has pointed out that, because negative core beliefs form the individual's dominant mode of thinking, they will not be able to access or arrive at a different or more balanced meaning for their intrusions apart from that which is congruent with their underlying schemas. For this reason, negative core beliefs need to first be addressed before intrusions can be resolved.

In Anna's case, schema-focused therapy was integrated into her treatment process to address her early maladaptive schemas as can be seen in therapy sessions nineteen to thirty-two. Imagery rescripting was used to transform the memories that supported her schemas. The same theoretical principles underlying imagery rescripting in the Ehlers and Clark (2000) model apply when using this technique to rescript early memories that support schemas. Rescripting Anna's early memories allowed her to derive new meanings from her negative childhood experiences. She was able to express emotions that she had found threatening and have her feelings acknowledged and appropriately responded to. In addition, imagery rescripting served to empower her. Furthermore, it challenged the sense of threat she originally associated with social settings and that had subsequently been reinforced by the rape and maintained her intrusive memory. This has described in the final discussion of her treatment process (*see section 5.1.7.*).

6.1.2. COMPROMISED SENSE OF SAFETY AND SECURITY

Gauntlett-Gilbert et al. (2004) briefly touch on the negative impact of DFSA on a victim's sense of safety and security. They identify two characteristics of DFSA that enhance the victim's experience of vulnerability following the trauma. The first is that DFSA is usually perpetrated by someone known to the victim and this, in combination with the premeditated nature of the

attack, can lead to the victim feeling gullible and questioning their own judgement. The second is that victims are usually drugged in a familiar location which can result in the victim feeling overly alert in places that they previously regarded as safe. Although these characteristics apply to non-DFSA and lead to enhanced feelings of vulnerability, the degree of premeditation involved in DFSA is a distinctive feature of this crime.

In the case series, enhanced feelings of vulnerability were not the result of the assault having been drug facilitated and premeditated. Instead, they were related to other features of the crime including, as stipulated by Gauntlett-Gilbert et al. (2004), that it was perpetrated by a known assailant and in a familiar location. Lori was raped by a friend whom she had trusted. This led to her questioning her own judgement and ability to accurately gauge the intentions of other people. It fostered self-blame in that she believed she should have been able to "read" the perpetrators intentions given that he had been a friend. Lori was raped in her bedroom after returning home from a visit to a night club. She had regarded her room as her sanctuary but following the trauma, she felt hyper-vigilant and afraid when in her bedroom. She experienced sleep disturbances including difficulty falling asleep and staying asleep and nightmares. She also felt overly alert and anxious when she subsequently visited the same night club. Emmy was raped by an acquaintance in her bedroom. This led to her feeling overly alert and anxious when in her bedroom and contributed to her experiencing difficulties falling and staying asleep. However, the assault did not lead to her viewing herself as gullible or questioning her judgement. Anna was raped by a stranger in her hotel room after attending a party. She also felt overly alert and easily startled after the trauma and had considerable difficulty falling asleep and staying sleep. In addition, she experienced symptoms of hyper-arousal whenever she entered situations reminiscent of that party. However, like Emmy, she did not experience herself as being gullible because of the assault or come to question her own judgement.

In addition to the characteristics identified by Gauntlett-Gilbert et al. (2004), increased feelings of vulnerability in the case series were related to two other factors. The first involved the impact of the rape on the victim's pre-existing beliefs. In terms of the literature, traumatic events either shatter certain positive assumptions about the self, the world and other people or confirm existing negative beliefs (Janoff-Bulman, 1992; Epstein, 1991; Dunmore et al., 1999). This can lead to feelings of vulnerability, powerlessness and helplessness. In Anna's case, the rape

confirmed her pre-existing negative belief that social situations and interpersonal interactions were dangerous and this served to heighten the sense of threat she associated with such settings. In Lori's case, the assault had affirmed her negative assumptions regarding her capacities and the degree to which she could trust other people to care for and protect her. For Emmy, the rape had shattered her assumptions of personal invulnerability and her belief in the benevolence of other people. This led to her feeling insecure, helpless and vulnerable.

The second factor involved in enhancing feelings of vulnerability was not being able to prosecute the perpetrator and ensure that he was removed from the community. Cases of DFSA are particularly difficult to prosecute because of the victim's amnesia for the assault and the time delays involved in reporting. Only one case of DFSA in South Africa resulted in the conviction of the perpetrator. In 2001, a Cape Town judge sentenced a perpetrator to ten years imprisonment after he was proven to have utilised drugs to facilitate a rape. The victim was offered alcohol tainted with an undisclosed chemical substance that subsequently caused her to lose consciousness. She had no memory for the rape itself and only upon waking realised that she had been sexually assaulted. She reported the incident to the authorities within twenty four hours of the trauma. The medical report in conjunction with a psychologist's report proved instrumental in securing the case against the perpetrator (Ellis, 2001). The inability to prosecute the perpetrator can lead to the victim feeling insecure, vulnerable, powerless and helpless. Lori had consulted with an attorney and was informed that the time delay in reporting in conjunction with her amnesia for the assault would limit the chances of her being able to successfully prosecute the rapist. As such, she believed that there were no legal recourses available to her. This enhanced her feelings of vulnerability and her sense of powerlessness and helplessness. Emmy, in contrast, had legal recourse and this contributed to the restoration of her sense of security. She was a North American citizen and believed the legal options available to her in her home country would ensure that she was able to make the perpetrator accountable for his crime. In Anna's case, the assault had occurred twenty five years previously and the perpetrator had been a stranger. She chose not to seek legal recourse due to the time delay in reporting and the limited likelihood of locating the perpetrator. However, in Anna's case, not being able to take legal action against the perpetrator was not a factor that contributed to her feelings of vulnerability. Instead, the assault itself represented another instance in her life in which she had

been rendered helpless and unable to protect herself and this was a primary factor underlying her sense of vulnerability.

i) Clinical implications

Using the Ehlers and Clark (2000) cognitive model Gauntlett-Gilbert et al. (2004) have found that restoring a DFSA victim's sense of safety involves: challenging maladaptive appraisals of the trauma and its sequelae; rebuilding adaptive meaning structures and; enhancing social support structures. The case series corroborates these findings. Lori's negative belief that she should have been able to "read" the perpetrators intentions was challenged by enhancing her social support base. The support she received from her friends led to the disconfirmation of this belief as can be seen in the discussion of the assessment phase (*see section 5.3.1. (i)*). In Emmy's case, rebuilding her assumptive world proved beneficial in challenging her feelings of vulnerability. She was able to view the rape as a distinct incident that did not have global negative implications for her capabilities and future. This can be seen in the discussion of the assessment phase (*see section 5.2.1. (i)*).

According to Ehlers and Clark (2000), symptoms of hyper-arousal can be addressed by facilitating the processing of the trauma memory, identifying and neutralising triggers and reducing safety behaviours. These techniques were found to be useful in reducing symptoms of hyper-arousal following DFSA. Lori could not identify any triggers in her room but by processing her kinesthetic intrusion, rescripting her nightmares and reducing her safety behaviours, it was possible to significantly reduce the sense of threat she associated with being in her room. Lori relocated to a different house after temporarily discontinuing therapy and her residual symptoms resolved following this relocation. However, had she remained in the house, her symptoms of hyper-arousal would have been targeted by extensively investigating the presence of possible triggers and determining whether the trauma memory required further processing. To enhance the sense of safety associated with remaining in the house in which the rape occurred, pragmatic considerations need to be included as a focus of treatment. These include, for example, investigating the security features within the home (e.g. locks on doors, presence of an alarm system, burglar bars on windows, etc) and advising the victim on the necessity of ensuring that their home is secure from intruders.

Emmy's symptoms of hyper-arousal were addressed by identifying triggers in her room. She was repeatedly guided to visualise returning to the house in which the rape had occurred to facilitate habituation to this setting as can be seen in the second therapy session. This was effective in reducing the sense of threat associated with returning to the site of the trauma. Processing the trauma memory further resolved her symptoms of hyper-arousal. In Anna's case, addressing the sense of threat she associated with social settings and interpersonal interactions first required challenging the early maladaptive schemas that supported these beliefs. Schema-focused therapy (Young et al., 2001) was integrated into the treatment protocol to achieve this. Anna was then able to appreciate that although social situations had been dangerous to her as a child and adolescent, this was not the case for her any longer. She was then able to participate in social activities without feeling threatened.

Challenging avoidance by encouraging the victim to resume activities that they had given up as a result of the trauma is an integral part of the Ehlers and Clark (2000) model and can serve as a means of empowering the victim. Lori was encouraged to resume participating in physical activities as a means of reclaiming her sense of physical agency. She found the suggestion that she use a punching a bag and visualise punching the perpetrator particularly helpful as a means of re-empowering her. Lori's sense of helplessness in relation to the rape was addressed by helping her to more extensively investigate her legal options. This led to the discovery that, irrespective of the time delay in reporting the rape, she would still be able to submit an affidavit to the authorities detailing the crime. The affidavit would serve as evidence in the event that the perpetrator committed a similar offence. Lori found this empowering and believed that it offered her closure.

6.1.3. RESPONSES OF OTHERS

Social support has consistently been shown to be a significant protective factor in facilitating recovery from traumatic events and Gauntlett-Gilbert et al. (2004) emphasise the significance of such support in helping DFSA victims to resume their normal life patterns. On the basis of their cases, these authors have found that two factors can impede a victim of DFSA from receiving social support. The first is that DFSA does not bear any similarities to stereotypical notions of rape. This can lead to the victim questioning whether their experience constitutes a sexual assault and this can inhibit disclosure. In addition, it can result in significant others disbelieving

the victim when they do disclose the rape. Secondly, because DFSA predominantly occurs against the backdrop of alcohol consumption, the victim can hold themselves responsible for the assault and this can prevent disclosure. Significant others may blame the victim for the rape if they had voluntarily consumed alcohol or recreational drugs prior to the trauma. A number of other researchers (Hall & Moore, 2008; Hensley, 2002; Zorza, 2001) have implicated the victim's amnesia and related sense of confusion for the assault as another factor contributing to non-disclosure. The present case series corroborates some of the above mentioned findings. Amnesia and self-blame were found to influence the decision to disclose the trauma. An additional factor influencing disclosure involved the victim's pre-existing beliefs. These aspects are further discussed below.

Lori kept the rape a secret for five months before disclosing the trauma to her step-father. Her social support base comprised her parents (mother and step-father), her boyfriend, her brother and a few close friends. Lori's initial reluctance to disclose the rape was related to her complete amnesia for the assault and her sense of confusion as to what exactly had transpired and to her self-blame. She believed she had colluded in the assault by consuming alcohol and expected that significant others would share this belief and blame her for the trauma. Following her disclosure, Lori received support from her parents. However, she was still reluctant to share her needs and feelings in relation to the trauma with anyone. She continued to keep the rape a secret from her boyfriend and close friends. Her continued reluctance to disclose the rape was the result of her self-blame and her maladaptive schemas. These schemas led to her expecting that others would not be able to provide her with the care and support that she needed and would abandon her.

Emmy kept her trauma a secret for close to a year before she disclosed the rape to her boyfriend. She was a North American citizen and had relocated to South Africa two months after the trauma. Emmy's social support base in her home country consisted of her parents, her three siblings and her best friend. In South Africa, her social support system comprised her boyfriend and a few close friends. Emmy's initial reluctance to disclose the rape was related to her partial amnesia and associated uncertainty as to what had occurred the night of the trauma. Although Emmy, like Lori, believed that she had facilitated her victimisation by drinking alcohol, her self-blame did not serve as a barrier to her reporting. Instead, her non-disclosure was motivated by her need to preserve her pre-existing conceptual world and sense of personal control.

Anna had kept her rape a secret for twenty-five years. At the time of the assault her social support base consisted of her mother, father and brother. Although Anna experienced partial amnesia for the assault, unlike Lori and Emmy, this did not serve as a deterrent to her disclosing the rape. Instead, her non-disclosure was related to the influence of her early maladaptive schemas. Anna was subjected to severe neglect and emotional and physical abuse at the hands of her early caregivers and this led to her developing certain negative core beliefs including the expectation that others would not respond to her with care or empathy. She also expected that her significant others would accuse her of having provoked the assault. For these reasons, she refrained from disclosing the rape.

i) Clinical implications

Using the Ehlers and Clark model (2000), Gauntlett-Gilbert et al. (2004) have found that challenging maladaptive beliefs can serve to promote disclosure in cases of DFSA and enhance access to social support. In the case series, this approach was found to be beneficial. Verbal cognitive restructuring proved useful in tentatively addressing Lori's negative expectations regarding the outcome of disclosure and prompted her to disclose the trauma to her boyfriend and close friends. This can be seen in the assessment process (*see section 5.3.1. (i)*). The support she received proved beneficial in challenging her self-blame and social isolation.

Emmy had considerable social support from her boyfriend and felt able to share her needs and feelings with him. As such, interventions aimed at enhancing her social support base mostly focused on helping her to prepare for her disclosure to her family as can be seen in her first two therapy sessions. Emmy expected that her family would respond positively to her disclosure and this motivated her to share the trauma with them. For Anna, the likelihood of her receiving negative response from her family was a definite reality. Her mother displayed narcissistic traits and had consistently verbally and emotionally abused her since childhood. Her father was a distant figure in her life and predominantly responded to her with indifference. Anna also had a distant relationship with her sibling and, because she had recently relocated, she had not made any close friends in her new home town. As a result, it was necessary to help Anna establish new relationships in which she could be genuine and share her needs and feelings. This was achieved by targeting the maladaptive schemas that kept her socially isolated. At the conclusion of Anna's

treatment process, she had begun to take the first steps towards establishing meaningful connections with others.

CONCLUSION

Gauntlett-Gilbert et al. (2004), on the basis of their clinical cases, identified three aspects that were salient in the treatment of victims of DFSA namely: memory disturbances; issues of safety and security and; the effects of the responses of significant others. The case series corroborated and expanded on these findings. According to Gauntlett-Gilbert et al. (2004), one of the salient effects of amnesia is a preoccupation with the trauma memory and ruminative replaying to fill in gaps in the exiting memory. The case series revealed that ruminate replaying, as in non-DFSA cases, can be focused on how the trauma could have been alleviated or prevented. Gauntlett-Gilbert et al. (2004) identified a specific maladaptive belief associated with the presence of amnesia that hinders recovery, namely the victim's assumption that they need to remember the trauma in order to recover. This appraisal was not present in the case series. Instead, a negative assumption that was significant involved the belief that amnesia was produced by excessive alcohol consumption which fuelled self-blame. A primary factor generating this assumption involved a lack of knowledge surrounding DFSA and the effects of the drugs used to perpetrate this crime. The similarities in the physiological reactions associated with excessive alcohol consumption and the symptoms produced by DFSA drugs can lead to the clinician attributing amnesia to alcohol intoxication. For this reason, when amnesia is present, the clinician needs to thoroughly assess for DFSA.

Gauntlett-Gilbert et al. (2004) found that intrusive memories in DFSA were mostly of a visual nature and reflected the features of the trauma that the victim could not remember and the case series corroborated these findings. However, the case series also revealed that intrusions in DFSA can be kinesthetic in nature and that these memories, like visual intrusions, represent the moments immediately preceding the trauma or during which the meaning of the trauma became more threatening. Kinesthetic intrusions were associated with certain peri-traumatic appraisals and these symptoms were amenable to interventions used to address visual intrusions. Furthermore, the case series found that the intrusions in DFSA, as in other traumatic events, persist due to thematic and affective links to other negative experiences. As a result, for these

symptoms to resolve, these links needed to be broken and additional interventions could be incorporated into the treatment protocol to achieve this.

On the basis of their clinical cases, Gauntlett-Gilbert et al. (2004) established that victims of DFSA were reluctant to disclose their trauma because of: the lack of resemblance to stereotypical notions of rape and; fears that others may blame them if they consumed alcohol before the assault. In the case series, certain additional features were found to influence non-disclosure. These included the presence of pre-existing negative core beliefs regarding the trustworthiness of others and the likelihood of receiving supportive responses. A further factor inhibiting disclosure was the need to preserve pre-existing positive assumptions about the world, other people and the self and to retain a sense of personal control.

A critical issue in DFSA, especially in the South African context, is the limited likelihood of prosecuting the perpetrator due to the presence of amnesia for the rape. For this reason, alternative avenues of empowering the client need to be a focus of treatment. From the case series, it was determined that one of the options available to victims of DFSA is submitting an affidavit to the police detailing the crime as this can serve as a means of helping the victim to reclaim their sense of agency

CHAPTER 7: INTERPRETION OF THE CASE SERIES

7.1. TREATING RAPE-RELATED PTSD IN THE SOUTH AFRICAN CONTEXT: OBSTACLES TO TREATMENT DELIVERY AND IMPLEMENTATION

This research project aimed to evaluate the efficacy and transportability of the Ehlers and Clark (2000) cognitive model in the treatment of rape-related PTSD in the South African context. In this chapter, the specific client-related personal aspects, client-related contextual factors and state level factors that impeded treatment delivery and implementation are comprehensively discussed. Identifying obstacles to treatment can sensitize clinicians to these issues and assist in developing strategies to maximize client retention and enhance the overall effectiveness of psychotherapy (Lambert & Ogles, 2004; Ogrodniczuk, Piper, & Joyce, 2004) for rape-related PTSD.

7.1.1. CLIENT-RELATED PERSONAL ASPECTS

Four client-related personal factors were found to influence treatment delivery and outcome and these include: the nature of PTSD symptomology (i.e. simple or complex PTSD); the presence of comorbid Axis II personality disorder; client motivation and; language barriers (which are discussed within the context of culture and ethnicity). These client-related personal factors do not operate in isolation but instead coalesce to influence treatment outcome.

(i) Simple and Complex PTSD

Simple PTSD develops in response to discrete, single episode traumatic events and corresponds to PTSD as defined by the DSM-IV-TR (APA, 2000). Five clients in the case series (Anna, Emmy, Lori, Lulama and Zinhle) presented with simple PTSD. Anna, Lori and Emmy were exposed to a single episode of DFSA. Lulama was raped on two separate occasions during the course of a single night and one of these traumas constituted a gang rape while Zinhle was raped on one occasion in childhood. In contrast to simple PTSD, complex PTSD arises from exposure to chronic, repeated relational trauma (*see section 1.3.3.*). Two clients in the case series presented with complex PTSD namely, Khuselwa and Sanele. The presence of this condition and the associated deficits in affect regulation, interpersonal relatedness and systems of meaning served as significant obstacles to their ability to engage with treatment.

a) Disorganised attachment as an antecedent to complex PTSD

Disorganised attachment relationships in infancy are argued to be the first step in the developmental trajectories of individuals who subsequently develop complex trauma reactions (*see section 1.3.3.)*. The case series offers support for this finding.

Khuselwa and Sanele were both raised in environments in which their primary caregivers severely abused alcohol and this impaired their capacity to form a secure attachment relationship. Alcohol abuse has consistently been shown to be associated with severe parental deficits and unpredictable family lifestyles. Alcohol abusing mothers tend to display lower rates of responsiveness to their infants' cues and are prone to impulsivity and unresponsiveness to their infants' needs. They engage in violent, irrational and self-indulgent behaviour and suffer from depression, irritability and angry outburst. These aspects have negative implications for their capacity to provide practical care (e.g. feeding, clothing, etc) and emotional support. In addition, parental deficits arising from alcohol abuse have been found to contribute to the development of attachment difficulties including disorganised attachment patterns because the behaviour of the parent inhibits the child from learning coherent strategies to regulate distress (Eiden, Edwards, & Leonard, 2002; Lyons-Ruth, Repacholi, McLeod, & Silva, 1991; Magura & Laudet, 1996; Smith, Johnson, Pears, Fisher, & DeGarmo, 2007).

Khuselwa was raised solely by her mother following the divorce of her parents when she was two years old. Her mother experienced severe problems with alcohol abuse and she regularly left Khuselwa at home alone and unsupervised for extended periods of time. She only offered her some care when she was present. Her unreliability and unpredictable behaviour when inebriated generated significant anxiety for Khuselwa and she felt afraid to approach her mother when distressed. Sanele's history was markedly similar to Khuselwa's. Her father passed away when she was two months old and she was raised solely by her mother who severely abused alcohol. When Sanele was a young child, her mother often took her with when she visited shebeens so that she would not be left home alone. As a child, Sanele experienced her mother as both a frightening and helpless figure and felt ambivalent about approaching her for care and support. She feared for her mother's safety when at the shebeen and tried to protect her by guiding her back home late at night after her drinking sprees. Both Khuselwa's and Sanele's experiences with their primary caregivers led to their developing a disorganised style of attachment that set the

foundation for problems with affect regulation and interpersonal relatedness that would later be reinforced and consolidated by exposure to repeated trauma.

b) Repeated interpersonal trauma and complex PTSD: Obstacles to treatment engagement

The interpersonal trauma most significantly associated with the development of complex PTSD in women is repeated exposure to childhood sexual abuse (Cloitre et al., 2006; Dorahy et al., 2009; Zlotnick et al., 1996) beginning before the age of thirteen (McLean & Gallop, 2003) and this finding was supported by the case series. Khuselwa was raped on five separate occasions between the ages of twelve and seventeen by five different perpetrators including her mother's boyfriend, her own boyfriend, a neighbour and two acquaintances. Her most recent trauma involved being kidnapped and held captive for a month and repeatedly raped by an acquaintance.

As a result of exposure to repeated interpersonal trauma, Khuselwa experienced severe problems with affect regulation that manifested in alexythymia (*see A6*), suicidal ideation (*see A2)*, suicidal behaviour, dissociation (*see T3*) and deficits in interpersonal relatedness. These features compromised her ability to engage with and tolerate treatment. Khuselwa's alexythymia was reflected in her self-reports that she did not know what she was feeling (*see* A8) and in her limited emotional vocabulary. She often used the terms "not good" (*see A6*) to label and to describe her negative emotional states. Khuselwa's difficulties with interpersonal relating was evident in her self-reports that "she did not trust anyone not even" her mother (*see A6*) and in her absence of close friendships since childhood and in her behaviour in session. She sought proximity and care by coming for her appointments but, while in the therapy room, she would avert her gaze from me, burry her head in her lap or turn to face away from me. Furthermore, she remained unresponsive and withdrawn for extended periods of time while in session and it was extremely challenging to draw her out of her silence. She frequently responded to me with only cursory or monosyllabic replies. Her approach-avoidant tendencies were further evident in her behaviour at the end of our sessions. She would inform me that she could not make the next session but, once I responded with concern or by affirming that I would see her for the next appointment, she would immediately retract the statement and announce that she would see me soon. In support of the literature on complex PTSD, there were fundamental changes in Khuselwa's perception of self including the assumption that she had been permanently damaged.

She believed that she had been made "bad" by the first trauma because the assault had compromised her virginity and therefore her experience of herself as a good person. This assumption was reinforced by her revictimisation. There were fundamental changes in her systems of meaning in that she believed her future was hopeless and she had no personal control over her life and could do little to change her circumstances. These assumptions prevented her from engaging in self-protective behaviour including reporting her victimisation to the police (*see A3*). It also affected her willingness to engage with therapy because she believed she was not worthy of care and support and assumed she could not rely on or trust others to be consistently available to meet her needs (*see section 4.1.7.*). She withdrew from therapy after twelve sessions.

Sanele had a similar history to Khuselwa. She was repeatedly raped by her mother's boyfriend between the ages of eight and twelve. She was revictimised on two separate occasions in adulthood and one of these assaults comprised a gang rape by four men. Her revictimisation in adulthood was related to the homophobia present in her community and the practice of 'corrective rape'. As with Khuselwa, Sanele had difficulties with affect regulation that manifested in alexythymia, suicidal ideation and suicidal gestures as well as deficits in interpersonal relatedness. These deficits compromised her ability to engage with therapy. Her alexythymia was reflected in her difficulties identifying emotional experiences and her limited emotional vocabulary. She used the terms "not feeling okay" or "not fine" to label and describe her negative emotional states. Unlike Khuselwa, Sanele's difficulties with affect regulation were further reflected in her abuse of alcohol and cannabis and in her tendency to cut herself. She consumed between four and seven one litre bottles of beer on a daily basis to numb her feelings and forget her trauma. She also cut herself with broken pieces of glass to cope with the emotional distress evoked by reminders of the trauma (*see T1-T4*). Sanele's interpersonal difficulties were evident in her mistrust of other people. She refused to confide in her friends and kept information hidden from me such as the recent loss of her romantic partner (i.e. three weeks prior to her entry into therapy) (see *A5*). She threatened to terminate from treatment if I brought in a translator to assist with reliving (*see T1-T4*) and became extremely distressed when I went on leave because she believed I intended to abandon her (see A4). Furthermore, Sanele frequently contacted me outside of session and expected that I would accompany her for her visits to clinics and hospitals. As with Khuselwa, Sanele experienced fundamental changes in her system of meaning and

believed that her situation was hopeless and that she had limited personal control over her life and could not alter her circumstances or achieve her goals (*see section 4.2.1. (i), HIV status*). Her difficulties with affect regulation and interpersonal relatedness affected her ability to engage in self-protective behaviours despite my repeated attempts to encourage her to do so. She continued to consume alcohol excessively even after the gang rape and did not report the trauma to the police. Sanele prematurely terminated from therapy after our eighth session. As with Khuselwa, her termination was directly related to her limited capacity for affect regulation and her interpersonal deficits and related assumption that she was not worthy of support and could not trust others to care for her (*see section 4.2.7.*).

c) Clinical implications

Most cognitive behavioural approaches to the treatment of (simple) PTSD, including the Ehlers and Clark (2000) model, are phase oriented and include a focus on three areas namely: safety and stabilisation; facilitating engagement with active components of treatment and; active treatment which includes addressing triggers, targeting intrusions, correcting appraisals as well as repairing and enlarging social connections (*see section 1.5.*). In treating simple PTSD, there is a tacit assumption that the client will: form a collaborative relationship with the therapist relatively easily; be motivated to engage with the treatment protocol to achieve symptom resolution and; essentially progress relatively quickly from one stage to the next in treatment (van der Kolk, van der Hart, & Burbridge, 2002; Courtois, Ford, & Cloitre, 2009; Young et al., 2003). The case series provides some support for these findings in that two clients with simple PTSD (Zinhle and Emmy) fulfilled these expectations. Zinhle required five therapy sessions to complete treatment while Emmy required six therapy sessions to achieve full symptom resolution. In contrast, Anna, Lori and Lulama found it challenging to form a therapeutic alliance and engage with treatment. Anna's and Lori's difficulties were related to their comorbid characterological problems while for Lulama a dysfunctional family environment and lack of social support served as obstacles to engagement with treatment. Lori and Lulama subsequently withdrew from therapy while Anna was able to engage in a long term therapy programme. In effect, the evidence from the case series indicates that the presence of simple PTSD does not necessarily imply that the client will be able to form a therapeutic alliance easily or comply with the treatment protocol. Instead, various obstacles can impede treatment engagement and these are discussed in the course of this chapter.

For individuals presenting with complex PTSD, treatment follows a similar stage approach but with a significantly greater focus on safety and stabilisation (Briere & Lanktree, 2008; Courtois et al., 2009). In treating complex PTSD, a significant factor impeding the creation of safety is continued exposure to threat in the external environment. Many individuals presenting with complex stress reactions, such as Khuselwa and Sanele, continue to live in adverse social circumstances characterised by poverty, community violence, familial neglect or the presence of those involved in their victimisation. This hinders their capacity to feel safe in therapy and to engage with treatment (Briere & Jordan, 2006). For this reason, Briere and Lanktree (2008) and other researchers (Courtois et al., 2009; Edwards, 2009) have advocated the necessity of the clinician intervening on multiple levels to ensure safety. This includes working with the client's family, social services and the police and seeking residential care for the victim (Briere & Jordon, 2006; Coulter, 2001; Dorahy et al., 2009).

Khuselwa continued to live with her mother in circumstances of severe neglect. This meant that there was no caregiver outside of therapy to protect her or help her regulate her distress. This increased the likelihood of her engaging in maladaptive coping behaviours (e.g. suicidal behaviour). In addition, the perpetrators of her rapes lived within close proximity of her residence. The neighbour involved in her rape continued to live adjacent to her home and the perpetrator of her kidnapping tried to visit her home at times when her mother was absent. This meant that she was constantly faced with threat and had to be in a chronic state of hyper-arousal which impaired her ability to develop skills to regulate her emotions. It also meant that she could possibly be revictimised. For her to feel safe, it was necessary to intervene on a familial level and involve her mother (Nokhanyo) in the treatment process. Nokhanyo needed to undergo treatment for alcohol abuse and required parent training skills to enable her to better support and care for her child. In addition, it was imperative that Khuselwa's revictimisation be reported to the police so that the perpetrators could be removed from her environment. However, implementing these interventions was a significant challenge. Khuselwa adamantly refused to report her revictimisation to police and withdrew completely when I offered to assist with this process (*see A3*). Her behaviour reflected her deep mistrust of other people and her sense of hopelessness that anything could be done to change her circumstances. Furthermore, she would not allow me any contact with her mother and threatened to terminate therapy if I did (*see A4*). Khuselwa's behaviour reflected 'betrayal blindness' (Freyd, 2003 cited in Gobin & Freyd, 2009) in

that, despite suffering severe neglect, she still regarded her mother as her only source of comfort and nurturance and was therefore reluctant to be separated from her. Betrayal blindness has adaptive value in that it maintains needed attachment relationships but it also renders the individual at risk for harm (Gobin & Freyd, 2009). For Khuselwa this meant continuing to live in neglectful circumstances and in the vicinity of the men who raped her. Promoting Khuselwa's physical safety, therefore, first required enhancing her psychological security and her capacity for trust and self-regulation. Then only could interventions be directed at a social and familial level. This was achieved by: consistently validating her needs; respecting her capacities and; acknowledging and apologising for any actions on my part that she experienced as hurtful (*see T3 and T4*). Khuselwa moved into a girls' shelter shortly before out tenth therapy session. At the time, her mother had started consuming alcohol excessively while at home and Khuselwa had become extremely afraid of her behaviour when inebriated. Her decision reflected an increase in her capacity to recognise threats to her safety and to engage in self-protective behaviour. Despite this positive shift, Khuselwa unexpectedly terminated from therapy after our twelfth session (*see 4.1.7.*). She was still experiencing symptoms of complex PTSD at the time and her capacity for self-protection was still low. In addition, Khuselwa would have to move out of the girls' shelter within six months when she turned eighteen and would have no alternative but to return to her mother and continue to reside in circumstances in which she could be revictimised.

In Sanele's case, the perpetrator of her rape was arrested and subsequently imprisoned after he was discovered to be a serial rapist and murderer. However, the four men involved in perpetrating her gang rape continued to live in her environment and she was reluctant to report the rapes to the police. Her unwillingness to report the trauma was related to her difficulties with emotional coping (i.e. she did not believe she could cope with narrating her story to the police) and her assumption that her situation was hopeless and nothing could be done to help her. Sanele engaged in self-endangering behaviour such as excessively consuming alcohol and visiting the shebeen on her own at night and this was directly related to her deficits in affect regulation (*see section 4.2.7.*). In addition, she lived on her own in a community setting in which homophobia was highly prevalent and the practice of 'corrective rape' (*see section 1.2.2. (i)*) was common. As such, it was imperative for her to relocate to a safer neighbourhood. However, finding alternative accommodation was challenging owing to her low socio-economic status (she earned R500 a month) and the absence of a women's shelter in the town. Furthermore, Sanele

had few social supports. Her mother (Siboniso) resided in a different town some two hundred kilometres away. She still abused alcohol and lived with the man who had repeatedly raped Sanele in childhood.

Necessity of Closed Residential Care

The severe absence of safety and support in Khuselwa's and Sanele's social environments in conjunction with their limited capacity for self-protection placed them at severe risk for revictimisation. For Khuselwa and Sanele to be able to engage in and benefit from treatment, they needed to be placed in a closed residential treatment programme. These programmes generally involve intensive, multi-disciplinary treatment and have a number of benefits for individuals suffering from complex PTSD (Chiesa, Drahorad, & Longo, 2000; Coulter, 2001; Lovelle, 2008; Rivard et al., 2003; Rivard et al., 2004). Firstly, residential care facilities offer a safe, structured and predictable environment. People with complex PTSD often alternate between a state of hyper-arousal and emotional numbing and this inhibits their capacity to be aware of alternative emotional states. Being in a safe and predictable setting can provide them with the necessary security to begin experiencing feeling states including joy, happiness and curiosity. This, in turn, can enhance their willingness to engage with rather than avoid emotions. Secondly, residential care can ensure that patients are protected from both external threats such as exposure to perpetrators and self-endangering behaviours. Sanele tended to self-injure and she frequently visited shebeens late at night and these behaviours compromised her safety. Being in a closed residential facility would ensure that her behaviours were monitored and she would be safe from revictimisation. Similarly, Khuselwa would be in a safe setting away from the perpetrators of her rapes and this would allow her greater freedom to explore her memories of the trauma without being overwhelmed by trauma-related reminders in her environment

In South Africa, there is an absence of closed residential care facilities for traumatised populations at the state level with the majority of residential care programmes dedicated to alcohol and drug abuse. This presents a significant obstacle for the treatment of patients presenting with complex PTSD who live in unsafe environments and are at risk for revictimisation. Closed residential programmes for complex PTSD have been created in other countries and have reported promising results. Busuttil (2005) describes the development and implementation of a 90-day residential programme for the treatment of complex PTSD in a

hospital setting in East Sussex, England. Patients included both male and female victims of multiple traumas. They were admitted and discharged on set dates and the programme was conducted for eight hours every week day (from 9am to 5pm) with patients being allowed to choose their leisure activities during free times. The programme was divided into three thirty-day phases with each phase essentially corresponding to the stages in the treatment of simple PTSD (e.g. safety and stabilisation, active treatment and preparing for termination) but with significantly greater time spent on each area. In addition, group work was incorporated in the first phase which involved interactive psycho-education. Furthermore, clients were required to keep diaries which were reviewed by the treatment team on a daily basis. Participants in the study showed declines in symptoms of PTSD and self-harming behaviour as well as improvements in eating disorders and obsessive compulsive disorders by the end of treatment.

A similar 90-day programme would be ideal for clients such as Khuselwa and Sanele. Concomitant to individual psychotherapy, the treatment programme could be expanded to include other treatment modalities such as group and family therapy. Group therapy can be particularly useful in fostering the development of interpersonal skills and problem solving skills. It can also enhance a sense of interpersonal safety and self-esteem and address feelings of isolation and alienation that are typical to those with complex trauma. Farrell et al. (2009) used a schema-focused approach to group psychotherapy with patients with borderline personality disorder. These patients display considerable interpersonal problems that resemble those experienced by those with complex PTSD. The latter authors found group therapy to be particularly effective in promoting a sense of universality (Yalom & Leszcz, 2005). Patients came to realise that they were not alone in their problems and felt a sense of belonging and acceptance. Briere and Lanktree (2008) have provided guidelines for the use of group therapy when working with adolescents suffering from complex trauma and these guidelines can be expanded for work with adults. These authors advise that groups should be matched in terms of affect regulation skills so that the traumatic disclosure of one member does not emotionally overwhelm the capacities of other members. They also advise that it is helpful for groups to be comprised of members with similar experiences (e.g. specific trauma histories or those with specific stressors) as this can enhance feelings of safety. Sanele might benefit from being in a group comprised of members who identify themselves as homosexual or who have substance abuse problems. Similarly, Khuselwa might benefit from being in a group consisting of adolescents diagnosed with HIV or AIDS. Family

therapy sessions can be included to improve communication, resolve conflicts and ensure that family members are able to provide adequate care and support. In certain cases, primary caregivers might require a separate referral. Khuselwa's mother would need to be referred to an alcohol abuse programme for her to be able to care for and protect her daughter. She would require parent training skills to enable her to be attuned and responsive to her daughters needs and to help her protect Khuselwa from abuse. Sanele could benefit from having her primary caregiver involved in her therapy process. This would ensure that her mother was made aware of her childhood sexual abuse and the role of her partner in perpetuating the trauma. Sanele's mother would also require a separate referral to cope with this situation and to address her alcohol abuse (Briere & Lanktree, 2008; Lovelle, 2008; Rivard et al., 2003).

In the absence of safety in the larger environment, individuals with complex PTSD, like Khuselwa and Sanele, are merely at risk of further victimisation. They do not posses the internal resources or capacities for self-protection and are easy targets for perpetrators. For them to recover from complex trauma and develop the skills necessary for self-protection, they need to first be removed from their physical environments and housed in a safe and secure setting.

(ii) Comorbid Axis-II Disorders

Four clients in the case series showed signs of character pathology and these features inhibited their capacity to engage with treatment. Sanele met diagnostic criteria for borderline personality disorder (BPD) while Lori and Khuselwa showed significant borderline personality characteristics (BPC) but did not meet the full criteria for BPD. Anna met diagnostic criteria for avoidant personality disorder (APD).

a) Borderline Personality Disorder (BPD)

The constructs of PTSD and BPD "are grounded independently in well-articulated theoretical and empirical frameworks" (Zlotnick, Franklin, & Zimmerman, 2002, p. 1940). However, the significant comorbidity of BPD with PTSD (e.g. 24% in Pagura et al., in press; 68% in Shea, Zlotnick, & Weisberg, 1999; 76% percent in Southwick, Yehuda, & Giller, 1993) and the finding that both disorders share a common pathogenesis (i.e. trauma - individuals with BPD have consistently been shown to have a history of physical and/or sexual abuse) have lead certain researchers (Herman & van der Kolk, 1987; Herman, 1992b) to argue that BPD might be a

complex variant of PTSD (Golier et al., 2003; Hodges, 2003; Zlotnick et al., 2002). However, this contention has not been sufficiently investigated or supported in the literature. In an earlier study, Zanarini et al. (1998) examined the life time rates of occurrence of a full range of DSM-III-R Axis I disorders in a group of patients with borderline personality disorder and compared this with subjects diagnosed with other personality disorders. They used a sample of five hundred and four patients with personality disorders and concluded that PTSD was a common but not universal comorbid disorder among borderline patients and therefore could not be construed as a variant of PTSD. In a more recent study, Golier et al. (2003) investigated the relationship between BPD and PTSD with respect to the role and timing of trauma exposure. These authors subsequently examined these relationships among other personality disorders to investigate whether associations between trauma and PTSD were unique to BPD. They found that experiences of childhood trauma were prevalent in the lives of individuals with paranoid, narcissistic and passive-aggressive personality disorder. In addition, PTSD was not only encountered among individuals with BPD (25%) but also among those with paranoid (29%), narcissistic (10%) and passive-aggressive personality disorder (12%). On the basis of these findings, Golier et al. (2003) concluded that the association between BPD and PTSD was relatively weak and that BPD cannot be "singled out from other personality disorders as a trauma-spectrum disorder or variant of PTSD" (p. 2023). BPD shares many features with complex PTSD and certain researchers (McLean & Gallop, 2003) have argued that it can be subsumed under this category. However, the intention in doing so is to offer a way of thinking about the condition in terms of case formulation (Herman, 1992b; McLean & Gallop, 2003).

A diagnosis of comorbid BPD has been found to be associated with poorer outcomes in CBT treatment of Axis I disorders including PTSD. Cloitre and Koenen (2001) investigated group CBT outcome for PTSD and found that groups with at least one member with comorbid BPD showed no change in PTSD symptoms and depression and higher rates of anger than groups without members with BPD. In a different study, McDonagh et al. (2005) compared individual CBT to individual present-centred therapy for female victims of CSA and found that all participants with comorbid BPD dropped out of CBT treatment. These latter authors concluded that severe deficits in affect regulation and interpersonal relatedness found among borderline patients can impede their capacity to tolerate intensive CBT interventions. This includes imaginal reliving and cognitive restructuring thus contributing to premature termination. In addition, studies investigating

treatment outcomes for PTSD generally exclude patients with borderline character pathologies thus enhancing the assumption that individuals with BPD cannot benefit from treatment for Axis I conditions. However, certain recent studies (e.g. Linehan et al., 2006; Davidson, 2008) have provided conflicting findings in that individuals with comorbid BPD were shown to benefit from CBT treatment for PTSD. Feeny, Zoellner and Foa (2002) investigated the effects of BPC on treatment outcome among seventy two female victims of sexual and physical assault receiving treatment for chronic PTSD. They found that women with BPC were able to significantly benefit from CBT for PTSD despite greater overall impairment at the end of treatment. Clark, Rizvi and Resick (2008) in another study examined the effects of BPC on one hundred and thirty one rape victims receiving CBT for PTSD. They concluded that women with BPD can benefit significantly from cognitive behavioural therapy for PTSD and that such treatment can positively affect comorbid symptoms. These authors found no evidence that BPC was related to treatment dropout and patients were able to tolerate exposure based interventions. However, both the above mentioned studies excluded women with self-harming behaviours and significant suicide risk and, for this reason, Clark et al. (2008) emphasise that their results might not be generlisable to the treatment of women with more severe borderline characteristics or who meet the full criteria for BPD. In effect, it can be argued that it is the severity of borderline pathology that influences treatment outcome. Individuals with severe BPC (e.g. current self-harming behaviour, impulsivity, suicidal ideation and gestures, substance abuse problems, etc) may find it more difficult to engage with treatment for PTSD. In contrast, those with less severe BPD symptoms may be better able to tolerate such work (Clark, et al., 2008; McDonagh et al., 2005). The case series supports this contention.

Sanele was diagnosed with BPD. She engaged in frantic efforts to avoid any perceived abandonment and tended to either idolise or devalue others. This was evident in her behaviour towards me. She frequently contacted me outside of session to remind me of her presence and ensure that I did not mean to abandon her. She also had problems with impulse control and on one occasion purchased battery acid with the intention of committing suicide after she misperceived by remarks in session to mean that I was abandoning her to another therapist (*see T1-T4*). In addition, she had a negative self image and tended to engage in punitive and self-harming behaviours. This included starving herself as punishment for the rape, engaging in self-mutilation and drinking alcohol excessively at the local shebeen despite knowing that this placed

her at risk for victimisation. The severity of her borderline personality disturbances impeded her capacity to engage in treatment for PTSD.

Lori showed significant BPC but did not meet full criteria for borderline personality disorder. She also did not have a history of repeated sexual abuse. Lori, like Sanele, experienced a fear of being abandoned and to avoid this possibility she engaged in compulsive-caregiving behaviours throughout her life. Lori also had a negative self-image and believed she was simply "not good enough" irrespective of how hard she tried to achieve her goals or care for other people. She experienced suicidal ideation for most of her life and tended to use self-harming behaviours to soothe her distress including cutting and binge-eating. Furthermore, she engaged in impulsive behaviour such as punching walls when she felt angry. Despite her BPC, Lori was able to establish a tentative working relationship with me to recover from the trauma. This was evident in her providing a narrative account of the trauma and engaging with exposure based interventions and cognitive restructuring (*see T1 and T2*). Lori prematurely terminated from therapy (after her fourth therapy session) but at the time of her termination she had achieved significant symptom resolution and only experienced residual symptoms of PTSD and depression. Her withdrawal from therapy was directly linked to her inability to negotiate the role reversal inherent in the therapeutic relationship and the sense of threat associated with having to change a life long pattern (*see section 5.3.7.*).

Khuselwa showed BPC but did not meet the full criteria for a BPD. This was evident in her pleas for attention and help but then refusing any assistance offered. Khuselwa wrote letters to strangers explaining her situation and asking for their help and once they offered help, she refused it. It was also apparent in her alternating between a need for proximity and fearfulness about dependency needs. She often tried to prolong sessions by coming early to therapy or only revealing information at the close of a session. After appointments, she frequently informed me that she would not be able to make the next meeting and fabricated a variety of reasons for this.

b) Avoidant Personality Disorder (APD)

The Cluster C personality disorders, including APD, are the most prevalent personality disorders in the population (Shea et al., 2002; Svartberg, Stiles, & Seltzer, 2004). APD is associated with significant functional impairment and has been found to worsen over time (Alden, 1989;

Seivewright, Tyrer, & Johnston, 2002; Emmelkamp et al., 2006). Despite these features, there are very few published studies investigating the cognitive-behavioural treatment of APD. According to Beck, Freeman, Davis and Associates (2004), most of the published research on the treatment of this disorder using CBT consists of uncontrolled reports and single case studies (e.g. Gradman, Thompson, & Gallagher-Thompson, 1999; Newman, 1999). A number of researchers (Emmelkamp et al., 2006) have attempted to ameliorate the situation but there is still a paucity of controlled trials examining the effectiveness of individual psychotherapy for APD (Svartberg et al., 2004; Leichsenring & Lieberg, 2003).

APD has been found to be a comorbid disorder in individuals diagnosed with PTSD (Keane & Kaloupek, 1997; Southwick et al., 1993) but there are insufficient, if any, studies investigating the treatment of PTSD with comorbid APD thus making the impact of this personality disorder on PTSD treatment unclear (Najavits et al., 2009). On the basis of existing studies of cognitive behaviour treatment for APD, Beck et al. (2004) have identified two potential barriers to working with this group of patients. The first obstacle is the APD patient's deep seated fear of rejection and distrust of others and expectations of being used and controlled in relationships. This can make the formation of a collaborative relationship challenging. The second is their extreme avoidance of unpleasant cognitions and feelings which can contribute to difficulties with treatment adherence. The case series supports and adds to this finding in that these aspects were found to impact on the client's ability to engage with PTSD treatment.

Anna met diagnostic criteria for APD. As encountered in the literature, she believed she could not trust other people to treat her with respect, care, warmth or affection and expected to be criticised, ridiculed or shamed if she established close relationships with others. In addition, she assumed she was unlovable, socially awkward and undesirable in terms of her physical appearance. These assumptions contributed to her unwillingness to openly engage with me in session. This can be seen in her tendency to change the topic, discuss arbitrary issues and tell anecdotal stories to avoid entering into a meaningful discussion of her life experiences. Anna found it extremely threatening to actively engage with the treatment process as can be seen in her reactions to the presentation of the treatment plan in that she immediately changed the topic and started talking about arbitrary issues. After I used direct empathic confrontation to redirect the focus of the interaction, she started crying and tearfully disclosed that she was

threatened by the prospect of having to confront her issues. To address Anna's PTSD, schema therapy needed to be incorporated in the treatment protocol and the reasons for this are revisited in the section below.

c) Clinical implications

According to Beck et al. (2004), many individuals with personality disorders enter treatment to address an Axis I disorder and are not interested in treatment for their Axis II condition. This prompts the question of whether it is possible and feasible to treat an Axis I condition without addressing the Axis II personality disorder. Research on this issue has given rise to conflicting findings. In a review of thirty five studies investigating the impact of personality dysfunction on anxiety disorders, Dreessen and Arntz (1998) concluded that the presence of a personality disorder does not necessarily inhibit effective treatment of an Axis I condition. However, these authors emphasised that certain personality disorders when compared to others are more likely to affect treatment outcome. Their conclusions are supported by other researchers (Beck et al., 2004) and by the findings of the case series.

In the case series, the presence of comorbid BPD or BPC was found to negatively impact treatment outcome for PTSD. Sanele met diagnostic criteria for BPD and was unable to tolerate PTSD treatment and prematurely terminated. Khuselwa showed significant borderline traits and could not complete treatment. Lori displayed BPC but less severe than with Khuselwa and she was better able to engage with treatment for PTSD. However, she too prematurely terminated before complete symptom resolution. This offers tentative support for the finding that, for clients with comorbid BPC or BPD, it may not be possible to treat PTSD in isolation. Anna met diagnostic criteria for APD but in her case it was not possible to single out and treat her PTSD due to the intricate links between this Axis I condition and her personality disorder. For her to achieve complete symptom resolution, her underlying characterological problems needed to be addressed. In effect, the case series reveals that the decision to treat PTSD in isolation in patients with a comorbid personality disorder is partially dependent on the extent to which the personality dysfunction impedes the client's ability to tolerate such treatment. Another determinant, as was evident in Anna's case, is the degree to which there is congruence between symptoms which makes it impossible to treat the Axis I disorder in isolation.

(iii) Client motivation

The client's motivation to engage in therapy has consistently been regarded as a critical factor influencing treatment outcome (Krause, 1967; Derisley & Reynolds, 2000; Drieschner et al., 2004; Dreischner, 2005; Schneider & Klauer, 2001). Drieschner et al. (2004) see treatment engagement as involving certain client behaviours namely: attending session; being open about one's history, problems, needs, concerns and feelings (i.e. self-disclosure); making appropriate use of the therapist's contribution; co-operating both inside and outside of session (e.g. thinking over sessions, trying out new behaviours, avoiding or abstaining from harmful behaviour, completing homework tasks, etc) and making sacrifices (e.g. spending time and money on therapy, enduring the emotional strain of treatment, etc). These authors argue that motivation to engage in treatment is determined by six client-related cognitive and emotional factors namely: level of suffering (which is not only related to symptoms but also to fear of deterioration in various areas of life); outcome expectancy (beliefs about what will happen during or as a result of therapy and a sense of self-efficacy about fulfilling client role behaviours); problem recognition (awareness of the existence of problems); perceived suitability of the treatment (satisfaction with method and rationale for treatment; agreement on goals and perception of the therapeutic relationship – i.e. therapeutic alliance); perceived costs of the treatment (e.g. exposure to unpleasant emotional states, changes in behaviours) and; perceived external pressure (sources of external pressure can be friends, partners or family). In the case series, the first five of these inter-related factors were influential in determining client motivation and as a consequence treatment engagement and outcome. These are discussed below.

Level of suffering

For the majority of participants in the case series, level of suffering did not motivate them to engage with or remain in treatment. In contrast, increased levels of suffering adversely impacted willingness to participate in therapy. This finding is supported by the literature. A number of studies (Chiesa, Wright, & Neeld, 2003; Thormählen et al., 2003) have reported higher drop out rates among clients with more severe diagnosis and more complicated symptom pictures (e.g. Axis II characterological problems) indicating that the level of symptom severity and distress does not imply engagement or retention in session. Sanele experienced considerable distress following her revictimisation which occurred while she was still in treatment but this did not motivate her to continue with the therapy process. Instead, it had the opposite effect and she withdrew.

Similarly, Khuselwa was markedly distressed after having severe flashbacks of the first trauma and she was equally upset after tentatively engaging with reliving in session (*see T9-T11*) but she too prematurely terminated. Lulama was still experiencing flashbacks related to her gang rape at the time of her withdrawal from treatment (*see T4, T6*) while Lori was experiencing distressing symptoms of hyper-arousal and difficulty sleeping at the time of her premature termination. For these clients, the perceived costs associated with continuing in treatment (i.e. further engagement with distressing emotions and experiencing further distress) overshadowed any immediate distress they experienced. This was a critical contributing factor in their withdrawal and these aspects are further considered in the course of this chapter.

<u>Outcome expectancy</u>

Lulama and Sanele had no prior exposure to the profession of psychology and did not know what therapy entailed and had certain negative assumptions about what would happen in session. Khuselwa had some prior exposure to psychology but, as with Sanele and Lulama, she too had negative assumptions about what would occur in session. Sanele, despite my initial attempts to psycho-educate her, did not understand why I could only see her on specific days and for limited periods of time. She also assumed that my role was similar to that of a medical doctor and she would only be seen for a specific number of sessions. In addition, she expected that if I saw no improvement in her functioning, I would tire of her and refer her elsewhere. Lulama assumed that if she were to engage in self-disclosure in session, I would blame her for the trauma, dismiss her needs and feelings and accuse her of being crazy and of fabricating her distress. Khuselwa, like Lulama, believed that I would engage in behaviours that could potentially harm her (e.g. contacting her mother or the police). For these three clients, their negative assumptions as it related to outcome expectancies served as obstacles to their willingness to engage with me in session. In addition, both Sanele and Khuselwa had low self-efficacy in that they assumed they had limited personal control of their lives. These clients believed they had little personal control over their lives and could do little to change their circumstances. These negative assumptions adversely influenced their belief in their capacity to engage with and benefit from treatment and served as barriers to treatment delivery.

Problem recognition

In the case series, certain clients had better problem recognition when compared to others and this influenced their motivation to engage with treatment. Anna was aware that she was experiencing difficulties due to her exposure to DFSA. She also recognised that she suffered from social phobia and this was severely affecting her relationships. Similarly, Emmy was aware that her exposure to DFSA had significantly altered her conceptual world and was adversely affecting her work and relationships. Zinhle recognized that the trauma had negatively impacted her relationships with her family and her capacity to form friendships with men. Similarly, Lulama realised that the trauma affected her relationship with her mother and her peer group and that her symptoms were adversely affecting her ability to concentrate on her school work. For this reason, Lulama was initially willing to participate in session. It was her negative beliefs about what would happen in therapy and the perceived cost of treatment (*discussed below*) that served as the most influential barriers to her continued engagement. In contrast to the above mentioned clients, Lori, Khuselwa and Sanele did not fully recognise or appreciate the difficulties they were experiencing or the need for change in specific areas of their life. In Khuselwa's case, this was evident in her limited capacity to engage with me in the formulation of treatment goals. It was also apparent in her unwillingness to let me contact the police to ensure she was protected from three of perpetrators who had sexually assaulted her and who were still present in her community. Sanele, similarly, did not appreciate that her alcohol abuse represented a significant health problem and her daily visits to the shebeen placed her at risk for revictimisation. In addition, she did not recognise the necessity of her visiting a doctor to attend to her health concerns (e.g. inter-menstrual bleeding). Lori was not aware of the harmful effects of her maladaptive assumptions and problematic patterns of relating. This can be seen in her remarks towards the close of the second therapy session where she reported that she was only gradually becoming more aware of the existence of these difficulties and their adverse effects on her life. Limited problem recognition served as barriers to treatment engagement for these clients.

Perceived costs of treatment

For four clients (Lori, Lulama, Khuselwa and Sanele), the perceived costs of treatment specifically as it related to accessing and experiencing threatening emotions and altering patterns of behaviour served as obstacles to their motivation to engage with therapy. For Lori, therapy

directly conflicted with her usual pattern of relating which involved subjugating her own needs and feelings and compulsive-caregiving. Lori believed that if she shared her needs with others, they would abandon her. For these reasons, it was extremely threatening for her to engage in a relationship in which the roles were reversed in that I provided her with care and support and she did not have to tend to my needs. In addition, her pattern of compulsive-caregiving served the purposes of preventing threatening emotions from coming to the fore. For this reason, the prospect of having to access and experience unpleasant emotional states in therapy was extremely frightening for her. Essentially, for Lori, the cost associated with treatment (i.e. completely transforming an ingrained pattern of beliefs and behaviours) was too high and so she prematurely terminated. Khuselwa and Sanele, like Lori, found it extremely challenging to engage with threatening emotions. This can be seen in Khuselwa's reaction to tentatively engaging with the trauma memory (*see T9-T11)* and in Sanele's reluctance to speak about her experiences of victimisation (*see A1, T5-T6).* In addition, as with Lori, the therapeutic relationship conflicted with both Khuselwa's and Sanele's internal representations of self and others (*see 4.1.7. and 4.2.7.*). For these reasons, the costs associated with treatment were untenable and they both dropped out of therapy. Lulama found it extremely threatening to engage with difficult emotions as can be seen in her emotional avoidance in session. She maintained a cheerful demeanour and often smiled and chuckled in session even when speaking about extremely traumatic events. Lulama expected that she would be overwhelmed if she engaged with her emotions and would not be able to cope. Her avoidance was related to her assumption that if she were to reveal herself, she would be hurt and rejected. These costs of treatment led to her inconsistent attendance at session and to her premature terminating after she tentatively engaged with imaginal reliving of the trauma memory (*see T6*). In contrast to the above mentioned clients, Anna, Emmy and Zinhle were able to accept and tolerate the costs of treatment. This was related to their awareness of their difficulties, ability to tolerate the perceived costs associated with treatment and belief that their problems could be addressed through participation in therapy.

Perceived suitability of treatment (therapeutic alliance)

Finally, perceived suitability of treatment (i.e. agreement on treatment goals; satisfaction with methods and rational for treatment; perception of the therapeutic relationship) influenced motivation to engage with and complete therapy. This factor essentially represents the therapeutic alliance (Drieschner, 2005; Drieschner et al., 2004) and the quality of the alliance has

consistently been found to be a predictor of therapeutic outcome across treatment modalities (Horvath & Bedi, 2002; Martin, Garskye, & Davis, 2000; Puschner, Baur, Horowitz, & Kordy, 2005; Orlinsky, Rønnestad, & Willutzki, 2004; Garcia & Weisz, 2002). The strength of the therapeutic alliance can enhance client motivation since weak alliances have been found to be associated with early drop out from psychotherapy (Drieschner et al., 2004; Kazdin, Whitley, & Marciano, 2005; Robbins et al., 2006). The indicators of a strong therapeutic relationship include the client feeling secure or safe enough to: share experiences, concerns and feelings; work with the therapist in formulating goals and tasks for treatment (e.g. being involved in or making suggestions about goals); respond to therapist requests and; actively participate with the tasks of therapy (e.g. completing homework assignments, engaging with reliving, etc) (Edwards, 2009; Herman, 1992a; Karver et al., 2008; Pearlman & Courtois, 2005).

Lori, Lulama, Khuselwa and Sanele did not form secure bonds and consistent with the literature, these clients prematurely terminated. In Lori's case, the absence of a secure therapeutic bond was evident in her: persistent difficulties with self-disclosure; attempt to avoid coming to session (e.g. she used an ankle injury to do this) (*see A5-A6*); hesitance to engage with reliving (*see T1*); missing her fifth therapy session and contacting me two weeks later to disclose that she wanted to discontinue therapy for another six weeks and; premature termination. In Lulama's case, the absence of a secure bond was evident in her: unwillingness to display her emotions in session (*see A1, A5 and T1*); keeping information secret (e.g. her involvement with an older man) (*see T3*); sporadically attending therapy; reluctance to engage with the active components of treatment and; not returning to therapy for five weeks after tentatively engaging with reliving (*see T6*). Khuselwa's lack of a secure bond was apparent in her: difficulties sharing her experiences in session; not actively collaborating in developing treatment goals; ambivalence about being in session (e.g. she would frequently inform me at the close of sessions that she would not make the next appointment); threats to terminate (*see A4; T3*) when she felt emotionally distressed and; sudden decision to stop coming for treatment (*see T12*). With Sanele, the absence of a strong therapeutic bond was evident in her: emotional distress at my going on leave (*see A4*); keeping information secret (i.e. the death of her girlfriend) (*see* A5); assumption that I intended to abandon her (*see T1-T4*); not collaborating on the tasks of treatment (e.g. continuing to visit shebeens despite the risk to her safety); difficulties speaking about the trauma (*see A1 and T5-T6*) and; reluctance to continue treatment (*see T7-T8*).

In contrast to the above mentioned clients, Anna, Emmy and Zinhle were able to establish secure bonds with the therapist. Anna suffered from avoidant personality disorder and her related uncertainty as to whether she could trust me not to respond to her in a hurtful way initially impeded her from engaging in self-disclosure. However, she persisted in coming to session and in doing so was able to test the validity of her assumptions. She gradually came to trust that I would not respond to her harshly. Her perseverance was related to her awareness that her problems were adversely affecting her life and her resolve to address these issues. She expected therapy to be emotionally challenging as can be seen in her remarks in the first session (*A1*). This awareness helped her to remain in and engage with treatment. Emmy and Zinhle established therapeutic alliances relatively quickly as can be seen in their: willingness to share their experiences; collaboratively work on their goals for therapy and; in their capacity to express any concerns they had about treatment. For example, in the assessment phase, Emmy disclosed that she did not feel emotionally able to tolerate reliving. Her ability to self-disclose indicated that she felt safe in the therapeutic relationship. Similarly, Zinhle disclosed in the first therapy session that she was concerned about feeling emotionally overwhelmed by the trauma memory. Emmy required six therapy sessions to achieve her treatment goals while Zinhle required five and this further reflects their having established secure therapeutic bonds.

<u>Early maladaptive schemas influence the formation of a therapeutic alliance</u>

The capacity to form a therapeutic alliance is determined by the individual's pre-existing internal working models of self and others. The presence of maladaptive schemas and associated difficulties with trust and negative expectations of others predicts poor initial alliance formation and early drop out (Beretta et al., 2005; Eltz, Shirk, & Sarlin, 1995; Hawley & Weisz, 2005; Hoagwood, 2005; Shirk & Karver, 2003; Kanninen, Salo, & Punamäki, 2000; Stubenbort, Greeno, Mannarino, & Cohen, 2002; Young et al., 2003). This finding was supported by the case series. Anna, Lori, Lulama, Khuselwa and Sanele had negative developmental experiences that contributed to the formation of early maladaptive schemas that influenced their capacity to form an alliance.

Anna's early maladaptive schemas involved: emotional deprivation; mistrust/abuse; abandonment/instability; vulnerability to harm and; defectiveness/shame. Her schemas developed as a result of repeated emotional and physical abuse from childhood onwards. As a

child, Anna was repeatedly criticised, ridiculed and belittled by her mother while her father remained distant and uninvolved in her upbringing. Her brother was also physically and emotionally Due to the influence of these schemas, she was extremely wary of social interactions. However, she was able to form a therapeutic alliance and this was partly due to her awareness of her problems. It was also related to her expectation that despite therapy being emotionally taxing, through engagement with the process, she would benefit from treatment and improve her life. This can be seen in her comments in the first assessment session. In addition, Anna, in contrast to the other clients, was not exposed to severe and repeated trauma in childhood or adolescence (e.g. severe physical, sexual abuse or extreme neglect). This tempered her schemas (Young et al., 2003; Courtois et al., 2009) and increased her capacity to form a meaningful relationship.

Lori's early maladaptive schemas involved defectiveness/shame; emotional deprivation; abandonment instability; mistrust/abuse; punitiveness and subjugation. These core beliefs developed in the context of specific childhood traumas including witnessing domestic violence and being abandoned by her father. As a result of these schemas, Lori avoided expressing herself to others and suppressed her needs and feelings. She maintained an overly cheerful, bright demeanour when interacting with other people. She engaged in compulsive-caregiving behaviours and excessively focused on supporting and caring for other people so as to feel needed and valued. She berated herself if she was unable to fulfil her expectation in terms of caregiving. For Lori, the therapeutic relations essentially represented a role reversal and this was markedly threatening and contributed to her termination.

Lulama's early maladaptive schemas involved: abandonment/instability; mistrust/abuse; emotional deprivation and; subjugation and this affected her capacity to form a therapeutic alliance. Her schemas had developed in the context of early experiences of being in an unstable, neglectful and abusive home environment. She was abandoned by her father and step-father and her mother abused alcohol and emotionally and physically abused her. Her grandmother was neglectful and used corporal punishment to control her grandchildren. Lulama's early maladaptive schemas left her feeling unsafe with adult figures. She expected adults to disregard or minimise her needs and concerns and to mistreat her. She assumed that she would be hurt if she failed to meet the expectations of an adult figure. These assumptions were activated in the

context of the therapeutic relationship as was evident in her maintaining a cheerful demeanour in session, as Lori had done, even when speaking about painful events. It was also apparent in her keeping information secret. Her mistrust and negative expectations of adult figures contributed to her forming a weak alliance and prematurely terminating treatment.

Khuselwa's early maladaptive schemas included: defectiveness shame; emotional deprivation; abandonment/instability and; mistrust/abuse (*see section 4.1.3.*). Her schemas developed in the context of her experiences of severe neglect and repeated sexual victimisation. Based on her early experiences of, Khuselwa believed she was deficient and unworthy of care and protection and others could not be relied upon for care and support. These assumptions affected her capacity to bond with the therapist (*see section 4.1.7.*) and influenced her dropping out of therapy.

Sanele's early maladaptive schemas were characterised by: emotional deprivation; abandonment/instability; mistrust/abuse; defectiveness/shame and; punitiveness. She was raised in circumstances of severe neglect and was subjected to repeated sexual trauma. These core beliefs impacted on her ability to form a secure alliance as was apparent in her expectations that she would be abandoned by the therapist (*see A4 and T1-T4*) and her difficulties sharing distressing experiences (*see A5*). Sanele behaved punitively towards herself and this inhibited her from forming a secure bond (*see section 4.2.7.)*

Emmy and Zinhle, in contrast, were raised in intact, supportive, loving and caring family environments. Emmy was raised by her parents and had three siblings. Throughout her life her parents encouraged her to be self-reliant but also instilled in her the belief that she could turn to others when she was distressed. This can be seen in her attitude towards her boyfriend in that she expected that she could turn to him for reassurance and comfort. It was also evident in her willingness to disclose the trauma when she returned home so that she could have additional support structures. In addition, it was apparent in her candidly speaking about her experiences in session with the expectation that she would be guided in the process of recovery. Emmy's parents provided her with a stable and structured home environment and this conferred a sense of responsibility that allowed her to attend to her sessions, notify me if she was not able to keep an appointment and complete treatment.

Zinhle, like Emmy, was raised by her parents and had three siblings. She had a very close relationship with both her mother and father and felt able to turn to them when distressed. As with Emmy, Zinhle's parent's encouraged their children to share their concerns and provided them with guidance, advice and support and served as good role models. This contributed to Zinhle believing she could turn to others when she was troubled and would receive reassurance, guidance and care. This was apparent in her willingness to share her experiences in session and in her expectation that therapy would produce positive results. It was also evident in her willingness to reach out to her family and reconnect with her parents and siblings. In addition, as with Emmy, Zinhle's family was stable and structured and she was provided with regular routines throughout her life. As a result, she too was able to attend to her responsibilities in terms of treatment.

a) Clinical implications

The case series reveals the inter-relationship between various motivational factors and their influence on treatment engagement and outcome. In terms of clinical practice, considering and assessing specific motivational aspects and being attuned to the impact of these features on client engagement can help to promote treatment retention (Drieschner et al., 2004). For example, once I became aware of Lulama's negative outcome expectations in relation to my responses in session, I intervened immediately to target these negative beliefs. She was subsequently more willing to share her concerns and feelings in session. However, for her to remain in therapy additional interventions were indicated and these are discussed in the course of this chapter. Similarly, an awareness of Anna's avoidant traits and her negative assumptions regarding self-disclosure sensitised my responses to her and facilitated the creation of trust and safety. This allowed Anna to complete treatment. In effect, for certain clients in the case series, intervening to enhance motivation served to improve treatment outcome. However, where additional barriers apart from motivation were present, multiple levels of intervention were necessary. In certain circumstances, as with Khuselwa and Sanele, it was not possible to intercede.

(iv) Issues of race, culture and language

Eagle (2005) and other researchers (Cooper, 2007; Emsley, 2001; Swartz & Drennan, 2000) have observed that practicing psychotherapy in South Africa is complicated by the country's cultural, ethnic, racial and linguistic diversity. Herman (2000, cited in Bhui and Morgan, 2007) defines

culture as "a set of guidelines inherited by members of a particular society that tells them how to view the world, how to experience it emotionally and how to behave in relation to other people" (p. 188). Culture is transmitted through a variety of mechanisms including language, ritual and art. Ethnicity refers to "shared social features such as language, religion, customs, traditions and history within a particular social group" (Swartz, de lay Ray, Duncan, & Townsend, 2008, p. 325). In South Africa black South Africans generally belong to one of four ethnic groups namely Nguni (which includes both the Xhosa and Zulu cultural groups), Sotho, Shangaan-Tsonga and Venda. Racial categories are generally based on ethnic differences in terms of biological characteristics including skin colour, facial features and hair texture (Swartz et al., 2008).

Culture, ethnicity, race and language have a particularly contentious history in this country as these aspects were used as ideological devices to justify an apartheid system of governance aimed at securing white privilege (Leach, Akhurst, & Basson, 2003). Given these historical aspects, researchers (Eagle, 2005; Leach et al., 2003; Swartz & Drennan, 2000) have emphasised that, in conducing psychotherapy in South Africa, an important part of cross-cultural sensitivity is an awareness of the history of the country and its possible effects on therapeutic relationships.

In the case series there were racial, cultural and language differences among the participants. In terms of racial background Lulama, Khuselwa, Sanele and Zinhle were black while Anna, Emmy and Lori were white. With respect to cultural differences, Lulama, Khuselwa and Sanele formed part of the Xhosa cultural group while Zinhle was Zulu. Anna's and Lori's families had lived in the country for generations while Emmy was North American and had immigrated as an exchange student. I am of Indian decent and my family came to South Africa in 1987 when I was a child and we lived in the Transkei which represented a homeland state. As a result, I was attuned to the political and racial issues in the country and experienced many of the subtle and explicit effects of being in segregated society. The racial and cultural differences between myself and the participants in the case series did not, however, have a salient impact on the provision of psychotherapy. Racial and cultural differences did not impede clients from sharing their experiences or engaging with the treatment model. Instead, the barriers that did inhibit clients were related to other commonly encountered psychological aspects that have been previously discussed.

Eagle (2005) has emphasised that black South African clients draw on both western and African cosmologies in making sense of traumatic experiences and that in certain instances traditional African belief systems can complicate recovery. As a result, she emphasises that these aspects need to be handled with sensitivity and care. In the case series, none of the black clients drew on traditional belief systems (e.g. involving mystic, magical or animalistic causation) (Eagle, 2005) to explain their experience of victimisation and these aspects did not influence their appraisals of the trauma and its sequelae. Instead, their appraisals corresponded to those described by universal models of the cognitive impact of trauma (Janoff-Bulman, 1992; Lerner, 1980; McCann & Pearlman, 1990). Khuselwa believed that the first traumatic event had affected her sense of personal goodness because it had compromised her experience of herself as a virgin. She interpreted her subsequent victimisation as further evidence that she was not a good person. Lulama believed that the trauma had contaminated her and that this was contributing to the negative responses she received from other people. Emmy, a white North American participant, had similar appraisals to these latter two clients in that she believed that the trauma had compromised her construction of self as a virgin and impacted on her sense of being pure. In addition, as with Lulama, Emmy believed that the perpetrator had contaminated her. Lulama and Zinhle believed that if they revealed their trauma and distress, others would respond in an extremely negative way and grow distant and rejecting. These appraisals where shared by Lori and Anna. The case series essential confirms the universality inherent in certain cognitive appraisals ascribed to sexual traumas.

Swartz and Drennan (2000) have emphasised that, due to South Africa's political history, all languages apart from English and Afrikaans were marginalised and due to historical privileges the majority of clinicians are white and English and/or Afrikaans speaking. As a result, they are unable to provide psychological services to a significant majority of people (Leach et al., 2003). This system is gradually changing with training programmes increasingly requiring prospective candidates to have fluency in an indigenous South African language but the majority of practitioners are still not fluent in an indigenous language (Swartz & Drennan, 2000). In the case series, language differences did pose a barrier when it came to the use of self-report scales and the application of the active components of treatment. Lulama was fluent in spoken English and could understand the language but she had difficulty understanding and interpreting the self-report scales. She could not read isiXhosa and, for this reason, it was not possible to administer

the isiXhosa version of the BAI or BDI with her. Similarly, Sanele could understand English but due to her limited education (she only studied till Grade six) she had difficulty speaking English and understanding the self-report inventories. She too could not read isiXhosa. As a result, for these clients, I used close questioning throughout the course of the treatment process to gain insights into their symptoms and to monitor any changes in their reactions to the trauma.

The language barrier in Sanele's case was more severe than with Lulama. For this reason I encouraged her to speak in isiXhosa whenever she had difficulty expressing herself as I could understand the language relatively well. However, this language barrier presented a challenge when it came to engaging with the active components of treatment. One of the primary reasons for conducting a reliving is to gain insight into peri-traumatic appraisals (Ehlers & Clark, 2000). However, if the therapist is not fully conversant in the client's language important information can be lost. For this reason, I proposed an interpreter be used. However, the case series revealed that for certain clients like Sanele an additional barrier in using an interpreter is the client's lack of trust and concerns about safety. Sanele believed that my intention in suggesting that we use an interpreter was actually to refer her to this person for therapy. She subsequently became suicidal and threatened to terminate. The therapeutic focus then shifted to enhancing trust and to achieve this it was important that I not immediately use an interpreter.

a) Clinical implications

The case series reveals that even when self-report scales are available in the client's language, due to educational or socio-economic factors, they may not be fluent in reading their mother tongue. In these circumstances, close questioning can be highly beneficial in gaining insights about symptoms. Clients can also be encouraged to provide information about any reactions that they experience as being unsettling.

In South Africa there are no designated posts for interpreters and this poses a significant obstacle in the delivery of services to non-English speaking clients (Swartz & Drennan, 2000). In addition, specific researchers (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005) have emphasised that, even with an interpreter present, certain nuances in communications may be missed and this can have implications for the treatment process and formation of a working alliance. For this reason, it can

be highly beneficial when working in a cross-cultural setting for practitioners to be fluent in one other language apart from English or Afrikaans (Swartz & Drennen, 2000).

7.1.2. CLIENT-RELATED CONTEXTUAL FACTORS

This section describes the client-related contextual factors that had implications for treatment delivery and outcome, specifically with regard to the impact of the family and social environment.

(i) The family environment

In the case series, certain aspects of the clients' social environment were found to influence treatment delivery and implementation. This included the presence of dysfunctional home environments and parental psychopathology and issues of social support.

a) Familial dysfunction and parental psychopathology

Three participants in the case series were adolescents namely, Lulama (16), Khuselwa (17) and Zinhle (19) and studies (Hawke, Hennen, & Gallione, 2005; Garcia & Weiz, 2002; Robbins et al., 2006; Shelef, Diamond, Diamond, & Liddle, 2005) have shown that in psychotherapy with adolescents family functioning and parental involvement critically influence outcome. One aspect of family functioning that is influential is helping younger clients to attend sessions and stay in therapy is family routines. Family routines refer to behaviour patterns related to events, occasions, or situations that are often repeated regularly or consistently by members within a family. This includes morning routines, mealtime routines, homework routines and bedtime routines. Such routines provide order and structure to daily activities and a predictable timing for interaction among family members. These routines provide a framework that allows children to learn how to manage their time, structure their lives and attend to their responsibilities (Denham, 2003). In Zinhle's family, her parents provided a safe and stable environment and set down clear routines for their children. In the morning, Zinhle was required to wake up at a specific time, bathe, organise her school books, come to breakfast and then take the bus to school. In the evenings, she had to complete her homework, help with chores and was allowed to watch television before having to go to bed at a set time. There were repercussions if she did not engage in the expected routines such as being verbally reprimanded or having a privilege revoked. These experiences instilled in Zinhle a sense of responsibility and the capacity to

structure her life and tend to tasks timeously and efficiently. At the time of her entry into therapy, Zinhle was staying in a different province to that of her family for the purposes of completing her tertiary education. However, her parents had already instilled in her the skills and capacities necessary to tend to her duties in respect of treatment. This included arriving on time for session, keeping to scheduled appointments, consistently attending sessions and notifying me and rescheduling if she could not make an appointment.

In contrast to Zinhle, Lulama's family unit was not intact in that she had been abandoned by her father and step-father as a child. Her parental figures were her mother and grandmother but they did not provide her with a structured home environment. There were no specified times for waking up in the morning, having meals, completing chores, doing homework or going to bed. Lulama had no curfew and was not required to return home immediately after school and could visit friends till late in the night. She was not instructed to inform her caregivers of her whereabouts when she went out. Furthermore, her mother abused alcohol and behaved erratically and often lashed out at her physically and verbally for no apparent reason. Her grandmother was largely uninvolved in parenting but still beat Lulama if she did something she deemed unacceptable. The unstructured, unpredictable and chaotic nature of her home environment affected Lulama's ability to structure her life and tend to her responsibilities. For example, one morning she had trouble finding one of her school books and so decided she would not attend school that day (*see T3*). Her dysfunctional home environment also compromised her capacity to tend to her duties in respect of therapy. Lulama forgot to bring a homework task to session (*see T5)* and frequently arrived late for appointments. On one occasion she arrived two hours late and expected that we could continue as usual. In addition, she consistently failed to notify me when she could not make sessions despite my repeated attempts to encourage her to do so.

Parental or caregiver involvement has been found to be a critical factor influencing client engagement, retention and satisfaction with therapy. Parents have been shown to positively influence treatment outcome by: monitoring and promoting adolescent attendance in session; applying consequences for non-attendance; encouraging the completion of home work tasks; facilitating behavioural changes in the home environment and; providing necessary emotional support outside of session. In contrast, lack of parental involvement has been found to adversely

affect the capacity to remain in and complete treatment (Briere & Lanktree, 2008; Brookman-Frazee, Haine, Gabayan, & Garland, 2008; Hawley & Garland, 2008; Nock & Ferriter, 2005; Nock & Kazdin, 2001; Nock, Phil & Kazdin, 2001). The case series corroborates these findings.

Lulama's caregivers were not involved in her treatment process and this was related to two factors. Firstly, Lulama's mother (Thando) severely abused alcohol which affected her capacity to adequately supervise and care for her children and this influenced her willingness to be involved in her daughter's treatment process. I had written a letter to Thando (with Lulama's consent) explaining the reasons her daughter was in therapy and inviting her to contact me but she never responded to my letter or initiated contact with me (*see A5*). Secondly, Lulama did not want her mother to be involved in her treatment process. Her previous experiences of abandonment, neglect and abuse with primary caregivers led to her developing negative core beliefs (*see section 3.2.3.*) involving a mistrust of adult figures including her mother. She did not regard Thando as a reliable or trustworthy figure and was hesitant to have her involved in her therapy process.

Khuselwa's family was not intact in that her parents were divorced and her father had abandoned her when she was a child. She was raised solely by her mother (Nokhanyo) who severely abused alcohol. As a result of her neglectful parenting practices, Nokhanyo was unaware that Khuselwa had been repeatedly raped by different perpetrators and had entered therapy. Partly for this reason, she was not involved in her daughter's treatment process. As with Lulama, Khuselwa's experiences of neglect contributed to her mistrusting her mother and this inhibited her from involving Nokhanyo in her treatment (*see section 4.1.1. Anniversary Reaction*). In addition, Khuselwa feared that any contact on my part with Nokhanyo would lead to her removal from her mother's care (*discussed earlier*). This further inhibited her from disclosing her participation in treatment and having her mother involved in her therapy process.

For both Lulama and Khuselwa, a dysfunctional home environment and the absence of a responsible and involved parent severely impaired their ability to attend and engage with treatment.

b) Clinical implications

Consistent with the literature, the case series reveals that dysfunctional home environments and uninvolved caregivers have negative implications for treatment engagement. For this reason, it is necessary for clinicians to direct interventions on multiple levels (Briere & Lanktree, 2008). In Lulama's case, I intervened through the Department of Social Development to facilitate the creation of a safer home environment. A social worker was subsequently involved in monitoring her family situation and this prompted her mother to stop abusing her. It motivated her grandmother to assume a more parental role. In addition, with the help of her school teacher it was possible to deter her peer group from taunting her for the rape. These interventions were not sufficient for her to stay in treatment but it ensured that she had safe environments outside of session. In addition, it revealed to Lulama that positive results could be achieved through participation in treatment. This possibly influenced her decision to return to therapy, even after prolonged absences, when she felt markedly distressed and enhanced her willingness to engage in self-disclosure (*see T1 and T3*).

(ii) The social environment: Presence of supportive others

For individuals exposed to trauma, the presence of supportive others is essential for a number of reasons. Firstly, exposure to traumas such as sexual assault severely compromises the victim's sense of security and their trust in other people and leads to feelings of increased vulnerability and helplessness. The supportive of others can help the victim to once again feel safe and protected. Secondly, social support challenges the formation of negative beliefs about the self. Victims of sexual assault often believe that they are to blame for the rape leading to feelings of guilt and shame. These feelings can affect core positive beliefs about the self (e.g. that the self is good and worthwhile) and lead to an increase in distress. However, the knowledge that others still value them and regard them as worthwhile can counter-act the formation of such negative beliefs and thereby protects against PTSD. Thirdly, by sharing and reflecting on the trauma in the presence of supportive others, victims facilitate the integration of the traumatic event into autobiographical memory thereby preventing ongoing PTSD. Fourthly, significant others often encourage the victim to participate in activities and to express their needs and feelings which decreases the victim's avoidance symptoms including behaviour withdrawal and emotional disengagement (Andrews, Brewin, & Rose, 2003; Edwards, Sakasa, & van Wyk, 2005; Hyman, Gold, & Colt, 2003).

Apart from these factors, social support is critical in influencing treatment outcome and has been consistently found to be a significant factor enabling client attendance and completion of treatment. In contrast, social isolation and a poor quality of supportive relations had been found to predict dropout (Baekeland & Lundwall, 1975; Barrett et al., 2008; Berghofer, Schmidl, Rudas, Steiner, & Schmitz, 2002; Becker et al., 1997; Edwards et al., 2005; Sörgaard et al., 2001). Berghofer et al. (2002) investigated the factors associated with outpatient mental health care utilisation in three community mental health centres in Austria and found that the patients' social network encouraged and supported treatment attendance. These authors established that a low perceived quality of relationships with family and significant others increased withdrawal from treatment. In another study, Ayuso-Mateos et al. (2007) examined the predictors of treatment compliance and found that social support was a main factor promoting treatment adherence. These authors established that individuals who had a confidante were more likely to accept psychological treatment and participate in therapy. In addition, individuals who believed that others cared for them were found to be more likely to complete treatment. The case series offers additional support for the above mentioned findings in that the presence of supportive others and the individual's capacity to access and make use of these social resources affected treatment engagement and completion.

Emmy was an exchange student from North America and was away from her family at the time she sought treatment but she received considerable social support from her boyfriend (Farai) in South Africa. Farai had originally encouraged Emmy to seek professional help to cope with the trauma and remained supportive of her while she was in treatment. He invited her to share her experiences in session with him and encouraged her to reveal how she was coping. This gave Emmy an additional opportunity to work through the trauma and her reactions to her ordeal. Farai's presence ensured there was a supportive other in her environment monitoring and encouraging her attendance and engagement with treatment. Furthermore, Emmy's history of positive relational experiences within the context of family (*discussed earlier*) conferred the capacities and skills necessary for her to make use of the support being offered and contributed to her positive expectations regarding the outcome of accessing supportive others. For this reason, she was able and willing to share her experiences with her boyfriend and with her friends.

Zinhle, like Emmy, was away from her family while in therapy but this was due to their living in a different province. She was new to varsity and had not yet established any close friendships by the time she entered therapy. However, the absence of immediate social support did not impede Zinhle's ability to attend or complete session and this was due to two factors. Firstly, as discussed previously, Zinhle's prior history of being raised in stable, caring and supportive home environment conferred the skills necessary to tend to her responsibilities. Secondly, these experiences instilled positive expectations regarding the outcome and benefits of self-disclosure. For this reason, Zinhle had decided to enter treatment on her own accord and was able to share her experiences and use the information offered in sessions to enhance her coping. This was evident in her self-initiated attempts at exposure to the trauma memory and to situations she had previously avoided. Through participation in therapy she was quickly able to form friendships and reconnect with her parents and siblings which gave her added incentive to continue with treatment.

Lori had a number of social supports and this included her mother, step-father, boyfriend and a few friends, and her parents had originally encouraged her to enter into treatment. However, while in treatment, she was not able to access and use the support being offered by these sources. This was evident in her unwillingness to share her concerns with her boyfriend, parents or friends. Lori's difficulties accessing social support were related to her history of negative relational experiences and to the maladaptive assumptions that had arisen from these events. She essentially believed that, to maintain relationships, she needed to disavow her needs and feelings and look after other people. This inhibited her from being able to use the social support being offered. Her reluctance to share her experiences with others meant that there was no one in her environment who was intimately aware of the difficulties she was experiencing and who could, as a result, provide her with comfort, reassurance and encouragement.

Lulama had little social support from her caregivers and had received extremely negative responses from her social network upon her disclosure of the trauma. Her mother accused her of provoking the rapes by walking alone at night and told her that she should have been killed by the perpetrator. Her grandmother did not intervene to stop the abuse. Lulama's peers and boyfriend had also reacted negatively to news of the trauma and distanced themselves from her. In addition, her peer group ridiculed her for having been raped and accused her of being

responsible for the attacks. These negative social responses directly contributed to the creation and maintenance of her symptoms (*see section 3.2.3.*) and affected her willingness to confide in genuinely supportive others. For these reasons, at the time Lulama came to therapy she was largely socially isolated and had no one to turn to outside of session. Through participation in therapy she was gradually able to re-build social bonds (*see T4*) and this contributed to a significant reduction in her symptoms. However, her dysfunctional home environment, the absence of an involved parent and various motivational factors combined to influence her premature termination.

Khuselwa and Sanele had virtually no social support. Sanele was living alone for almost one year at the time she entered therapy. She had previously been residing with her grandfather but he cast her out of the family home following her disclosure that she was homosexual and she had no contact with him thereafter. Her mother (Siboniso) abused alcohol and lived in a different town three hundred kilometres away with the man responsible for repeatedly raping Sanele when she was a child. Sanele had no close friendships and this was related to her mistrust of other people and her difficulties confiding in others. Furthermore, she was very dissatisfied with the quality of her relationships with her family. She desperately wanted to reach out to her mother but expected that Siboniso would choose her relationship with her boyfriend over supporting her daughter. She did not believe that her grandfather wanted any further contact with her and this deterred her from approaching him. The lack of actual support in her environment meant that Sanele had no one to turn to for care, reassurance and support outside of session. As a result, she generally had to cope with any distress she experienced on her own. This frequently led to her resorting to maladaptive methods of coping (e.g. cutting, drinking alcohol excessively and using cannabis). Khuselwa lived with her mother who was frequently absence from the home and abused alcohol which impaired her ability to be responsive and attentive to her daughters needs. Khuselwa mistrusted her mother due to her erratic and unpredictable behaviour and so would not confide in her when distressed. This was evident in Khuselwa's reports that, after experiencing severe anniversary reactions with respect to the first trauma, she had isolated herself in her room because she did not want her mother to notice she was upset (*see section 4.1.1. Anniversary Reaction*). Khuselwa established one friendship in adolescence and her friend (Nomsa) had started living with the family for a period of six months after being cast from her own home. Her presence was comforting for Khuselwa and she tended to confide in Nomsa.

However, shortly after Khuselwa entered therapy, Nomsa's mother had called her back to their family home and Khuselwa was again socially isolated (*see A3*). Her interpersonal deficits impeded her from forming new friendships and relating to others. The absence of supportive others and dissatisfaction with the quality of social support impeded Khuselwa's and Sanele's capacity to remain in and engage with treatment.

Anna had recently relocated to the town with her family at the time she entered therapy. Her APD and social phobia inhibited her from entering social situations and establishing close relationships. However, as with Zinhle, the absence of immediate supports did not hinder her attendance in session and engagement with treatment and this was due to a variety of other factors. Anna, for one, was an older client (43 years old) compared to all the other participants in the case series and older age has been associated with increased treatment attendance and completion (Ayos-Mateos et al., 2007; Edlund et al., 2002). Secondly, Anna was not exposed to severe traumas in childhood when compared to Lori, Sanele or Khuselwa. As a result, her relational schemas were not as extreme as these latter clients and she was therefore better equipped to negotiate the therapeutic relationship. Thirdly, Anna was acutely aware of the nature of her difficulties and was motivated to resolve her problems and so, despite the distress associated with being in therapy, she persisted with treatment.

a) Clinical implications

Enhancing the quality of social support is critical in promoting recovery and client retention. However, for many clients a history of negative interpersonal experiences or traumas can confer negative internal working models that impair their capacity to form social bonds. For this reason, enhancing the quality of social support can be extremely challenging. In Lori's case, I actively encouraged her to share her concerns with her boyfriend and close friends and she was tentatively able to do so. However, for her to form meaningful relationships she needed a more long term therapy programme that focused on addressing her schemas. At her current stage, she was simply not motivated or ready to engage in such a process. For Anna, long term therapy proved instrumental in targeting her maladaptive core beliefs and allowed her to take the first steps towards forming genuine relationships.

7.1.3. RESPONSES AT THE STATE LEVEL

The case series revealed that the responses of certain state level agencies had implications for treatment. These included the response of the primary health care sector, Department of Social Development and the criminal justice system

(i) Primary health care sector responses

Historically, in South Africa, the responses of the primary health care sector to the needs of rape victims have been highly inadequate (Jewkes et al., 2009a; Smythe, Artz, Combrinck, Doolan, & Martin, 2008). However, over the past decade significant efforts have been made to improve the quality of care such as the development of a management policy on sexual assault (i.e. The Sexual Assault Policy, Department of Health, 2005) and guidelines for the clinical care of rape victims (Department of Health, 2004, 2005). These initiatives were designed to comprehensively cover the needs of victims in the immediate aftermath of the trauma. They make provision for HIV testing, the administration of post-exposure prophylaxis (PEP), antiretroviral therapy (ART) and the collection of forensic evidence that can assist the criminal justice system. The Sexual Assault Policy (Department of Health, 2005), as observed by Abrahams, Martin and Vetten (2004), provided for specialised training of health care workers in all aspects of post-trauma counselling (e.g. issues related to gender-based violence, PTSD and rape trauma syndrome) and advocated for victims to be referred to appropriate mental health care providers. However, at ground level translating policy into action has remained a major challenge (Christofides et al., 2003, 2005; Killian, Suliman, Fakier, & Seedat, 2007; Kim et al., 2003; Martin, 2004; Roehrs, 2008).

a) Accessing HIV testing and PEP

Rape has been identified as a significant factor enhancing vulnerability to HIV infection (Dunkle, et al., 2004; Jewkes, Dunkle, Nduna, & Shai, 2010; Kim, 2000; Olley et al., 2006). In recognition of this link government policy has stipulated that rape victims receive HIV testing and be provided with PEP following sexual assault (Killian et al, 2007). However, there are significant barriers inhibiting implementation of these services. Firstly, access to health facilities remains a major problem in South Africa, particularly for women living in rural South Africa, in that they have to commute considerable distances to access clinics or hospitals and transport can often be a problem. Logan, Evans, Stevenson and Jordan (2005), for example, investigated barriers in the

provision of health care services to rape victims in rural and urban areas and found that one of the major obstacles when it came to seeking services included the affordability and accessibility of services. Two participants in the case series (Lulama and Sanele), lived in a township settlement on the outskirts of the town and had to commute twenty kilometres to reach the nearest government hospital and, due to financial barriers, they chose to walk the distance.

Secondly, many women in South Africa are not aware of the existence of PEP or the necessity of it being administered as soon as possible following rape to reduce the risk of HIV transmission (i.e. ideally within twenty-four hours of exposure but no longer than seventy-two hours after exposure) (Kim et al., 2003). This was evident in Sanele's case in that she did not request PEP after being admitted at the hospital following her rape because she did not know about the drug. In addition, specific categories of victims may not posses the necessary psychological and emotional capacities to report their rape and thus access PEP. Khuselwa experienced severe developmental trauma and did not possess the self-capacities or ego resources to visit a designated hospital, disclose her trauma to a stranger and ensure that she received PEP. This severely compromised her health as she was later diagnosed as HIV positive.

Thirdly, there are barriers when it comes to timeously accessing PEP at health facilities. In terms of current legislation, for a rape victim to receive PEP, she either has to first lay a charge at a police station or report the assault to a designated health care provider (Roehrs, 2008). There is an average delay of twelve hours at police stations (Kim et al., 2003) before a victim presents at a hospital and this can severely increase the risks of contracting HIV. In addition, certain victims may not be willing to disclose their assault due to fears that the perpetrator might retaliate or due to expectations of insensitive treatment from health care providers (Killian et al., 2007). These latter expectations are often well founded. Kim and Motsei (2002) investigated the experiences and attitudes of primary health care nurses with regard to gender based violence. One of the findings to emerge from their study was that both male and female nurses viewed rape as an act provoked by the victim. These attitudes can lead to tacit or explicit victim-blaming behaviours and can exacerbate the stigma associated with sexual assault. In another study, Christofides et al. (2005) found that a significant number of primary health workers (nurses and doctors) did not regard rape as a serious medical problem and this influenced the quality of care they provided to victims. These findings are supported by the case series. Sanele visited a public

hospital after having been raped and the attending doctor had shouted at her for drinking alcohol excessively and attributed her rape to her having been inebriated. As a result of the rape, Sanele experienced severe inter-menstrual bleeding and a vaginal infection but because of her negative experiences with the doctor she avoided returning to the hospital. This merely worsened her condition. Sanele was subsequently readmitted to the same hospital after having been brutally gang raped but she did not disclose the rape to attending staff because she feared she would once again be blamed for the trauma. As a result, only her physical injuries (i.e. injuries to her face and bruises on her body) were tended to and she did not receive PEP. The insensitive treatment she initially received essentially had the effect of compromising her future willingness to disclose her trauma and jeopardised her health and wellbeing.

Fourthly, there are severe inconsistencies in the quality of care provided to rape victims in respect of HIV testing and provision of PEP. Rape victims are often not provided with information about the health risks associated with rape and the treatment options available. They are therefore not able to make informed decisions when they present at clinics or hospitals (Kim et al., 2003). Sanele visited a government hospital within hours of her rape but an HIV test was not administered and she was not advised on the necessity of such testing. Instead, a blood sample was drawn and she was informed that it would be sent for analysis. She was subsequently contacted by the hospital, five months later, and informed that her test results were ready. By this stage Sanele was highly distressed about the possibility of her having contracted HIV and desperately wanted to know her status. However, upon visiting the hospital, she was informed that the blood sample analysis had not included a test for HIV. She subsequently visited a local clinic to be tested but was told by the nurse that because she was menstruating an HIV test could not be administered. This information was highly inaccurate and left her feeling helpless and distraught. Sanele was not aware of PEP but she was provided with certain drugs (presumably PEP) after she initially reported her rape at the government hospital and advised to follow a specific regimen in taking the course of medication. She was not told about the nature of the drugs or its intended purpose. In addition, she was not advised to return to the hospital so that the treatment regimen could be monitored and, at the time of her presentation in therapy (five months after the rape), she was uncertain whether she had strictly adhered to the regimen. Adherence to PEP treatment among rape victims in South Africa has been found to be low (Kim & Motsei, 2002) and for this reason researchers (Roehrs, 2008) have emphasised the necessity of

health care workers ensuring that victims keep to their treatment routines. However, demonstrated in Sanele's case, this does not always occur. In contrast to Sanele, Lulama who visited the same hospital was afforded a better quality care. She was given an HIV-test that included pre-and post-test counselling and PEP within hours of her rape. She was also educated about the nature of PEP and the necessity of her following the treatment regimen. In addition, she was advised to return to the hospital once a week for approximately one month so that her treatment regimen and physical condition could be monitored. This served to ensure her treatment compliance. Lulama was given another HIV test approximately three months after the rape at the hospital to account for the window period in HIV testing and she was found to be HIV negative.

An additional shortcoming in service provision at the level of primary health care that was salient in the case series was that appropriate assessments of the patient's psychological status and personal history were not being conducted prior to the administration of an HIV test. Khuselwa, who was seventeen years old, visited a clinic by herself and requested an HIV test. The attending nurse promptly administered the test and informed her that she was HIV positive. Khuselwa had been raped on five different occasions by different perpetrators and, at the time of her testing, she had limited capacities for affect regulation and no social supports. Given this situation, it was psychologically harmful for her to be tested. However, it was clear that the nurse had not conducted a proper assessment or determined if Khuselwa had social resources and could cope with the possibility of receiving a positive result. Realising that she was HIV positive added another dimension to her difficulties and confirmed her existing negative beliefs that bad things simply happened and she could do nothing to change her circumstances. This enhanced her sense of despondency, helplessness and powerlessness.

b) Post-trauma counselling

Despite the provision for specialised training in post-trauma counselling, the majority of primary heath care workers, including nurses and doctors, have received only medical training in the care of rape victims. As a result, they possess little knowledge about the gendered nature of sexual assault, the social factors contributing to sexual violence and the psychological impact of rape (Kim & Motsei, 2002). For this reason, they are often unable to appreciate the harm arising from rape and the necessity of responding to a victim with sensitivity. This was apparent in a study by

Christofides et al. (2005). These authors, in a cross-sectional study, interviewed one hundred and twenty-four clinicians (i.e. doctors and nurses) from thirty one randomly selected hospitals in nine South African provinces and found severe deficits in the quality of care being provided to rape victims. The study found that only thirty percent of clinicians had received adequate training in the care of rape victims but these individuals provided a better quality of care than their colleagues who received mostly medical training. The case series lends additional support to these finding. The two participants (Lulama and Sanele) who approached primary health care providers were not provided with any information about the psychological impact of rape and did not receive any counselling. Instead, only one client (Lori) who saw a private medical practitioner with expertise on gender-based issues was advised on the necessity of professional psychological care and provided with some counselling.

Primary health care workers have been found to have poor relationships with NGO's and mental health providers and therefore seldom refer patients for trauma counselling (Christofides et al., 2003; Kim et al., 2009; Vetten, Ntlemo, & Mokwena, 2009). In the study by Christofides et al. (2005), only forty-seven percent of clinicians (i.e. nurses and doctors) were found to refer rape victims for psychological counselling. This means that the majority of victims are unlikely to receive appropriate psychological attention and care. These shortcomings were evident in this research project. In recruiting participants for the case series, I had visited community clinics situated within the town and in the surrounding township settlement and met with nurses and nursing supervisors. I had explained the nature of the research project and distributed posters to these clinics and requested participants. In addition, I also visited the only government hospital in the area and met with doctors, nurses and other staff members at the institution and circulated posters around the hospital. However, I did not receive any referrals from these sources in respect of the research project. Instead, on two occasions, I received referrals for non-rape related cases and one of these cases involved an adolescent suffering from learning difficulties and substance abuse problems. The adolescent's mother, grandmother and aunt were informed by the referral source (i.e. a nurse at the government hospital) that they needed to meet with me to obtain a referral letter so that the client could be admitted to the substance abuse facility at the local psychiatric hospital. I have no direct relationship with the substance abuse treatment centre and do not specialise in treating substance abuse cases. The family subsequently commuted to my offices and requested that I issue them with a referral letter. They were very

upset to learn that the information they had received from the hospital was highly inaccurate. I subsequently learnt that the family had commuted from a town situated two hundred kilometres away to ensure that the adolescent received appropriate treatment. The inaccurate information they received meant that they had to make the trip again.

c) Collection of forensic evidence

The primary health sector plays a critical role in the collection of forensic evidence necessary to assist courts in prosecuting rape cases. For this reason, the SAPS introduced a uniquely South African sexual assault evidence collection kit (SAECK) in 2001. This kit allows for the collection of all biological evidence specimens from a victims body (Brouwer, 2005). However, significant deficiencies in medico-legal services at the level of primary health care still exist. Suffla, Seedat and Nascimento (2001) evaluated medico-legal services provided to rape victims in Gauteng against the Health Departments objectives and found that reforms had not been consistently applied and that minimum standards of care had not been met. One of the critical findings of the study was that medico-legal evidence was not being competently collected and this was due to inadequate training of primary health care workers. Similar findings have been reported in other studies (Brouwer, 2005; Christofides et al., 2003; Jewkes et al., 2009a; Vetten et al., 2008). In the case series, forensic evidence was collected from two victims (Lulama and Sanele) but there were differences in the quality of care provided. In Lulama's case the process involved in using the kit was explained and for this reason she was not overly distressed at having a male doctor physically examine her. Sanele was not provided with this type of information and did not understand the purpose of the forensic exam and so she felt distressed. Lulama was subsequently informed that the rape test kit had been sent to the forensic laboratory but Sanele did not receive any such feedback. The differences in the care of these two individuals probably reflect disparities in the quality of training provided to primary care workers in respect of the care of rape victims.

d) Clinical implications

A failure to provide HIV testing and PEP means that a victim not only has to contend with the psychological sequelae associated with the rape itself but with the highly distressing possibility of their having contracted a fatal disease. There is significant psychological stigma associated with having HIV/AIDS and the virus has significant negative implications for a victim's quality of life

(Kim et al., 2003). In the event that a rape victim has not been tested, significant professional time and resources subsequently have to be directed towards pre-and post-trauma counselling, ensuring that a victim obtains an HIV test and subsequent management in the event that a victim is HIV positive. This was evident in both Sanele's and Khuselwa's cases.

(ii) Criminal justice system responses

In South Africa, various legal reforms have been implemented at the level of the SAPS and the judicial system to ensure that vulnerable population groups are protected (Artz & Smythe, 2005, 2007). However, certain aspects of the functioning of the criminal justice system still contribute to the further victimisation of those exposed to sexual trauma (Vetten et al., 2008) and this has certain implications for victims receiving psychological treatment. These aspects are further discussed below in relation to the case series

a) Responses of the SAPS and implications for treatment

A significant number of researchers (Artz & Smythe, 2008; Jewkes & Abrahams, 2002; Jewkes et al., 2009a; Vetten et al., 2008) have identified deficiencies in the responses of the criminal justice system at the level of policing. These include a lack of sensitivity to the needs of victims, a lack of commitment in terms of investigating rape cases and protecting victims, careless case management and poor collaboration with the judicial system (*see section 1.2.3.*). These deficiencies contribute to secondary victimisation, the attrition of rape cases and place victims at risk of further harm (Vetten et al., 2008). In terms of the case series, inadequate management of rape cases by the SAPS represented a significant problem and contributed to the victim being placed at risk of harm.

Lulama reported her rape to the police within hours of the trauma and opened a case docket and her statement was taken by the attending officer and forensic evidence was collected. A police investigator subsequently visited her home and requested that she accompany him to the site of the gang rape where he took pictures but he did not contact her thereafter. A week after the rape, Lulama spotted two of the perpetrators walking along the roadway near her home and felt intensely afraid and asked her grandmother to notify the police. The perpetrators were subsequently arrested but released shortly thereafter on bail and remained in her immediate environment. As a result, Lulama was often frightened to leave her house lest she be further

harmed. She continued to visit the police station once every two weeks, for five months after the rape, to enquire after her case and monitor the investigation. On one occasion she was informed that the police were awaiting results from the forensic laboratory (five months after her initial report) and asked to return two weeks later. She persisted in her visits to the police station but received the same response. Six months after Lulama's rape, the police were still awaiting forensic results and were unwilling to pursue her case without this information. Given that there are reported backlogs of up to twenty thousand cases at the South African Forensic Science Laboratory and that cases that receive the highest priority are those involving young children (Jewkes et al., 2009), it was highly unlikely that Lulama's forensic results would become available. Furthermore, despite the significance ascribed to DNA evidence in assisting a court in prosecuting a perpetrator, Jewkes et al. (2009a), found that the medical documentation of injuries (specifically ano-genital injuries) was significantly more influential in determining the progression of cases from the SAPS to the trial and conviction stages. This essentially means that the police do not need such forensic evidence to pursue a case and, in Lulama's situation, the unavailability of forensic results appeared to merely be used as a means of not attending to her case. Furthermore, while the police were awaiting forensic results, one of the men involved in perpetrating her gang rape behaved in an intimidating manner towards her sister and this left Lulama and her sister feeling extremely frightened. If the police had been more committed to investigating her case it was probable that the perpetrator would not have behaved in such a brazen way towards her family. Sanele reported her rape to the police and the perpetrator was arrested but released on bail shortly thereafter. He was subsequently rearrested and denied bail after he was found to have raped and murdered several other women in her community after being released.

These cases demonstrate the implications of poor investigation and management of rape cases in compromising a victim's safety and increasing the probability of them being further harmed. It illustrates the ramifications of releasing perpetrators without due consideration of their potential to re-offend. In Sanele's case, it was clearly evident that poor police practices had compromised the lives of other women in her community through the release of a dangerous offender. Similar instances of police failure to protect victims have been cited in the literature. Payne and Edwards (2009), for example, cite the case of a victim (Zanele) who was raped by a member of her community and as a result contracted HIV, chlamydia and syphilis. She report the rape to the

police and the perpetrator was arrested but released on bail shortly thereafter and returned to his home which was situated close to that of the victim. As a result, Zanele felt intensely afraid of encountering the rapist. She was also afraid to be left home alone lest the perpetrator retaliate and harm her. The case against the perpetrator was subsequently dropped by the police due to insufficient evidence and the perpetrator remained in Zanele's immediate environment. He therefore not only continued to pose a risk to her wellbeing but also that of other women. Van Niekerk (2004) also cites the case of a child victim who was revictimised by the perpetrator as punishment for reporting the rape to the police. In this instance, the SAPS directly contributed to the child's revictimisation by not acting to remove the perpetrator from the environment. The release of rapists from police custody conveys the tacit message that rape is a crime that is not taken seriously by those in positions of legal authority and that the men who rape will be released by the SAPS with impunity. This tacit acceptance of rape means that perpetrators will be highly likely to re-offend.

Implications of the responses of the SAPS

One of the pre-requisites for treating trauma victims is the establishment of safety (Briere & Lanktree, 2008) and the SAPS have a critical role to play in promoting such safety by arresting perpetrators and ensuring their removal from society (Payne & Edwards, 2009). However, the case series reveals that the SAPS are inadequate in fulfilling this function. As a result, to ensure the safety of a victim, mental health professionals are faced with having to monitor police investigations to ensure that the SAPS fulfil their obligations. In Lulama's case, I contacted the Public Prosecutors Office as I was concerned that little was being done by the police. I was advised that Lulama needed to inform this office in writing of her difficulties with the SAPS so that they could investigate the issue further. However, she prematurely terminated before it was possible to accomplish this. At the time of her termination, Lulama had informed her grandmother of the perpetrator's threatening behaviour and the family intended to visit the police station to report this issue. It is unlikely that anything was done to ensure her protection. This means that not only does she remain at risk but other women in her community are also vulnerable to being harmed.

Payne and Edwards (2009), in their study, reported that the therapist had to repeatedly contact the investigating officer to ensure that Zanele's case was being attended to. Zanele was

subsequently informed by the police that they were attempting to find witnesses to corroborate her story. While this possibly indefinite police search was underway, the perpetrator remained in her immediately environment. The perpetrator had not only raped her but infected her with HIV and therefore significantly shortened her life span and yet he could escape with impunity. Payne and Edwards (2009) reported that, after presenting their case study at an international conference, an attorney had offered to look into the matter and the police had subsequently reopened the case. This essentially indicates that for the police to actually attend to a case, a variety of role players have to be involved or the victim will simple be left in an unsafe environment. Van Niekerk (2004) provides additional support for the role of mental health care providers in having to monitor police investigations to ensure that cases are actually attended to. She indicates that, in the absence of persistent monitoring by external sources, cases are overlooked or disregarded by the SAPS. This means that for mental health professionals working with vulnerable populations monitoring police investigations would have to form part of daily practice if victim safety is to be assured. In the absence of such safety, victims find it extremely difficult to engage with treatment. Lulama, for example, found it challenging to speak about her trauma because she felt unsafe. As a result, she continued to experience PTSD symptoms even at the time of her premature termination and one of the primary triggers for her intrusive memories was seeing the rapists when she was out in her community. As long as the perpetrators continued to remain in her immediate environment, her fear of being revictimised as well her PTSD symptoms are unlikely to abate and her quality of life would remain impaired.

b) Responses of the judicial system and implications for treatment

In South Africa a growing number of specialist Sexual Offences Courts (SOC) have been established to cater to the needs of rape victims and address the prevalence of sexual violence in the country. These courts are victim-centred and consider the victim's wellbeing their primary concern and therefore incorporate the principles of therapeutic jurisprudence. Therapeutic jurisprudence is based on the assumption that the process and outcome of legal proceedings can be healing for a victim (Casey & Rothman, 2000). To ensure this therapeutic effect the SOC aims to prevent secondary victimisation and ensure that cases are attended to promptly and efficiently. A variety of professionals are recruited by these courts to ensure the wellbeing of the victim including social workers, psychologists and medical professionals. Victims are thoroughly prepared for court proceedings and they are provided with the option of testifying through

closed circuit television cameras (CCTV). Judges and prosecutors in the these courts have specialised training when it comes to sexual offences and as a result, these courts are highly efficient and produce higher conviction rates than normal courts in South Africa (Walker & Louw, 2003). However, these high conviction rates are partially related to the cases that are selected for trial (i.e. only cases with a high probability of conviction are chosen) and the extent to which victims are prepared for legal proceedings (such preparation ensures that the victim presents as a credible witness) (Artz & Smythe, 2007). These specialist courts are growing in number due to international funding (Walker & Louw, 2003) but they are still not available in many parts of the country. Therefore, a significant majority of rape cases are seen in normal courts and the responses of these institutions are wanting in many respects and contribute to secondary victimisation (Vetten et al., 2010; Walker & Louw, 2003). Three aspects that contribute to such secondary trauma include leniency in the granting of bail, low conviction rates and insufficient attention being given to the safety of the victim when they appear in court (Woods et al., 1998; Barday & Combrinck, 2002; Combrinck & Skepu, 2003). These aspects have been comprehensively described in the literature review (*see section 1.2.3. (ii)*) and will only be discussed in this section in relation to the case series.

Bail

Rape victims in South Africa are regularly not informed of the bail status of the perpetrator and this compromises their safety. Lulama was not informed that the perpetrators of her gang rape had been released on bail and subsequently felt extremely frightened upon seeing them in her community. The outcome of the release of the perpetrator of Sanele's rape has already been discussed and provides clear evidence of the dangers inherent in leniently granting bail.

Low conviction rates

In South Africa less than seven percent of perpetrators of sexual offences are convicted (Jewkes & Abrahams, 2002). Vetten et al. (2008) found that rape trials commenced in one in five cases and that conviction only occurred in four percent of cases. These findings were echoed by the case series in that in only one case (Sanele's) did proceedings reach the trial stage and result in the perpetrator being convicted. However, in this instance, the accused had not only perpetrated rape but also murder and it is highly probable that these factors contributed to increased police interest in the case and subsequent conviction. Poor convictions rates not only compromise the

safety of victims but increase the likelihood of rapes being perpetrated in the country (Jewkes & Abrahams, 2002).

Victim safety in court proceedings

In specialised courts special provisions are made to prepare the victim for trail. However, in normal courts the victim's needs are not taken into account to the same degree. Sanele was summoned to testify against the man who physically assaulted her and then raped her at knife point. However, she was not provided with information about legal proceedings and what was required of her in court. For this reason, she was extremely distraught at the possibility of having to see the perpetrator. When she appeared in court she became so distressed at the sight of the rapist that she collapsed and had to be admitted in hospital.

Sanele's case demonstrates certain shortcomings in respect of the treatment of rape victims in normal courts in the country. Firstly, legislation provides for rape victims to give evidence in a separate room that is linked to the court via CCTV (Waterhouse, 2008). However, not all courts have these facilities. In Sanele's case, the court house had a separate room with a one way mirror attached to the main court. This facility was frequently used when children were required to give evidence. However, in Sanele's case this facility was not used, in all likelihood because an appropriate assessment of her needs and capacities was not conducted beforehand. If this facility had been made available Sanele might have been better able to tolerate being in court. Secondly, inadequate preparation of victims for court can lead to secondary victimisation. The sight of the perpetrator has the potential to trigger intrusive memories of the rape and this can leave a victim feeling intensely distressed and disconcerted which can then affect their credibility as a witness. For the victim to be adequately prepared to appear in court she needs to be informed about: the nature of the legal process; the parties that will be present at the trial; the layout of the court room; the process of cross-examination and; what will be required of her in terms of her testimony (van Niekerk, 2004). If such preparation is not undertaken, rape victims like Sanele face being re-traumatised within the judicial system.

Implications of the responses of the judicial system

The judicial system has a salient role in promoting the safety of victims by: appropriately assessing the risks to the victim and community before granting bail to perpetrators and;

convicting perpetrators and thereby ensuring their removal from society. In the absence of felt security, victims are essentially unable to recover from their trauma and this was apparent in both Lulama's and Sanele's cases.

One of the roles of psychologists in the judicial system is the provision of expert witness testimony that can alert the court to the psychological harm done by rape and the impact of the rape on the victim's life. Such testimony can enhance the victim's credibility and promote their safety by ensuring that a perpetrator is convicted (Maw, Womersley, & O'Sullivan, 2008). However, to provide such testimony in a credible way and to ensure that the court is furnished with information that can benefit the victim's case, the expert witness needs to be a specialist in the relevant area (Allan & Louw, 2001). There are very few clinicians in South Africa with expertise when it comes to the issues underlying sexual trauma, the impact of rape and the treatment of rape victims. This represents a significant obstacle for their capacity to provide expert witness testimony (Allan & Louw, 2001; Higson-Smith et al., 2005). In terms of the case series, only Sanele's case went to trial and I was not required to provide expert testimony. However, I did provide such testimony in a case that was not included in the present case series as it represented an extremely prolonged case (the client was in therapy for three years). In this case, the victim (Rachel), a fifteen year old high school student, was repeatedly raped between the ages of three and then. The perpetrator was the son of her baby sitter. In providing expert witness testimony, I furnished the court with comprehensive evidence regarding the impact of the rape on Rachel's life. The perpetrator was found guilty and subsequently convicted.

(iii) Responses of the Department of Social Development

The Department of Social Development in collaboration with other agencies finalised the Integrated Victim Empowerment Policy in the period 2008-2009. The Victim Empowerment Programme (VEP) aims to enhance inter-sectoral collaboration thereby improving the quality of care provided to victims. It also aims to prevent victimisation, secondary victimisation and reduce vulnerability to crime. Policy guidelines of the VEP are extremely comprehensive and specify the roles of various stakeholders including the SAPS, the Department of Health as well as the Department of Justice. The VEP has made significant gains in enhancing the care of rape victims. This includes the establishment of one stop rape care centres termed Thuthuzela Care Centres (Thuthuzela is an isiXhosa word meaning "comfort") and shelters for abused women

(Department of Social Development, 2010). However, these centres and facilities are not yet available in many parts of the country. Another policy established by this sector involves Minimum Standards for Service Delivery in Victim Empowerment which aims to offer service providers information about their role in providing sensitive and appropriate care for victims. However, translating policy into practice, as revealed by the case series, has been challenging.

The Department of Social Development has policies in place for specific populations and one of these is Child Protection Services. This policy offers specific categories of children (i.e. people below the age of eighteen) protection. This includes children who live in "circumstances likely to cause or be conducive to [their] seduction, abduction or sexual exploitation" or who are "exposed to circumstances that may seriously harm [their] physical, mental or social well-being" (Department of Social Development, 2010). In such instances, children can be removed from the environment and placed in a children's home or foster care following an investigation by a social worker. However, such intervention is usually dependent on communities or concerned parties actually reporting incidences of child abuse or neglect to a social worker or to the department offices. The case series offers tentative support for the efficiency and commitment of this agency towards helping rape victims. Lulama and Khuselwa both lived in highly dysfunctional environments in which they were at risk for harm. After her mother evicted Lulama and her sister from their home, I contacted this social agency. Within an hour of my consultation a social worker was allocated to investigate the case and she met with the family the subsequent day. Thereafter, this social worker monitored Lulama's situation on a weekly basis and had regular meetings with her family. As a result, Thando's abusive behaviour ceased and Lulama felt much safer when at home as can be seen in her comments in the fifth assessment session.

Khuselwa was at significant risk for sexual exploitation as her primary caregiver was often away from the home and, during one such occasion, she was raped. In addition, the perpetrator of one her rapes was a neighbour. However, Khuselwa adamantly refused to have me contact any external parties and threatened to terminate if I did so. For this reason it was not possible for me to intervene more directly. However, as Khuselwa's internal capacities grew, she took the initiative to move into a girls' shelter and this ensured that she was safe and protected. Shelters for girls and women exist in many parts of the country and fall within the framework of the Department of Social Development. However, in the present setting, there was no women's

shelter and this meant that Khuselwa would have to leave the girls' shelter after she turned eighteen and return to her mother's care. The absence of a women's shelter also had implications for Sanele. She lived in a dangerous environment and was revictimised as she approached her house one night. She had limited financial resources to acquire alternative accommodation and this meant that she was forced to stay in a potential dangerous setting.

a) Clinical implications

A critical issue in the case series was the absence of a women's shelter and it is evident that more resources need to be directed towards providing such services. Living in a shelter ensures that women who are at immediate risk of harm can be afforded a temporary sanctuary and be assisted in, for example, finding safe accommodation. Living in a shelter, even on a temporary basis, can also promote a sense of safety. In Khuselwa's case this felt security motivated her willingness to tentatively engage with exposure work.

CONCLUSION

In terms of the case series, specific client-related personal and contextual obstacles were found to effect treatment delivery and implementation. Client-related personal obstacles included the nature of post-traumatic symptomology, the presence of comorbid Axis II condition; client motivation and language barriers. In this respect, complex stress reactions and related deficits in interpersonal relatedness and affect regulation were found to impede treatment engagement. In addition, for clients with complex PTSD residing in community settings, difficulties promoting safety in the environment was found to significantly impede treatment engage and indicated the need for closed residential care. Borderline character pathology was found to be another obstacle affecting treatment outcome for PTSD in that clients with severe borderline traits were less able to tolerate treatment. Four motivational factors coalesced to influence treatment outcome for certain clients. These factors included limited problem recognition, negative outcome expectancy, weak therapeutic alliances and the perceived negative costs associated with treatment. The contextual factors found to hinder treatment engagement included aspects of the social environment and issues of physical safety. Language barriers inhibited certain clients from completing self-report scales and had implications for the delivery of the active components of treatment. In addition, it was argued that in certain instances it is first necessary to promote

safety before an interpreter can be engaged. Specific client-related contextual factors affected treatment delivery and outcome. This included dysfunctional home environments and limited parental involvement specifically in the case of adolescent clients. In addition, adverse social responses, social isolation and the inability to access available social supports served as obstacles to engagement.

Deficiencies at the state level, specifically with regard to the responses of the primary health sector and criminal justice system, were found to impact on treatment. Failure to provide HIV testing PEP meant that certain clients had to contend with the additional psychological trauma of having contracted a fatal illness. The criminal justice system was argued to have a central role in promoting the safety and thereby allowing victims to feel safe enough to engage with treatment. However, at the ground level, the case series revealed deficiencies in the responses of the SAPS and judicial system that directly compromised the safety of the victim and hindered their capacity to recover from their trauma. These deficiencies included leniency in the granting of bail, low conviction rates and issues of victim safety in the context of the judicial system. The case series revealed deficits when it came to translating the policies of the Department of Social Development surrounding victim empowerment into appropriate action on the ground level.

CHAPTER 8: CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

This research project was driven by specific aims and in this chapter the objectives and results of the study are reviewed and recommendations are provided for future research.

8.1. EVALUATING THE EHLERS AND CLARK (2000) MODEL

This research project evaluated the applicability of the Ehlers and Clark (2000) cognitive model in the treatment of rape-related PTSD in South Africa through the use of systematic case-based research. Systematic case studies offer an intensive analysis and description of the particular phenomena under study within its real-life context (Yin, 1994). The approach uses a systematic set of procedures to generate and develop theory about a specific phenomenon (*see section 2.2.1. (i)*). Case studies have a number of advantages that make them well suited to psychotherapy research (*see section 2.2.1. (i)*) including that they are grounded, holistic and communicate tacit knowledge (Guba & Lincoln, 1994).

Seven case studies were generated and six of these cases involved South African women. Each of the six studies provided contextualised knowledge on the range of ways that South African clients responded to the same treatment. The case studies captured the emergent and immanent features of the lives of South African women going through a process of psychotherapy. They illuminated, amplified and extended current understandings of the treatment of rape-related PTSD in the South African context. This included the aspects involved in the maintenance of trauma-related symptoms, the mechanisms involved in change and the moderators and mediators of change in psychotherapy. The evidence from the case series was supported by other South African case studies (Davidow & Edwards, 2006; Payne & Edwards, 2007; van der Linde, 2007) and a wealth of international research findings. This research project was initiated in 2007 and many of the findings are consonant with much of the emerging literature since that time. It has contributed one aspect to a broader interconnected or interlocked approach to the creation of empirically grounded clinical knowledge (Edwards et al., 2004; Salkovskis, 2002).

The case series provided evidence that in South Africa, as in the rest of the world, sexual victimisation takes various forms and includes: drug-facilitated sexual assaults or DFSA (*Anna and*

Lori); isolated non-drug facilitated rape such as a single episode of sexual abuse or an isolated gang rape *(Zinhle and Lulama*) and; repeated and multiple sexual traumas over an extended period of time (*Khuselwa and Sanele*). Irrespective of the nature of sexual trauma, one central and pervasive phenomenological aspect of sexual violence is the development of PTSD. PTSD compromises the trauma victim's capacity to perform occupationally and in terms of schooling and takes a severe toll on interpersonal relationships. It is also associated with increased risk of suicide, high rates of depression, alcohol and drug abuse and self-harming behaviours. Anna could not enter a shop for more than five minutes without needing to flee the setting or hold a conversation without feeling the need to escape. She often had to forgo obtaining needed items such as new clothing and had very few genuine relationships. These difficulties were critically linked to her rape and resultant intrusive memories. Lulama could not concentrate on her school work after her rape because of trauma-related intrusions and feelings of hyper-arousal. As a result, her grades dropped and she took on additional homework to try to make up for her marks. She also isolated herself in her home to reduce her anxiety and not feel overly alert. Her social isolation only exacerbated her depressed mood and PTSD. Lori could not sleep at night because of intrusive memories and physiological hyper-arousal and due to physical exhaustion she could not concentrate on her academic work during the day. Khuselwa engaged in suicidal gestures to cope with her memories of rape and on one occasion had to be admitted to the hospital after a suicide attempt. Sanele could not perform her job as a car guard because each time certain men approached her to pay for parking she experienced flashbacks of the rape. To cope with intrusions, she started cutting herself, abusing alcohol and smoking cannabis.

There are three inter-related phases in the responsive treatment of rape-related PTSD when using specialist cognitive-behavioural treatment approaches such as the Ehlers and Clark (2000) model. The first phase is to promote client safety (Briere & Lanktree, 2008; Courtois et al., 2009; Edwards, 2009) and the case series revealed that, for specific vulnerable populations in South Africa, achieving such safety is extremely difficult and this impedes the application of the treatment model. Khuselwa was seventeen years old and she lived in close proximity to three of the men who had raped her since her early adolescence. Her mother abused alcohol and was not able to care for, supervise, support or protect her. Sanele was a twenty-three year old, lesbian identified woman and she lived alone in a community in which 'corrective rape' was frequently perpetrated. She had been raped on two separate occasions while in her community and one of

these attacks was a gang rape by four men. Lulama was sixteen years old and lived in the same community as the men who perpetrated her gang rape. Her mother abused alcohol and was not invested in supervising or protecting her.

In these circumstances, promoting safety is only possible if specific external support structures are available. These structures include: women's shelters; closed residential care programmes and; safe community environments. In the absence of these structures, women are vulnerable to revictimisation and chronic psychological problems and cannot adequately engage with or benefit from treatment. In the setting in which treatment took place, there were no women's shelters and only a girls' shelter. There are no closed residential care facilities for rape victims at the state level in South Africa. Promoting safe community environments in the present setting was compromised by inadequate SAPS management of rape cases and leniency in the granting of bail. Six months after Lulama's gang rape, the SAPS were still awaiting forensic test results and refused to investigate her case further without such evidence. In the meantime, one of the perpetrators of her gang rape harassed her sister. The perpetrator of Sanele's rape was released on bail and went on to rape and murder a number of other women before he was re-arrested. Without external support structures, practitioners can find it extremely challenging to enhance the safety of women exposed to sexual trauma and move to the next phase of treatment.

The second phase is facilitating engagement with the active components of treatment. This is achieved by initially assessing and promoting the client's understanding of the treatment model and encouraging them to engage with therapy. However, the case series provided evidence that client's have particular difficulty moving to this stage of treatment if safety has not first been established. Sanele was psycho-educated about the necessity of her providing a comprehensive narrative of the trauma and she was subsequently able to do so. However, she was gang raped while still undergoing treatment and she found it extremely difficult to re-engage with therapy. She dropped out and continued to experience debilitating symptoms of PTSD and coped with these reactions by engaging in self-harming behaviours. Lulama was better able to engage with treatment and this was due to the steps taken to enhance safety. This included disconfirming her negative expectations of the outcome of self-disclosure and promoting safety in her school and home environment. However, Lulama too withdrew from treatment. This was directly related to the continued presence of the perpetrators in her environment and the sense of threat this

situation generated. Psycho-education and fostering trust in the therapeutic relationship motivated Khuselwa to tentatively engage with treatment but she too found it threatening and subsequently terminated. She continued to experience PTSD reactions and had difficulty regulating her distress.

The third inter-related phase in treating rape-related PTSD involves addressing triggers, targeting re-experiencing and maladaptive trauma-related assumptions. It also involves repairing and enlarging social connections. The case series reveals that this process is often extremely challenging when the perpetrators are still in the client's environment. Lulama's PTSD continued to be triggered whenever she sighted the perpetrators of her gang rape and, for this reason, she found it extremely threatening to engage with reliving and dropped out. Khuselwa lived in close proximity to the men who raped her and this served as a constant reminder of her trauma and triggered and reinforced her assumption that she was a bad person and to blame for the trauma. Sanele lived in a dangerous environment and her revictimisation served to reinforce her negative assumptions about her capacities and self-worth and led to her prematurely terminating. The case series provided formal evidence that, in the absence of safety in the external environment, active treatment components of the Ehlers and Clark (2000) cognitive model cannot be effectively applied in treating South African women exposed to rape.

Enhancing social support can be particularly challenging for certain clients. Sanele and Khuselwa experienced complex PTSD and related deficits in interpersonal relating and affect regulation. They found it difficult to trust other people and form meaningful connections. Khuselwa had no friendships in childhood and by the age of seventeen she had made only one friend. This friendship lasted for six months until her friend was forced to relocate to another neighbourhood. Khuselwa's only source of social support was then her mother whom she did not trust and therefore did not want included in her treatment. Sanele's relationships were largely superficial in nature and she was reluctant to confide in others. Her social support base also comprised her mother who continued to live with the man responsible for repeatedly raping Sanele when she was a child. As a result, she found it difficult to access her mother's support and was socially isolated. Lulama's mother and her peer group reacted negatively to the news of her rape by blaming her for the trauma. This contributed to her isolating herself from others. In her case, however, it was possible to intervene to promote her social re-engagement. This involved:

challenging the negative assumptions that kept her isolated; identifying genuinely supportive others in her environment and; actively encouraging her to engage with them. Lulama eventually disclosed the rape to a close friend and her friend's family and this ensured that she had supportive others to turn to. However, this was not sufficient for her to remain in therapy. The case series provided evidence that in certain circumstances clients have no active social supports outside of session and they are left to cope with their distress on their own. In these situations, the therapeutic relationship needs to serve as the basis from which the client can learn skills for relating and transfer these skills to their external environment. However, for this to occur the client needs to remain in therapy and threats to safety can impede this process from occurring.

8.2. BUILDING A CLINICAL KNOWLEDGE BASE: REFLECTIONS ON METHODOLOGY

8.2.1 CONTRIBUTIONS TO APPLIED CLINICAL KNOWLEDGE

As Edwards et al. (2004) explain, the first step in theory building is to document a particular process in a case and then to demonstrate that same process in other cases. Through this process, "a theoretical structure of distinctions, principles, and hypotheses is formulated and progressively refined to account for the whole range of phenomena observed in all cases" (Edwards et al., 2004, p. 592). The theory that is subsequently generated is grounded in the data itself and has immediate practical applicability because it is not removed from the phenomena it addresses. In this way, this research project has contributed to the building and refining of clinical knowledge and the creation of case law in the South African context. A multiple case study approach was used and the case series added six new cases to an existing data base of South African case studies evaluating the Ehlers and Clark (2000) model in the treatment of rape-related PTSD. Edwards et al. (2004) point out that "when a large number of observations from the case correspond with what is already present in the theory, the evidence gained is as persuasive as that obtained in studies using statistical hypothesis testing" (Edwards et al., 2004, p. 593). The case series provided formal evidence of the types of factors and mechanisms that are involved in the maintenance of PTSD in the South African context and clarified how specific procedures could be used to achieve change. The case series offered evidence that certain responses to trauma are universal and that specialist treatment models, like the Ehlers and Clark

(2000) approach, are not culturally biased but transportable to community settings. The findings were consistent with evidence from other South African cases and a wealth of international knowledge and can be considered very robust.

8.2.2. QUALITY CONTROL

In this section, the conclusions drawn from this case series will be evaluated in terms of the criteria for rigor and trustworthiness in qualitative research established by Guba and Lincoln (1994) (*see section 2.2.1. (ii)*). One of the primary concerns with case study research is the extent to which the findings represent a credible interpretation of the information that has been drawn from the raw data (Midgley, 2006). Morrow (2005) and other researchers (Dattilio et al., in press; Midgley, 2006) have observed that data analysis, interpretation, and writing are a reflexive and interactive process that often leads the researcher back into the field for additional data. Through such repeated reviewing and re-reading of the data, the researcher is able to achieve "a deep understanding of all that comprises the *data corpus* (body of data) and how its parts interrelate" (Morrow, 2005, p. 526). The nature of this process as it related to the present project is extensively described in the section below on methodological reflexivity (*see section 8.2.3.*). The credibility of the interpretations arrived at is, according to Morrow (2005), achieved by presenting the findings in a way that exemplifies a "balance between the investigator's interpretations and supporting quotations from participants" (p. 526). In the current project, this balance was achieved by providing such supporting quotations. This can be seen in the provision of direct quotations of the client's words and the inclusion of portions of transcripts and results of self-report scales. Direct quotes are included in each of the case studies and for certain case studies, such as with Anna, Lori and Khuselwa, portions of the transcript have been included. This ensured that the interpretations were grounded in the lived experience of the participants allowing readers to observe the interrelationship between the data and the interpretation (Morrow, 2005). The credibility of these supporting quotations was further enhanced by the use of an independent assessor and supervisory input (*see section 2.2.1. (ii)*). Furthermore, the readers are provided with sufficient information to derive their own hypothesis and test the credibility of their own interpretations against that which has been offered (Midgley, 2006).

The interpretations that are provided are also consonant with a substantial body of existing research but are uniquely South African. Anna was diagnosed with APD and she initially

experienced marked difficulty with self-disclosure and found it difficult to engage with therapeutic tasks due to her maladaptive schemas. This finding was congruent with existing research (Beck et al., 2004; Emmelkamp et al., 2006) on clients with APD. Lulama, Khuselwa and Sanele found it extremely difficult to engage with treatment due to issues with safety in their external environment. This finding corresponded to that of other South African case studies (Payne & Edwards, 2009; van der Linde, 2007) and a wealth of international research (Briere & Lanktree, 2008; Cloitre & Rosenberg, 2006; Ford & Courtois, 2009). Lori had a disorganised attachment history and showed signs of a hostile-helpless state of mind with relation to attachment figures which influenced her capacity to engage with treatment. Portions of transcript were included to depict these features. The findings in Lori's case were consonant with extensive international literature on individuals with hostile-helpless interpersonal schemas (Lyons-Ruth & Spielman, 2004; Lyons-Ruth et al., 2004; Lyons-Ruth et al., 2007). Furthermore, this research project expanded on specific areas in which there was limited research. Anna's case contributed to the small but growing body of international research on the treatment of PTSD for individuals with APD. The case study exposed the inter-relationship between the appraisals underling APD and those that maintain PTSD and provided evidence that in certain circumstances PTSD cannot be treated in isolation. Emmy's case expanded on the very limited research (Burgess & Holmstrom, 1979) investigating the impact of rape in circumstances where a victim was a virgin. The case study exposed the nature of the trauma-related appraisals that can arise in circumstances where the victim was a virgin, how these appraisals maintain symptoms and the means through which these reactions can be addressed. Lulama's and Emmy's cases expanded on the relatively small body of research on the role of disgust and contamination in maintaining rape-related PTSD symptoms.

A second concern with case based research is generalisability (Midgley, 2006). This is achieved by ensuring that a sufficient number of participants are included in the study and, as Patton (1990, cited in Morrow, 2005) points out, "the information-richness of the cases" (p. 225). In the present project, a multiple case study approach was used and 'rich, thick descriptions' were provided about the therapy process, participant's experiences and the context of the research. This enhanced the likelihood that the characteristics of any new case would match features of one of the cases in the series. Morrow (2005) and other researchers (Dattilio et al., in press) emphasise that in the creation of case law, data are typically collected to the point of redundancy. This

means that no new insights or information will be forthcoming from new cases. The present case series has been supported by: an existing database of case studies (Davidow & Edwards, 2007; Payne & Edwards, 2009; van der Linde, 2007) that have documented the treatment of rape-related PTSD in South Africa using the Ehlers and Clark (2000) treatment model; a larger database of systematic case studies that have provided evidence that the basic components and principals of the model are transportable to the treatment of a variety of traumatic events encountered in the South African context (Boulind & Edwards, 2008; Karpelowsky & Edwards, 2005; Laas, 2009; Smith, 2006; Swartz, 2007) and; international research findings (Gillespie et al., 2002) that the model is transportable to community settings and is not culturally biased. The presence of this extensive body of research limits the likelihood that the presentation in any new case will not be largely interpretable within the framework that has been built up here.

8.2.3. REFLEXIVITY AND THE ROLE OF THE CLINICIAN/RESEARCHER

I served as both the clinician and researcher in this study and as Salkovskis (2002) points out, "the scientist-practitioner/clinical science approach has clinical practice at its heart. Clinical practice is both the target of our work and a source of information and inspiration that drives other aspects of the process of empirically grounded clinical practice" (p. 4). Being a clinician-researcher allowed me to have a firm grasp of the phenomenology of the psychological problems that I encountered and, as observed by Salkovskis (2002), this "is a necessary pre-requisite for deriving and refining theories of such problems" (p. 4). Being a clinician-researcher allowed me to convey information in a way that was meaningful and accessible to practitioners working in real-world settings and directly suggest clinical interventions. Based on my own experiences as a practitioner I was aware of the types of information that I would find useful when working with clients. This includes, for example, information about how to react to challenging situations such as: a client who contacts you late at night to tell you that she loves and misses you (*see Sanele*); a client who has been cast out of her home (*see Lulama*) and has no place to go and; a client who tries to belittle you in session (*see Anna*). Other information that I would find useful includes how to address certain contextual obstacles such as: problems with safety in the client's environment; a client's limited legal recourse and; negative responses from the client's social network. In addition, I would find information about when to apply certain techniques and how best to go about doing so highly beneficial. I therefore used my own knowledge of the challenges that I faced as a practitioner to inform the therapy narratives. I included information about: my

understanding of the client's dynamic; my reasons for choosing specific interventions at a particular point; how I used a specific technique and; any challenges I encountered in working with a client. This type of information would allow other practitioners to relate to the material and use it in their own clinical practice. It informs the type of interventions that should be used and specifies what kind of therapeutic processes lead to good outcomes for the client.

The process of compiling and interpreting therapy narratives was iterative and reflexive and there were three levels of methodological reflexivity in this respect. The first level occurred in therapy sessions where I drew on my implicit and procedural knowledge as a practitioner to inform my understanding of a client and how I responded in session. For example, while in session with Lulama I found it noteworthy that she smiled and chuckled while relating her trauma. Based on my prior experiences as a practitioner, I was aware that clients frequently used these tactics to minimise distress. I also sometimes smiled while speaking about a very painful event to a complete stranger so as to prevent myself from becoming emotional. I used these experiences to generate a hypothesis about her behaviour, namely that she felt unsafe and was uncertain whether she could trust me. I responded by promoting trust rather than directly challenging her behaviour. Only in our first therapy session did I use a more direct approach to address her avoidance because by this stage it was clear a sense of safety and trust had started to develop. Similarly, I had prior experiences of working with client's who displayed borderline personality characteristics. I was therefore able to recognise these features in specific clients such as Sanele and was aware of the necessity of establishing firm boundaries to promote a sense of safety and stability. For this reason, I was firm when it came to session times and any contact outside of session. Furthermore, I had worked with clients with social phobia and this enabled me to recognise that Anna displayed symptoms of this disorder. However, in my previous experiences, I had not found it as challenging to motivate a client to engage with the protocol for social phobia. This helped me to further appreciate that Anna's difficulties were better conceptualised as APD and she needed a more intensive treatment approach to address her social anxieties. As a practitioner, I had contact with various state level organisations such as the Department of Social Development and NGO's. For this reason, I was able to act expediently to address certain contextual challenges that clients experienced. This included HIV testing and safety in the home environment. I used my experiences with each client to inform what I included in the therapy narratives.

The second level of reflexivity occurred while writing the therapy narratives. I took note of my experience of a particular client and the issues that arose in the context of treating that client. I also kept in mind the research questions while interrogating the data and then compiled each therapy narrative. While writing each narrative, I noticed that certain clients shared certain features in terms of their background or specific aspects of their presentation. For example, I realised that Lulama, Khuselwa and Sanele all came from broken homes and their primary caregiver abused alcohol. Anna, Emmy and Lori experienced DFSA but only Anna was aware that her rape had been drug facilitated. Furthermore, Emmy and Lori had kinesthetic intrusions while Emmy and Lulama experienced a sense of contamination following their trauma. Once I found commonalities between specific clients, I returned to the therapy narrative that I had already written to ensure that these similarities were appropriately represented. There were also commonalities in terms of my experiences of specific clients and this further informed the therapy narrative. For example, I experienced a sense of helplessness and frustration while working with three clients namely, Lori, Khuselwa and Sanele. I therefore had to include these phenomenological aspects while writing the narrative. Again, these commonalities often only became apparent once I had written specific cases. I therefore had to return to the older cases and edit it to incorporate the insights I had gleaned from the present case.

While compiling therapy narratives, I noticed subtle and explicit variations in the presentations and responses of clients as well as aspects that were interesting in terms of the research questions. For example, Emmy's sense of contamination was related to the impact of the rape on her identity as a virgin. In contrast, Lulama's experience of having been contaminated was related to the negative responses of her social network. As such, despite similarities in appraisals, different techniques needed to be used to address these reactions and I ensured that these aspects were incorporated in the therapy narrative. Anna behaved in an adversarial fashion from the outset of treatment and had severe avoidant traits but she was still able to complete treatment. This contrasted with the other clients who displayed personality disturbances. Consequently, when writing the narrative, it was important to draw out how these aspects influenced their capacity to engage with and complete treatment. This process was circular in nature.

The third level of reflexivity occurred while interpreting the cases that comprised the case series. In this process, I kept the research questions in mind and then reviewed each therapy narrative. I noticed that certain clients were able to engage with and complete treatment but others did not. I then reviewed the narratives to determine which aspects hindered or helped clients to engage. Emmy and Zinhle, for example, only required a bit of encouragement to engage with therapeutic tasks and they achieved their treatment goals relatively quickly. I also experienced them as being highly motivated and committed in session. I therefore interrogated their therapy narratives and sometimes had to go back to the raw data (e.g. transcripts) to determine the features that enabled these clients to engage with treatment quickly. I found that they shared similar familial experiences in that they came from intact, stable and structured families. I subsequently conducted a literature search to: determine if this had already been noted as a factor influencing treatment outcome and; further illuminate the role of the client's family environment in determining treatment engagement. I found that family routines were one feature that enabled attendance particularly for adolescent clients. I realised that Emmy and Zinhle were raised in environments in which such routines were present but that Lulama had not been. I subsequently used this information to interpret their cases.

Similarly, in understanding Khuselwa's dynamic, I did further research on attachment theory, particularly on the nature of disorganised attachment. This proved to be a useful framework in understanding her presentation and so I used it to interpret her case. While writing up Sanele's case, I found that she too showed signs of having had a disorganised attachment history. I therefore made sure to include aspects in her therapy narrative that revealed her disorganised style of attachment and used this theoretical perspective to interpret her case. In this way, existing literature served to inform the manner in which therapy narratives were written and this further demonstrates the circular nature of writing case studies. Lori's case study was among the first I had written. However, after researching disorganised attachment and writing up on both Sanele's and Khuselwa's cases, it was apparent that these three clients shared certain commonalities. I therefore went back to Lori's case and re-wrote it to ensure that these similarities were included. This demonstrates the way new knowledge and insights obtained from new cases can influence the way a previous case is interpreted. It also illustrates how increased exposure to certain categories of clients can inform the interpretation of case studies.

Once the case studies had been compiled and interpreted, a fourth level of reflexivity came into play. I found that I had to return to the literature review chapter to ensure that I included and explained certain features that formed a dominant focus in the cases. For example, I had only briefly mentioned complex PTSD in the original literature review. However, after treating Sanele and Khuselwa and further researching disorganised attachment, I realised that I needed to significantly expand on that section. Similarly, I had not originally included disgust and contamination as part of the phenomenology of rape. However, after Emmy and Lulama experienced these features, I realised it was critical to review these aspects.

Methodological reflexivity meant that there was a reciprocal and intrinsic relationship between the collection of data, the analysis of the data and the resulting theory. Through this reflexive and iterative process, it was possible to identify and illuminate the factors that maintained particular problems and clinical presentations and suggest ways in which specific issues could be addressed or modified in the course of treatment. The end result of this process was a theory that emerged from and was grounded in the data itself (Dattilio et al., in press; Edwards et al., 2004; Morgan, 2007; Salkovskis, 2002).

8.3. PRACTICAL IMPLICATIONS

8.3.1. SUPERVISION, TRAINING AND TREATMENT DELIVERY

The case series has specific implications for supervision and training. Trainees require contextually-grounded and research-based knowledge to enable them to make sound clinical decisions and apply interventions effectively (Sexton, 1999). The theoretical framework that emerged from the cases series offers contextually-grounded and accessible guidelines for responding to a range of issues affecting South African victims of rape that are firmly rooted in research. A study of these cases and the discussion of them would provide up-and-coming clinicians with the tools necessary to identify when specialised care or more long-term treatment is required and when specific client aspects can impede treatment delivery. It teaches clinicians when and how to apply specific techniques, how to monitor treatment delivery and client progress and how to be responsive to the needs of clients. Furthermore, an examination of the case series would serve to normalise phenomenological aspects of the therapist's experiences and encourages trainees to be self-aware and take ownership of their experience of a client and

use it to inform their responses. This report on the case series could, therefore, play a crucial role in nurturing the development of clinical judgement, creativity and flexibility.

On a broader, societal level, the case series has provided evidence that resources need to be prioritised for clients who are at high risk (e.g. clients who engage in self-harming behaviour) and significant attention needs to be given to the role of the external environment in hindering recovery. Evidence from the case series suggests that training must emphasise the role of specific client features in influencing treatment engagement and outcome (e.g. dysfunctional families, lack of safety in the environment) and the need for multiple level responses on the part of the clinician (e.g. monitoring SAPS investigations; addressing negative responses of the social network). By using the case series, supervision can be anchored to the reality of the South African situation and the latest research on the treatment of vulnerable populations in the country.

8.3.2. POLICY AND SERVICE DELIVERY

The present study has evaluated the effectiveness of the Ehlers and Clark (2000) model in South Africa. The case series has exposed a range of individual-client related and contextual features as well as state level factors that coalesce in specific ways to impede treatment engagement and recovery following rape. The treatment of rape-related PTSD, in many circumstances, cannot be achieved in isolation, that is, at an individual level. Instead, other agencies have a critical role in promoting recovery. This includes the Department of Social Development, the primary health sector and criminal justice system. Policy guidelines for these sectors have been developed and are comprehensive in the majority of instances. However, at the ground level there are significant deficiencies in the implementation of policy requirements, particularly with respect to the latter two agencies as was evident in the case series. As such, accountability measures need be put in place to ensure that vulnerable populations receive the care that the country's legislation deems their right. Finally, support for women who have been sexually victimised needs to be part of a comprehensive strategy to address the problem of rape itself. This involves developing strategies to uplift communities and prevent the transmission of attitudes that condone violent behaviour. It also entails targeting the gender-based ideologies that contribute to the persistence of violent practices towards women.

8.4. RECOMMENDATIONS FOR FUTURE RESEARCH

A valuable next step in evaluating the Ehlers and Clark (2000) model in the South African context would be to apply it in a setting in which a large number of people can be treated, such as a hospital setting. An ideal context for this could be the Refentse model (Refentse means "we shall overcome" in Venda) described by Kim et al. (2009). The Refentse model is a nurse-driven post-rape care model integrated into an existing hospital setting in rural South Africa (Bohlabela District in Mpumalanga Province). Prior to the implementation of the model the services for rape victims within the hospital setting was of a poor quality and highly fragmented with little inter-sectoral collaboration. The Refentse model overcame this by integrating five interventions: the creation of a sexual violence advisory committee; implementation of a hospital rape management policy; provision of training workshops for service providers; ensuring the availability of a designated examination room and; launching and promoting a community awareness campaign. After intervention there were considerable improvements in a variety of areas including: clinical history taking; the performance of forensic examinations; HIV testing; provision of PEP; trauma counselling; referral to a psychiatric nurse for long-term counselling and; inter-sectoral collaboration between the community, police, prosecutors, social workers and primary care workers. As a result of these interventions, more victims were willing to access the facility and were provided with a higher quality of service. The study essentially showed that it is possible to significantly enhance the quality of care provided to rape victims with minimal costs and using existing resources and that nurses, with additional training, could efficiently provide these services.

One critical implication of this study is that nurses within a hospital setting could be trained to apply a specialist treatment model. The Ehlers and Clark (2000) model has been shown to be accessible to professionals with no prior training as psychologists. Gillespie et al. (2002), for example, described the use of the Ehlers and Clark (2000) model in the treatment of individuals affected by PTSD in a community setting in Northern Ireland. The therapists chosen to implement the model varied in terms of professional background and included nurses, social workers and psychiatrists. The study found that the treatment package could be successfully used by professionals with limited prior exposure to such interventions and by those professionals with no prior training as psychologists. In the South African context, nurses constitute the single

largest category of health care personnel in the public health sector and they are widely distributed throughout the country including rural areas (Kim & Motsei, 2002). For this reason, they are well placed to provide comprehensive care which includes effective psychological treatment to rape victims who cannot access professional mental health services.

Evaluating the Ehlers and Clark (2000) model within a hospital setting would require: (1) assessment of the resources present in the setting including the training background, interests and capacities of nursing staff (e.g. whether they have any training in psychology and the capacities and basic skills to deliver treatment) and practical considerations (e.g. whether there are separate and private rooms available for clients to receive therapy); (2) assessment procedures for rape victims who approach the hospital (i.e. each potential client would need to be assessed in terms of a traditional clinical assessment and with respect to aspects of their physical environment such as safety and social support); (3) intensive training for nursing staff (i.e. in terms of the sequelae associated with rape, the gendered nature of sexual violence, PTSD and the nature and application of the treatment model) and ongoing supervision and support; (4) allocation of cases on the basis of the training and expertise of the nurse (e.g. complex cases would need to be seen by a clinician or a psychiatric nurse with appropriate training); (5) evaluation of training and treatment (e.g. interviewing nurses to determine their experience of using the model and using outcome measures when treating clients to determine treatment effectiveness) (Anda et al., 2006; Royse, Thyer, & Padgett, 2010; Patton, 2002). It is therefore recommended that researchers seek to build on the findings of the present study by developing and evaluating a programme integrated into an existing hospital setting. As recommended by Dattilio et al. (in press) evaluation could comprise several strategies including a further series of systematic case studies.

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APPENDICES

Appendix A: Research recruitment poster

ARE YOU A SURVIVOR OF RAPE OR SEXUAL ASSAULT?

ARE YOU HAVING DIFFICULTY COPING?

DO YOU FEEL YOU NEED HELP?

My name is Anita Unni. I am a registered Counselling Psychologist and PhD student with the Department of Psychology at Rhodes University. My PhD research involves offering survivors of sexual abuse psychotherapy using a specialist treatment approach that is designed to specifically address the difficulties arising from the experience of rape or sexual assault. These difficulties can include: having intrusive thoughts, images or dreams about the traumatic event, avoiding people or places that remind you of the event, feeling jumpy or overly alert, feeling anxious, sad, angry, guilty or ashamed because of the event, having difficulties with relationships and also problems coping with daily life. The aim of the research is to further develop this specialist treatment model to ensure that it specifically caters to the needs of South African rape victims.

If you feel you would like to participate in this project by allowing your therapy sessions to go towards further developing this treatment model, please be assured that your participation will in no way compromise the process and professional standards of therapy. A pseudonym will be used for research purposes and your identifying details will be changed to protect your anonymity. Since you will be contributing to the formation of a body of clinical knowledge through your own experiences, all fees for therapy will be waived.

If you would be willing to consider participating in this project please contact me by phone or e-mail (see details below). I will then arrange to meet you to give you further information so you can make an informed decision.

This advertisement has been approved by the Human Research Subcommittee of the Rhodes University Ethical Standards Committee

CONTACT DETAILS:

anitaunni05@gmail.com
082 854 0930

Appendix B: Client consent form

Rhodes University

Department of Psychology

Agreement Between Student Researcher and Research Participant

I ____________ give consent that my psychotherapeutic treatment with ______________may form part of research aimed at identifying suitable treatments for people affected by trauma.

1. I understand that my participation in this research project will not in any way compromise the process and professional standards of therapy.
2. I give permission for my therapy sessions to be audio-taped and consent to their being heard by psychology professionals bound by the standard regulations of confidentiality.
3. I understand that one of the aims of the research project is to produce publications, including publications of case studies.
4. In the event of publication, I understand that a pseudonym will be used and identifying details changed to protect my anonymity.
5. I understand that since I am contributing to the formation of a body of clinical knowledge through my own experience, all fees for my treatment are waived.
6. I understand that I am invited to voice to the researcher any concerns I have about my participation in the study and to have these addressed to my satisfaction.
7. I understand that I may, at any time, withdraw my consent to participate in the research. However, I will only withdraw consent in exceptional circumstances. In the event that I do withdraw consent, the researcher will still be permitted to use the information garnered from my treatment process for the research project.

Signed

Client

Date:

Anita Unni	Professor David Edwards
Counselling Psychologist	Supervising Clinical Psychologist
Date:	Date:

Appendix C: Parent/Guardian consent form

Rhodes University

Department of Psychology

Agreement Between Student Researcher and Guardian of Client

I _____________ give consent that psychotherapeutic treatment for __________with __________may form part of research aimed at identifying suitable treatments for people affected by trauma.

1. I understand that participation in this research project will not in any way compromise the process and professional standards of therapy.
2. I give permission for therapy sessions to be audio-taped and consent to their being heard by psychology professionals bound by the standard regulations of confidentiality.
3. I understand that one of the aims of the research project is to produce publications, including publications of case studies.
4. In the event of publication, I understand that a pseudonym will be used and identifying details changed to protect anonymity.
5. I understand that since this research aims to contribute to the formation of a body of clinical knowledge through the client's personal experience (s), all fees for treatment are waived.
6. I understand that I am invited to voice to the researcher any concerns I have about participation in the study and to have these addressed to my satisfaction.
7. I understand that I may, at any time, withdraw my consent. However, I will only withdraw consent in exceptional circumstances. In the event that I do withdraw consent, the researcher will still be permitted to use the information garnered from the treatment process for the research project.

Signed

Guardian of Client

Date:

Anita Unni

Counselling Psychologist

Date:

Professor David Edwards

Supervising Clinical Psychologist

Date:

Appendix D: Evaluation form for third party assessor

Transcript Evaluation

The transcript needs to capture the reality of the spoken interaction as closely as possible. In evaluating the transcription, check for the following:

1. Additions

Identify any words or sentences added to the transcript but absent from the audio recording.

- Where there any additions (e.g. words, sentences) to the transcript? Y N
- How many additions did you identify?
  Number of words:
  Number of sentences:
- Are the additions attributable to typographical errors? Y N
- Do the additions alter the meaning of the text? Y N

2. Omissions

Identify any words or sentences omitted from the transcript but present in the audio recording.

- Were there any words or sentences omitted from the transcript? Y N
- How many omissions were present?
  Number of words:
  Number of sentences:
- Are the omissions attributable to typographical errors? Y N
- Do the omissions alter the intended meaning of the communication?
  Y N

Evaluation of Session Narrative

The session narrative represents a summary of the main features of the session. One aspect of this is the process of interaction between therapist and client and the experiences that each expresses as the session proceeds. The narrative is selective in that some sections may be omitted altogether, others summarized quite briefly while others are represented in much more detail. Selection is done on the basis of relevance to the theoretical and practical aspects of the treatment model. Sections with no relevance (such as discussion of appointment times or themes not relevant to the therapy) can be omitted entirely. Sections may be summarized in ways that capture important aspects of the client's and therapist's experience. However it is important that material is not omitted that might be relevant to a critical evaluation of the treatment model. For example, if the client is angry with the therapist or fails to collaborate on a particular

task, it may be inappropriate to omit it. Use the headings below to evaluate whether the session narrative offers an accurate and concise summary of the content of the session.

1. Additions

- List any sections in which information was added to the narrative summary that was not present in the transcript for that session. In each case, evaluate whether the addition might mislead the reader in any significant way.

2. Omissions

- List any section in which information was omitted from the narrative summary. In each case, evaluate whether the omission is legitimate in terms of the principles stated above or it might mislead the reader in any significant way.

3. DISTORTIONS

- List any sections in which information was distorted in the therapy narrative. An example would be a section where a summary represents an interpretation of what happened that does not seem warranted by the material in the transcript. In each case evaluate whether the distortion might mislead the reader in any significant way.

Appendix E: Evaluation form for Lulama

Transcript Evaluation [*Therapy Session 04*]

The transcript needs to capture the reality of the spoken interaction as closely as possible. In evaluating the transcription, check for the following:

1. Additions

Identify any words or sentences added to the transcript but absent from the audio recording.

- Where there any additions (e.g. words, sentences) to the transcript? Y ✓ N
- How many additions did you identify?
  Number of words: 8
  Number of sentences: 0
- Are the additions attributable to typographical errors? Y ✓ N
- Do the additions alter the meaning of the text? Y N✓

2. Omissions

Identify any words or sentences omitted from the transcript but present in the audio recording.

- Were there any words or sentences omitted from the transcript? Y✓ N
- How many omissions were present?
  Number of words: 35
  Number of sentences: 1
- Are the omissions attributable to typographical errors? Y✓ N
- Do the omissions alter the intended meaning of the communication?
  Y N✓

Evaluation of Session Narrative

1. Additions

- List any sections in which information was added to the narrative summary that was not present in the transcript for that session. In each case, evaluate whether the addition might mislead the reader in any significant way.
  - There were no additions that alter what happened in the therapy session

2. Omissions

- List any section in which information was omitted from the narrative summary. In each case, evaluate whether the omission is legitimate in terms of the principles stated above or it might mislead the reader in any significant way.

- There was nothing very important that was left out of the therapy narrative for this session

3. DISTORTIONS

- List any sections in which information was distorted in the therapy narrative. An example would be a section where a summary represents an interpretation of what happened that does not seem warranted by the material in the transcript. In each case evaluate whether the distortion might mislead the reader in any significant way.
    - No distortions were present

Appendix F: Evaluation form for Khuselwa

Transcript Evaluation [*Assessment session 08*]

The transcript needs to capture the reality of the spoken interaction as closely as possible. In evaluating the transcription, check for the following:

1. Additions

Identify any words or sentences added to the transcript but absent from the audio recording.

- Where there any additions (e.g. words, sentences) to the transcript? Y ✓ N
- How many additions did you identify?
  Number of words: 75
  Number of sentences: 8
- Are the additions attributable to typographical errors? Y N✓
- Do the additions alter the meaning of the text? Y N✓

2. Omissions

Identify any words or sentences omitted from the transcript but present in the audio recording.

- Were there any words or sentences omitted from the transcript? Y✓ N
- How many omissions were present?
  Number of words: 18
  Number of sentences: 0
- Are the omissions attributable to typographical errors? Y✓ N
- Do the omissions alter the intended meaning of the communication?
  Y N✓

Evaluation of Session Narrative

1. Additions

- List any sections in which information was added to the narrative summary that was not present in the transcript for that session. In each case, evaluate whether the addition might mislead the reader in any significant way.
    - No additions were present in the therapy transcript.

2. Omissions

- List any section in which information was omitted from the narrative summary. In each case, evaluate whether the omission is legitimate in terms of the principles stated above or it might mislead the reader in any significant way.

- Details about what she read out in her written stories were omitted. I don't know whether this is imperative to include?

Commentary on use of Feedback: Including a transcript of Khuselwa's narratives would have been extremely lengthy. For this reason, comprehensive summaries of these narratives were included. Transcripts of her poems were, however, included to capture the phenomenology.

- Details about Khuselwa's anger towards the perpetrator and his neglect of her rights were omitted – this is important to note because at the beginning of the session, she was self-punitive regarding the rape but further on, in her writing, seems to cast at least some blame on the perpetrator for disrespecting her body and rights.

Commentary on use of Feedback: The assessor's comments were used to enhance the summative account of the session as can be seen in the final assessment session. Content from the transcript of that session was included to emphasise Khuselwa's sense of ambivalence about blaming the perpetrator.

3. DISTORTIONS

- List any sections in which information was distorted in the therapy narrative. An example would be a section where a summary represents an interpretation of what happened that does not seem warranted by the material in the transcript. In each case evaluate whether the distortion might mislead the reader in any significant way.
    - No distortions were present.

Appendix G: Evaluation form for Sanele

Transcript Evaluation [*Therapy session 07*]

The transcript needs to capture the reality of the spoken interaction as closely as possible. In evaluating the transcription, check for the following:

1. Additions

Identify any words or sentences added to the transcript but absent from the audio recording.

- Where there any additions (e.g. words, sentences) to the transcript? Y✓ N
- How many additions did you identify?
  Number of words: 12
  Number of sentences: 1/5(Half a sentence)
- Are the additions attributable to typographical errors? Y N✓
- Do the additions alter the meaning of the text? Y N✓

2. Omissions

Identify any words or sentences omitted from the transcript but present in the audio recording.

- Were there any words or sentences omitted from the transcript? Y✓ N
- How many omissions were present?
  Number of words: 6
  Number of sentences: 0
- Are the omissions attributable to typographical errors? Y N✓
- Do the omissions alter the intended meaning of the communication?
  Y N✓

Evaluation of Session Narrative

1. Additions

- List any sections in which information was added to the narrative summary that was not present in the transcript for that session. In each case, evaluate whether the addition might mislead the reader in any significant way.

  - Please refer to "Distortions" section.

2. Omissions

- List any section in which information was omitted from the narrative summary. In each case, evaluate whether the omission is legitimate in terms of the principles stated above or it might mislead the reader in any significant way.

    - The inclusion of Sanele's income per month should also have warranted the inclusion of the amount a flat/ alternate accommodation would cost; being R200-400per month as she mentions. This gives the reader a better idea of the difficulty she faces in finding reasonably priced and safe accommodation.

    - After speaking about Sanele's reluctance to stay with her mother, it would be good to include that you tried to prompt her speaking more about "what happened to her that night" but that she was reluctant to speak further about it that day.

    - Maybe also to include her reluctance to seek resources (i.e. Fort England) when you are away?

    Commentary on use of Feedback: These aspects were included in the therapy narrative.

3. DISTORTIONS

- List any sections in which information was distorted in the therapy narrative. An example would be a section where a summary represents an interpretation of what happened that does not seem warranted by the material in the transcript. In each case evaluate whether the distortion might mislead the reader in any significant way.

    - Sanele comments that her face was sore after the assault outside her house but nothing was mentioned in the recording about her being hit on the head or on her left temple as the narrative does: *"She could not see clearly through her left eye as she had been struck close to her left temple and her eye lids had swollen. She had also been struck at the back of her head."*I don't know if this was perhaps evaluated by seeing her face to face or that perhaps something in her Xhosa words was omitted?

Commentary on use of Feedback: This latter information was gleaned from the telephone conversation with Sanele after her release from hospital. It was subsequently briefly detailed under a separate heading.

Appendix H: Evaluation form for Anna

Transcript Evaluations (*Therapy session 20*)

The transcript needs to capture the reality of the spoken interaction as closely as possible. In evaluating the transcription, check for the following:

1. Additions

Identify any words or sentences added to the transcript but absent from the audio recording.

- Where there any additions (e.g. words, sentences) to the transcript? Y✓ N
- How many additions did you identify?
  Number of words: 37
  Number of sentences: 1
- Are the additions attributable to typographical errors? Y✓ N
- Do the additions alter the meaning of the text? Y N✓

2. Omissions

Identify any words or sentences omitted from the transcript but present in the audio recording.

- Were there any words or sentences omitted from the transcript? Y✓ N
- How many omissions were present?
  Number of words: 48
  Number of sentences: 0
- Are the omissions attributable to typographical errors? Y✓ N
- Do the omissions alter the intended meaning of the communication?
  Y N✓

Evaluation of Session Narrative

1. Additions

- List any sections in which information was added to the narrative summary that was not present in the transcript for that session. In each case, evaluate whether the addition might mislead the reader in any significant way.
  - Nothing was added in the therapy narrative that distorts in any way what happened during the session.

2. Omissions

- List any section in which information was omitted from the narrative summary. In each case, evaluate whether the omission is legitimate in terms of the principles stated above or it might mislead the reader in any significant way.
    - One addition could perhaps be made: Anna's initial hesitance to engage in the memory restructuring is notable as she joked around perhaps out of discomfort or unwillingness to engage in a hurtful past memory.

Commentary on use of Feedback: I interpreted Anna's joking in this incident as indicative of her attempt to lighten the mood. I did not construe it as avoidance because she subsequently actively engaged with imagery rescripting and was eager to use the technique. In earlier sessions, her jokes were clearly motivated by avoidance. For this reason, in this session, her joking was initially excluded from the narrative.

3. DISTORTIONS

- List any sections in which information was distorted in the therapy narrative. An example would be a section where a summary represents an interpretation of what happened that does not seem warranted by the material in the transcript. In each case evaluate whether the distortion might mislead the reader in any significant way.
    - No distortions that I picked up on were evident in the narrative.

Appendix I: Evaluation form for Emmy

Transcript Evaluation [*Assessment Session 02*]

The transcript needs to capture the reality of the spoken interaction as closely as possible. In evaluating the transcription, check for the following:

1. Additions

Identify any words or sentences added to the transcript but absent from the audio recording.

- Where there any additions (e.g. words, sentences) to the transcript? Y✓ N
- How many additions did you identify?
  Number of words: 12
  Number of sentences: 0
- Are the additions attributable to typographical errors? Y✓ N
- Do the additions alter the meaning of the text? Y N✓

2. Omissions

Identify any words or sentences omitted from the transcript but present in the audio recording.

- Were there any words or sentences omitted from the transcript? Y✓ N
- How many omissions were present?
  Number of words: 94 – just words, excluding full sentences
  Number of sentences: 16
- Are the omissions attributable to typographical errors? Y N✓
- Do the omissions alter the intended meaning of the communication?
  Y N✓

Evaluation of Session Narrative

Just a note: the therapy narrative should be Session 1 while the transcript is Session 02.

1. Additions

- List any sections in which information was added to the narrative summary that was not present in the transcript for that session. In each case, evaluate whether the addition might mislead the reader in any significant way.
    - No additions.

2. Omissions

- List any section in which information was omitted from the narrative summary. In each case, evaluate whether the omission is legitimate in terms of the principles stated above or it might mislead the reader in any significant way.

- Emma felt that she needed to handle the rape situation by herself because she did not want to burden others with it – a coping mechanism you both recognised in this session.
- She also revealed that her emotional reliance on her boyfriend made her uncomfortable. She seems to shy away from available help and support.

Commentary on use of Feedback: Emmy's reluctance to use available supports was primarly related to her difficulty coming to terms with the rape. However, this could only become apparent to the assessor if more than one session was reviewed. Once Emmy accepted the trauma, she was more willing to use available supports.

3. DISTORTIONS

- List any sections in which information was distorted in the therapy narrative. An example would be a section where a summary represents an interpretation of what happened that does not seem warranted by the material in the transcript. In each case evaluate whether the distortion might mislead the reader in any significant way.

  No distortions I could pick up on.

Appendix J: Evaluation form for Lori

Transcript Evaluation [*Therapy session 02*]

The transcript needs to capture the reality of the spoken interaction as closely as possible. In evaluating the transcription, check for the following:

1. Additions

Identify any words or sentences added to the transcript but absent from the audio recording.

- Where there any additions (e.g. words, sentences) to the transcript? Y✓ N
- How many additions did you identify?
  Number of words: 64
  Number of sentences: 0
- Are the additions attributable to typographical errors? Y✓ N
- Do the additions alter the meaning of the text? Y N✓

2. Omissions

Identify any words or sentences omitted from the transcript but present in the audio recording.

- Were there any words or sentences omitted from the transcript? Y✓ N
- How many omissions were present?
  Number of words: 129
  Number of sentences: No complete sentences were missing; 3 half sentences
- Are the omissions attributable to typographical errors? Y N✓
- Do the omissions alter the intended meaning of the communication?
  Y N✓

Evaluation of Session Narrative

1. Additions

- List any sections in which information was added to the narrative summary that was not present in the transcript for that session. In each case, evaluate whether the addition might mislead the reader in any significant way.
    - No additions were present in the therapy narrative.

2. Omissions

- List any section in which information was omitted from the narrative summary. In each case, evaluate whether the omission is legitimate in terms of the principles stated above or it might mislead the reader in any significant way.

- The information that was omitted was done so due to it not being relative to the core of what the treatment model aims to explore. It seemed as though Lori spent a lot of time speaking about her friends life and thus shifting the focus away from herself in therapeutic scrutiny– which she was perhaps uncomfortable with. I think that this was however, adequately captured in the narrative.

3. DISTORTIONS

- List any sections in which information was distorted in the therapy narrative. An example would be a section where a summary represents an interpretation of what happened that does not seem warranted by the material in the transcript. In each case evaluate whether the distortion might mislead the reader in any significant way.
    - No distortions were present in the narrative.

Appendix K: Psycho-educative material – Rape Myths

RAPE MYTHS

A myth is a commonly held belief or idea that is NOT TRUE. Myths arise from people's need to make sense of acts that are senseless, violent or disturbing. They attempt to explain horrible events, like rape and abuse, in ways that fit with their existing ideas about the world. In this pamphlet, some common myths about rape are presented.

MYTH: RAPE OCCURS BETWEEN STRANGERS IN DARK ALLEYS

FACTS:

- more than half of all rapes are committed by persons known to the survivor
- date or acquaintance rape is very common
- women are often raped in their homes

MYTH: WOMEN PROVOKE RAPE BY THE WAY THEY DRESS OR ACT

Facts:

- dressing attractively and flirting is an invitation for attention and/or admiration, not for rape
- Only the rapist is responsible for the rape!

MYTH: WOMEN WHO DRINK ALCOHOL OR USE DRUGS ARE ASKING TO BE RAPED

Facts:

- women have the same rights to use substances as men do
- being vulnerable does not imply consent
- if a woman is unable to give consent because she is drunk, drugged or unconscious, it is rape
- Only the rapist is responsible for the rape!

MYTH: RAPE IS A CRIME OF PASSION

Facts:

- research and evidence from rapists themselves suggests that most rapes are premeditated and planned
- many rapists fail to get an erection or ejaculate
- interviews with rapists reveal that they rape to feel powerful and in control, not for sexual pleasure
- stereotypically unattractive women are raped, including the elderly and babies
- many rapists are involved in sexually satisfying relationships with wives or girlfriends at the time of the rape

MYTH: IF SHE DIDN'T SCREAM, FIGHT OR GET INJURED, IT WASN'T RAPE

Facts:

- women in rape situations are legitimately afraid of being killed or seriously injured and so co-operate with the rapist to save their lives
- rapists use many manipulative techniques to intimidate and coerce women
- women in a rape situation often become physically paralysed with terror or shock and are unable to move or fight
- non-consensual intercourse doesn't always leave visible signs on the body or the genitals

MYTH: WOMEN CRY RAPE WHEN THEY REGRET HAVING SEX OR WANT REVENGE

Facts:

- studies have indicated that only 2% of all reported rapes are false, which is slightly less than false reporting in all other crimes

MYTH: HUSBANDS CANNOT RAPE THEIR WIVES

Facts:

- it is always rape if the woman does not consent, no matter what her relationship with the man
- the Prevention of Family Violence Act of 1993 makes rape in marriage illegal throughout SA

MYTH: RAPE ONLY HAPPENS TO WOMEN WHO ARE ON THE STREETS LATE AT NIGHT

Facts:

- rape happens everywhere at school, at work, in the home, at the mall, etc

Appendix L: Psycho-educative material – Rape Trauma Syndrome

WHAT IS RAPE?
Rape is sex without consent. Many people think that rape only occurs between strangers. This is not true. Acquaintance rape and date rape are the most common kinds of rape. Many people also believe that a man cannot rape his wife, or that a boyfriend cannot rape his girlfriend. This is also untrue.

WHY DOES RAPE HAPPEN?
Many people believe that rape is a crime of passion: that men rape because they get so sexually aroused that they cannot help themselves. This assumes that men are incapable of delaying gratification or controlling sexual urges, which is untrue. It also suggests that rape is impulsive. Interviews with rapists reveal that most rapes are premeditated and planned. Rapists rape to feel powerful and in control, not for sexual pleasure.

RAPE TRAUMA SYNDROME

What is rape trauma syndrome?
Rape Trauma Syndrome (RTS) describes a set of reactions that most victims of rape experience after the attack. Post-traumatic stress disorder (PTSD) is one such reaction.

Do all rape survivors experience RTS?
Not necessarily. Different women respond to the trauma of rape in different ways. Some women will experience many severe RTS symptoms; others may have few or none at all. ALL rape survivors need to be believed, taken seriously and supported, regardless of whether they experience RTS or not.

Does having RTS make you crazy?
NO! The symptoms of RTS can be very powerful and distressing. If you are a survivor, you may fear that you are going mad. If you are supporting a friend or family member who has been raped, you may find the survivor's behaviour puzzling or upsetting. **HOWEVER, the fact is that the symptoms of RTS are a NORMAL reaction to a traumatic experience,** and that they will fade over time with care and support.

What influences how you react to rape?
A survivor's individual response to rape, including whether and how she experiences RTS, depends on many factors, including:

- Whether she knew or trusted the rapist
- Whether her family and friends are supportive and patient or blaming and unhelpful
- How the police and justice system treat her, should she choose to report the rape
- Her age and previous life experiences
- Her cultural and religious background
- The degree of violence used by the rapist
- Whether any injuries, illnesses or disabilities result from the rape
- Whether the rape brings up memories of past trauma she has experienced
- Her emotional state prior to the rape
- Her practical and material resources

Every rape situation is unique and it is thus very important to treat each rape survivor individually.

Is it possible to forget about a rape?
Many rape survivors may lose or suppress their memory of part or all of a rape. Some women find that they can remember before and after, but not the rape itself. The memories will almost always resurface later, and the survivor will need to face them. If the rape survivor is very young, or experiences the rape as especially traumatic, she may block the memory of the rape even as it is occurring. She may not consciously recognise that she has been raped or experience any symptoms until months or years later, usually when another event in her life, such as a new sexual relationship or another trauma, triggers the memories. Once she has her memories, the survivor will never forget what has happened, but she can learn how to live with it. Recovery from rape takes time. The survivor must allow herself to remember the rape, and feel whatever feelings it brings up, even though this is often very difficult.

She needs to work through the experience, and integrate it into her life so that she can move on.

Physical Symptoms of RTS

- **Shock:** usually a more immediate response; may include numbness, chills, faintness, confusion, disorientation, trembling, nausea and sometimes vomiting
- **Sleeping problems:** unable to sleep, sleeping more than usual, or other changes in sleeping patterns
- **Eating problems:** no appetite and subsequent weight loss, or compulsive eating and subsequent weight gain
- **No energy or too much energy**
- **Physical illness:** the stress may weaken her immune system and make her more vulnerable to sickness, she may have caught a sickness from the rapist, or she may simply feel sick
- **Pain in her body:** this may be as a result of injuries inflicted by the rapist, or a physical reaction to her emotional pain
- **Cardiovascular problems:** heart palpitations, breathlessness, tightness or pain in the chest, high blood pressure
- **Gastrointestinal problems:** loss of appetite, nausea, diarrhea, constipation, dryness in mouth, butterflies in stomach, feelings of emptiness in stomach, etc.
- **Exaggerated startle response:** over-reacting to sudden noise or movement
- **Oversensitivity to noise**

Cognitive Symptoms of RTS

- **"As if" feelings or flashbacks:** re-experiencing sensations that she felt during the rape, or actually reliving parts of the experience in her head
- **Intrusive thoughts:** sudden or forceful "intrusive" memories of aspects of the rape
- **Thinking about the rape all the time**
- **Memory loss:** the survivor may be unable to remember the rape or parts of it; this is usually temporary, although it can last for many years
- **Poor concentration**
- **Increased alertness**
- **Speech problems: stuttering, stammering or other difficulty talking**
- **Indecisiveness**
- **Difficulty problem solving**
- **Nightmares**

Behavioural Symptoms of RTS

- **Crying**
- **Avoiding reminders of the rape**
- **Pretending that it never happened**
- **Neglecting herself or other people**
- **Increased washing or bathing**
- **Self-blame**
- **Fear of being alone**
- **Not socialising or socialising more than before the rape**
- **Relationship problems:** the survivor may be irritable, argumentative or easily upset; she may withdraw from people that she felt close to before the rape or form sudden new connections; she may grow overly dependent on others or too independent.
- **Sexual problems:** the survivor may not want sex or be able to enjoy it - this may become worse if her partner blames her or is impatient with her recovery; alternatively, she might become more sexually active than before
- **Lifestyle changes:** the survivor may make drastic changes in her home, work, school or relationships; this can be an important part of helping her feel safe and in control again
- **Substance abuse**

Emotional Symptoms of RTS

- **Denial**

- **Numbness or lack of emotion**
- **Rapid, inexplicable mood changes**
- **Shame**
- **Guilt**
- **Feeling dirty**
- **Anger or desire for revenge**
- **Fear**
- **Nervousness and worry**
- **Being easily upset**
- **Powerlessness and loss of control**
- **Grief and loss**
- **Feeling "different" from other people**
- **Loss of Self-esteem**
- **Losing interest in life**
- **Depression**
- **Suicidal feelings**

Appendix M: Psycho-educative material – Social Phobia

What is social phobia?
Social phobia is an anxiety disorder characterised by a persistent fear of criticism or rejection by others. People with social phobias fear they may behave in a way that will be embarrassing or humiliating. Essentially, social phobia is a fear of the disapproval of others.

What are the symptoms of social phobia?
The symptoms of social phobia can be grouped into three major categories. The first category includes the bodily symptoms of anxiety, which you experiences when you are in, or when you are anticipating, the social situations you fear. The second category includes your cognitions (thoughts) and expectations about these social situations. In this respect, you are likely to have certain thoughts about what you <u>should</u> be like in social situations. The third includes your actions or behaviours related to these situations.

Examples:

Bodily Symptoms	**Cognitive Symptoms (Automatic Thoughts)**	**Behavioural Symptoms**
▪ Rapid heart rate, or heart palpitations ▪ Trembling or shaking ▪ Shortness of breath ▪ Sweating ▪ Dizziness	▪ I look out of place ▪ I look fat ▪ I look ugly ▪ I sound stupid ▪ I don't fit in	▪ Freezing ▪ Avoidance (Escape behaviour, distraction)

<u>SETTING GOALS AND OBJECTIVES</u>

Defining your goals answers the question, 'What do I want to accomplish?' Defining your objectives answers the question 'How will I know when I have accomplished my goal?'

GOAL

1. What type of social situation do you want to stop avoiding?
2. How do you want to feel in that social situation?

EXAMPLES

I want to be more outgoing and comfortable in social gatherings.

OBJECTIVES

1. How will you know when you have accomplished your goal? What will be different?

EXAMPLES

- I will feel less anxious when I am introduced to a stranger.
- I will be able to maintain eye contact
- I won't turn down invitations to social functions
- I will make new friends
- I will stop assuming that I am saying the wrong things all the time

YOUR GOALS AND OBJECTIVES

GOALS

1. ____

2. ___________________________
3. ___________________________
4. ___________________________

OBJECTIVES

1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________
5. ___________________________

ASSESSING YOUR FEARS

This involves getting a better idea of your specific set of fears.

Bodily Symptoms

Bodily symptoms of social phobia: How does your body react to disapproval? The following checklist can assist you in identifying your body's reactions. Tick the reactions you experience in social situations.

	Rapid heart rate		**Dry mouth**
	Shortness of breath		**Urinary urgency**
	Abdominal distress		**Tingling sensations**
	Sweating		**Muscle twitching**
	Blushing		**Chest pain**
	Trembling		**Numbness**
	Shaking		**Hot flashes or chills**
	Dizziness or feeling faint		**Other:**
	Tense muscles		**Other:**
	Choking or lump in throat		**Other:**

Cognitive Symptoms

Below is a list of some of the fearful thoughts or cognitions that you may experience in social situations. Place a checkmark next to any of these thoughts you experience when you are socially anxious.

	I look out of place		I'm unlovable
	I sound stupid		I look nervous
	I don't fit in		I'm so embarrassed
	I'm blowing it		I'm too quiet
	I know they hate me		I sound boring
	I look ugly		I'm such a klutz
	I look fat		I'm unattractive
	I'll be rejected		No one likes me
	I appear incompetent		Other:
	Others are talking about me		Other:

How do I try to avoid disapproval? You've already assessed how your body and mind react to disapproval. Now examine how you behave when you are scared. Typically, people tend to avoid the things they fear.

Behavioural symptoms

	Thinking about other things		Day dreaming
	Staying for only a certain length of time		Other:
	Staying close to a safe person		Other:

	Only going to safe places		Other:
	Not making eye contact		Other:
	Using alcohol or drugs		Other:

Appendix N: Client Updates

While in the final stages of compiling this project, I encountered Lulama's and Khuselwa's referral agents in the town. I learnt from Zamiwe (Lulama's referral) that, approximately five months after ending therapy, Lulama had started a relationship with a much older man and had dropped out of school after becoming pregnant with his child. According to Zamiwe, Lulama's boyfriend owned a drinking tavern in the area and she had moved out of her family home and was living with him. I learnt that Lindiwe (Lulama's sister) had remained in school but had failed to arrive for some of her final Grade 12 exams and would probably have to redo her grade.

Grace, Khuselwa's referral agent, informed me that, a few months after she terminated from therapy, Khuselwa had stabbed another girl at the shelter. Thereafter, the house mother was concerned that she represented a threat to the safety of the other girls and requested that she be removed. She was then forced to return to her mother's house. I learnt that while staying at the shelter Khuselwa experienced severe problems with bed wetting on an almost daily basis. In addition, she failed to follow curfew and on one occasion arrived at the shelter late at night and in an inebriated state. Furthermore, Grace revealed that Khuselwa had frequently been involved in disciplinary issues at school because she often did not wear any underwear underneath her school uniform. While attending a camp run by the NGO she had engaged in the same behaviour and many of the other students had complained. Grace intervened and insisted that Khuselwa wear under-clothing.

I learnt that after returning to her mother's care, Khuselwa started running away from home for weeks at a time staying in different places and usually with men who were strangers. She had frequently visited the NGO during this time and requested birth control pills and pregnancy tests and Grace indicated that it was clear Khuselwa was having sexual relationships with these men. On one occasion she arrived at the shelter in a bedraggled state and Grace described her as being "covered in semen" and smelling as though she had not bathed for weeks. Grace demanded that Khuselwa take her to her current place of residence and found that she lived with a "filthy" man in his late fifties. Grace reported that she was horrified at the condition of the man's flat and could not understand how anyone could live in such a place or have sexual relations with such an individual. She had advised Khuselwa to return to her mother's care but she refused.

Grace told me that Khuselwa had been to see two therapists prior to me. She had refused to continue with the first clinician after only one session and complained that her psychologist asked too many questions. She had seen the second clinician for two sessions before terminating for the same reason. Grace reported that she had been extremely relieved when she noticed that Khuselwa was managing to stay in therapy with me but felt saddened when she once again prematurely terminated. I explained that I still wanted to help Khuselwa but was uncertain whether she would want to return to therapy. Grace subsequently offered to arrange a meeting between the three of us but reported that she would first have to find Khuselwa and this would take some time. At the time of compiling this post-script, two weeks after meeting Grace, Khuselwa had not been located.