EYE MOVEMENT DESENSITIZATION AND REPROCESSING: A CASE STUDY OF A FEMALE ADOLESCENT SEXUAL ASSAULT SURVIVOR

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DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and had not previously in its entirety or in part been submitted at any other university for a degree.

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SUMMARY

This study explores the use of Eye Movement Desensitisation (hereafter referred to as EMDR), a form of psychotherapy on a female adolescent sexual assault survivor. Adolescence as a developmental stage is characterised by specific issues, such as the search for own identity. Sexual trauma may increase the inner conflict, because of the adolescent's ability to deal with the trauma at a higher cognitive level than in earlier childhood. Without support including psychotherapy, the adolescent sexual assault survivor may be at risk of developing mental health problems including Post-traumatic Stress Syndrome (hereafter referred to as PTSD).

This research is a qualitative case study, involving only one adolescent participant. Mary (pseudonym) a sexual assault survivor, was selected from referrals the Unit for Educational Psychology at the University of Stellenbosch received from the Child Protection Unit of the South African Police Services. She was referred because she displayed symptoms of depression and PTSD, which affected her relations with her parents, siblings and peers. She also struggled to cope emotionally with the academic demands of school. The ecosystemic approach was chosen as the preferred framework within which to locate this study. In assessment and intervention this framework lends itself to focussing on relationships and systems rather than merely the individual with a problem.

The study explores the use of EMDR to alleviate symptoms of depression and PTSD in Mary. She attended thirteen sessions of which the first three were used to assess her level of functioning. Data were collected by means of self-report questionnaires including the *Beck's Depression Inventory* and the *Dissociative Experiences Scale*, interviews and therapy sessions during which EMDR was used. The data were analysed using codes, categories and themes, interpreted and the study concluded with a discussion of the findings. The findings suggest that EMDR effectively alleviated Mary's symptoms of depression and PTSD. However, since the study was limited to a single participant, a larger sample is recommended to determine whether EMDR might be a feasible treatment tool for female adolescent sexual assault survivors.

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SAMEVATTING

Hierdie studie ondersoek die gebruik van Oogbeweging Desensitifisering Herprosessering (hierna verwys as OBDH), 'n tipe psigoterapie, om 'n vroulike adolessente slagoffer van seksuele misbruik te ondersteun. Adolessensie as 'n ontwikkelingsfase word deur spesifieke kwessies gekenmerk, onder andere die soeke na 'n eie identiteit. Seksuele trauma mag die innerlike konflik verhoog, weens die adolessent se vermoeë om dit op 'n hoër vlak van ontwikkeling as die jonger kind te hanteer. Sonder ondersteuning, insluitend psigoterapie, mag die adolessent die risiko loop om geestesversteurings soos Posttraumatiese stresversteuring (hierna verwys as PTSV) te ontwikkel.

Hierdie navorsing was 'n kwalitatiewe gevallestudie en slegs een adolessente deelnemer was daarby betrokke. Mary (skuilnaam) 'n seksuele geweld oorwinnaar, is gekies vanuit verwysings wat die Eenheid vir Opvoedkundige Sielkunde van die Universiteit van Stellenbosch van die Kinderbeskermings-eenheid van die Suid-Afrikaanse Polisie Dienste ontvang het. Sy is verwys aangesien sy blykbaar simptome van depressie en PTSV geopenbaar het, wat haar verhoudings met haar ouers, sibbe en portuurgroep beïnvloed het. Sy het ook emosioneel gesukkel om die akademiese eise van die skool te hanteer. Die ekosistemiese benadering is gekies as die raamwerk vir hierdie studie. In assessering en intervensie lê dié benadering groter klem op verhoudings en sisteme, as op 'n individu met 'n probleem.

Die doel van hierdie studie was om vas te stel of die gebruik van OBDH verligting van simptome van depressie en PTSV in Mary teweeg sou bring. Sy het dertien sessies bygewoon en die eerste drie is gebruik om haar vlak van funksionering te bepaal. Data is ingesamel deur middel van die *Beck's Depression Inventory* en die *Dissociative Experiences Scale* vraelyste, onderhoude en terapie sessies waarin OBDH ook gebruik was. Die data is ontleed deur middel van kodes, kategorieë en temas, geïnterpreteer en die studie eindig met 'n bespreking van die bevindinge. Die bevindinge het aangedui dat OBDH effektief Mary se simptome van depressie en PTSV verlig. Omdat die studie egter beperk was tot 'n enkele deelnemer, word 'n groter getal deelnemers aanbeveel om te bepaal of OBDH moontlik geskik is om vroulike adolesente oorwinnaars van seksueel geweld te ondersteun.

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CHAPTER ONE

THE CONTEXTUALISATION AND ORIENTATION OF THE STUDY

1.1 INTRODUCTION

Although figures for crimes reported to the South African Police Services (2003a) for the period 1994 to 2002 appear to indicate a decrease in certain kinds of crime such as burglary and housebreaking, South Africa still remains a very violent country. The crime statistics suggest that many children are exposed to an extremely high level of traumatic events including sexual abuse (South African Police Services, 2003b).

According to the recent crime statistics 23 615 cases of child abuse were reported to the South African Police Services in the period January 1994 and December 2002 (2003a). In the same period, more than 50 000 rapes or attempted rapes and 52 122 cases of indecent assault were also reported to the South African Police Services (2003b). Yehuda (1998:3-7) states that research on the prevalence of exposure to trauma such as childhood sexual abuse, and the risk of developing Post-traumatic Stress Disorder, has been done mainly in countries such as the United States of America, the United Kingdom, Canada and Australia. Very few studies on the problem of childhood sexual abuse have been done in South Africa. September and Loffel (1998:1) maintain this lack of research means that the full extent of the problem in South Africa remains unclear.

Kinchin and Brown (2001:40) argue that there is a large body of research on the effects of trauma such as childhood sexual abuse on the individual, including the risk of developing Post-traumatic Stress Disorder (hereafter referred to as PTSD[1]), Borderline Personality Disorder and Dissociative Disorder, for example. Friedman (2000:3) maintains that symptoms of PTSD could impact negatively on the daily functioning of the individual. Mental health practitioners need a variety of tools to effectively support survivors of sexual abuse, and Alan (in Bongar & Beutler, 1995:405) states:

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[1] Posttraumatic Stress Disorder is defined as an emotionally overwhelming or stressful experience (Friedman, 2000:1).

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> The overarching goal of psychotherapy research is to understand alternative forms of treatment, the mechanisms and processes through which these treatments operate, and the impact of treatment and moderating influences on maladaptive and adaptive functioning.

This study explored the use Eye Movement Desensitisation and Reprocessing (hereafter referred to as EMDR), a form of psychotherapy with a female adolescent sexual assault survivor.

1.2 THEORETICAL FRAMEWORK

Fouche and Delport (in De Vos, Strydom, Fouche & Delport, 2002:265-266) emphasise the importance of having a "paradigm, model or frame of reference" that underpins one's research. They regard a paradigm as essential, and maintain it guides the researcher's enquiry. A problem such as sexual assault of adolescents cannot be seen in isolation.

Combrink-Graham (1987:504) considers the ecosystemic approach as an alternative to the traditional lineal-causal approach, in the way in which an individual is assessed and treatment is provided. Cottone (1989:225) argues that in the traditional approach, by contrast, "people are viewed as 'things', having identities all their own, and having problems bounded to a large degree by their individual identities". According to Donald, Lazarus and Lolwana (2000:34-36) the main concern of the ecosystemic perspective is to show the interactions between an individual and the various environments, systems or levels within which that person lives and grows.

Thompson and Rudolph (2000:313) furthermore maintain that children and their families can be seen as subsystems or microsystems, operating within larger macrosystems. For the adolescent the systems include the environment of the home, school, society and cultural environment. According to Wilkinson and O'Connor (1982:985) there are complex and dynamic relationships, which exist between the various systems. The impact of sexual trauma will extend beyond the adolescent, and his or her family, to other systems.

For the purposes of this study I will also briefly outline some aspects of adolescent development including physical, psychosocial, cognitive and moral development as subsystems of the individual. I am especially interested in aspects pertaining to adolescent development and behaviour, and the impact of sexual assault on the individual and other systems. The theoretical concepts used in this study are derived from the stages of cognitive

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development proposed by Jean Piaget (Papalia & Olds, 1989:364), Erik Erikson's (1971:93-211) psychosocial stages of human development and Lawrence Kohlberg's who emphasised the moral development in individuals (Feldman, 1999:443).

My choice of framework however, should not be taken as indicating the inherent superiority of an ecosystemic perspective to other perspectives. This choice did, however, permit me to explain some of the issues of adolescent development and behaviour. It also provided me, as trainee educational psychologist, an understanding of these issues as they pertain to a sexual assault survivor.

1.3 MOTIVATION OF THE STUDY

A 17-year-old female adolescent sexual assault survivor was chosen as a case study for this research, because of my interest in EMDR as a therapeutic tool in the support of female adolescent sexual assault survivors. The Child Protection Unit of the South African Police Services of the Western Cape (Goodwood) referred Mary (pseudonym), to the Unit for Educational Psychology at Stellenbosch University. Her mother Ms Snell (pseudonym) sought assistance since Mary was struggling to cope with the psychological effects of the assault. She was reportedly displaying symptoms of depression[2] and PTSD.

As a trainee educational psychologist, I was trained in Eye Movement Desensitization and Reprocessing and completed level-one training. EMDR is a form of psychotherapy, and proponents (Edmond, Rubin & Wambach, 1999:103-117) claim it to be effective in the treatment of people suffering from various mental disorders including PTSD. Before completing the advanced training, I remained open-minded about the effectiveness of EMDR as a treatment tool. I was, particularly interested in the possibilities EMDR might hold and its appropriateness for the support of adolescent female survivors of sexual assault. There were three other reasons for my wanting to undertake this study. As stated previously, the recent South African crime statistics (2003) suggest that many children are exposed to sexual abuse. Second, as an employee of the Western Cape Education Department, I often have sexual assault survivors of school-going age referred to me for psychotherapeutic support. I felt I could use the knowledge and skills gained from this study to support other sexual assault survivors. Finally, this study could also form the basis of future research in the area of therapeutic support for adolescent survivors of sexual assault.

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[2] Depression is characterised by a disturbance in the mood of the individual (Tomb, 1999: 40).

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1.4 RESEARCH PROBLEM

This study sought to explore the use of EMDR in the therapeutic support of a female adolescent survivor of sexual assault. The central question for this study, therefore, is whether Eye Movement Desensitization Reprocessing used in the support of a female adolescent survivor of sexual assault could contribute to alleviating depressive and dissociative Post-Traumatic Stress Disorder symptoms.

1.5 RESEARCH DESIGN AND METHODOLOGY

Babbie and Mouton *et al.* (2001:72) maintain that with any scientific enquiry the researcher has to: "determine what you're going to observe and analyse". According to them the researcher has to know "why" and "how" a phenomenon is going to be observed, before interpretations can be made. This study is a qualitative case study with one adolescent participant. The participant, Mary, attended thirteen sessions which were all video-recorded. I used various self-report questionnaires including the *Beck's Depression Inventory* and the *Dissociative Experiences Scale*, interviews, field notes and the standard protocol for EMDR to gather data. The data were analysed using codes, categories and themes (Miles & Huberman, 1984:56-57). Several themes emerged which formed the basis of my discussion and conclusions drawn.

1.6 KEY CONCEPTS OF THIS STUDY

A review of the literature shows that adolescence, sexual assault, and EMDR as a psychotherapeutic tool are complex concepts, and the limitations of these concepts as used in this study, are fully recognised. Brief descriptions of my use of these concepts in his study are provided.

1.6.1 Adolescence

Papalia and Olds (1989:342-344) define adolescence as the period between childhood and adulthood, which starts at the age of twelve or thirteen and ends in the late teens or early twenties. They also state that this developmental stage is characterised by physical, cognitive, moral and emotional change. According to Nash, Stoch and Harper (1990:131) adolescents often struggle to cope with the specific developmental issues characteristic of this phase, such as the rapid physiological changes and the strong need to establish an identity. Ponce (in

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Tseng & Streltzer, 2001:195) also cautions that such developmental issues may influence the expression of mental health problems and requires special consideration by the therapist.

1.6.2 Sexual assault

Although the concept sexual assault and rape will be used interchangeably for the purposes of this study Feiring, Rosenthal and Taska (2000:312), maintain the concept sexual assault is complex and far more comprehensive and include the concept rape. Nash *et al.* (1990:492) define rape is an extreme form of violence and state that it occurs when one person forces another to submit to sexual activity such as intercourse or oral-genital sex. They also maintain that the "force can be physical or the threats of physical harm or death". For the purposes of this study I will use the concept survivor to refer to an individual who had been sexually assaulted. According to McLellan (2001:1953-1954) the sexual assault of adolescents often occurs during social encounters with the perpetrators, for example when the individual goes on a date.

1.6.3 Child sexual abuse

Kinchin and Brown (2001:38) regard child sexual abuse as the "exploitation of a child or adolescent". September and Loffell (1998:8-9) define child sexual abuse as "any sexual act between a child and a person who is more powerful, in terms of e.g. age, assertiveness or physical strength". Barlow and Durand (1995:541-542) postulate that children who suffer sexual abuse may be at risk of developing mental illnesses or emotional problems such as guilt, anxiety and depression (Feldman, 1999:346) as adults. Sexual abuse may lead to emotional conflict within adolescent survivors, because they function at a higher level of cognitive and moral development, than earlier in childhood (Feldman, 1999:427; Nash *et al.*, 1990:131).

Finkelhor in Wyatt and Powell (1986:62) maintains that children may experience confusion as to whether the abuse was forced or consensual, and may engage in risk-taking and inappropriate sexual behaviour. Capuzzi and Gross (1997:331-336) are supportive of child sexual abuse survivors receiving therapeutic intervention, but express the reservation that the above-mentioned developmental issues of adolescence pose a challenge to psychotherapists. Another matter that Ponce (in Tseng & Streltzer, 2001:206) advocates is "sensitivity", especially when dealing with adolescents in a cross-cultural therapeutic relationships.

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1.6.4 Eye Movement Desensitisation and Reprocessing

Shapiro (2002:1453) maintains EMDR is an integrative therapeutic approach utilising bilateral stimulation to process trauma, which if left untreated can cause PTSD and other mental disorders. Proponents of EMDR (Shapiro & Maxfield, 2002:934) claim it is effective for treating victims of rape and childhood trauma. In their research findings, Edmund, Rubin and Wambach (1999:103-117) claim that EMDR treatment reduced trauma symptoms among female survivors of childhood sexual abuse. Shapiro (2002:1455) states EMDR has particular value and unique advantages which other forms of therapy do not have. One is the simplicity and ease of the procedure, and another is the rapid favourable response in comparison to others forms of therapy. She maintains that immediate relief of emotional distress and the elimination of the effect of unresolved past trauma could be obtained even after just one session. Furthermore, one long-term benefit is the restoration of the client's natural state of emotional functioning. EMDR has, however, not been without controversy and other mental health professionals such as Rosen, Lohr, McNally and Herbert (1999:9-12) have been more sceptical and critical, and dispute claims made about its effectiveness.

1.7 AIMS

Due to the complex nature of the concepts, childhood sexual abuse, sexual assault and adolescence not all aspects can be dealt with in this assignment. Therefore, for the purpose of this study, the following aims have been identified:

- To explore the use of EMDR as a therapeutic tool to alleviate depressive and dissociative PTSD symptoms with a female adolescent survivor of sexual assault.
- To contribute to an improved understanding of the challenges and tasks that face adolescents coping with sexual trauma.
- To raise awareness of EMDR as a therapeutic tool for adolescent survivors of childhood sexual abuse among psychotherapists and other mental health practitioners.

Given the above-mentioned aims, this assignment will be structured in the following way.

Chapter 1 provides an introduction outlining the background to the study, the research problem and aims of the study.

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Chapter 2 contains a review of the literature. It attempts to define key concepts, such as adolescence, childhood sexual abuse, rape and EMDR.

Chapter 3 outlines the methodology employed in this study. It provides information on the participant in this case study and the manner in which data were obtained.

In **Chapter 4** the results are presented and reported. It also contains general information, as well as, information pertinent to this study.

Chapter 5 outlines a general discussion of the findings of this study. In addition, the limitations of this study, as well as recommendations for future research are highlighted.

This study ends with a **Summary** and some **Concluding Remarks**.

1.8 A SUMMARY OF THE CHAPTER

This chapter includes an introduction to this study, which provided statistics on the prevalence of certain types of crime in South Africa such as rape and child abuse. The theoretical framework that underpins the study is also outlined. In addition a motivation for the study and the research question were included. The research design utilised as well as, the key concepts relevant to this study, including adolescence, sexual assault and EMDR are outlined. In the following chapter the definitions of these key concepts will be expanded.

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CHAPTER TWO

ADOLESCENCE, SEXUAL ASSAULT AND EYE MOVEMENT DESENSITISATION

2.1 INTRODUCTION

This chapter will introduce the reader to aspects of adolescent development and several key concepts pertinent to this study including sexual assault, Posttraumatic Stress Disorder and Eye Movement Desensitisation and Reprocessing.

Since this study involved an adolescent participant, I needed to familiarise myself with the aspects of this developmental stage, especially since it is a period of major change in the individual (Papalia & Olds, 1989:342-344). The review of the literature made it possible to identify aspects of development that seemed pertinent to this study.

2.2 ASPECTS OF ADOLESCENT DEVELOPMENT

As stated previously, adolescence is characterised by major change (Papalia & Olds, 1989:342-344). My discussion of adolescence focuses on some of the major changes that occur and the impact of sexual assault on the adolescent survivor. Kazdin and Johnson (1994:217-226) emphasise the need for early intervention:

> The continuity of many dysfunctions across the life span, beginning in childhood, heightens the significance of early interventions, not only to reduce suffering of children and adolescents, but also to prevent or to attenuate impairment in adulthood.

Kazdin and Johnson (1994:217-226) furthermore maintain that the dysfunctions that may occur include depression and posttraumatic stress disorder. If left untreated, these can lead to mental illness.[3] They also suggest that the treatment of adolescents be given careful

[3] Barlow and Durand (1995: 679) define a person with a mental illness as one *"who has a mental or emotional condition which has substantial adverse effects on his or ability to function and who requires care and treatment"*.

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consideration, because of the particular challenges of this developmental stage on the individual.

The various aspects of development that will be discussed below include aspects of physical, psychosocial, cognitive and moral development. Although the focus is often on physical maturation which occurs during this time, the adolescent also reaches a higher level of cognitive and moral functioning than the child in early childhood (Feldman, 1999:427; Nash *et al.*, 1990:131).

Apart from the need to be aware of aspects of adolescent development, I also recognised the need to understand how sexual assault impacts on that development. This would help to make me aware of and create sensitivity around developmental issues during my involvement with the participant.

2.2.1 Aspects of physical development

According to Papalia and Olds (1989:344-350) physical growth continues throughout childhood. However, there is a rapid increase in the rate of growth during puberty, which marks the first phase of adolescence. Kimmel and Weiner (1995:70-71) state the hormones play an important role in the physical aspects of puberty including changes in height, bone density and the development of gender characteristics and the capacity to reproduce. Newman and Newman (1997:666) point out, however, that "the timing and patterns of physical changes vary widely and are different for males and females". According to Roger's (1981:63) the adolescent's own-body image becomes a major concern to the individual. She states that because the body changes so rapidly and drastically, "the adolescent invests emotions of security, self-worth, and competence" in it. Dacey and Kenny (1997:90-91) furthermore maintain that because of the importance of their bodies adolescents are particularly critical of their own and the appearance of others. Sexual assault survivors may therefore display physical, psychological and behavioural symptoms as a result of the violation of their body (Burgess & Holmstrom, 1974 cited in Hazelwood & Burgess, 2001:29-38).

2.2.2 Aspects of psychosocial development

According to Feldman (1999:421), Erikson was interested in the influence of the environment on the development of the individual and developed a comprehensive theory of psychosocial development. Erikson (1971:93-96) postulates that human beings develop from birth to death

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through eight different psychosocial stages. In each of the stages he identified, individuals encounter crises or conflicts that must be negotiated and successfully overcome in order to progress to the following stage. A crisis that is not resolved could have a cumulative negative effect on subsequent stages. According to him the successful resolution of crises contributes to the formation of the human personality. Erikson argues that these developmental stages are linked, with the result that social and cultural factors impact on the development of an individual's personality.

According to Erikson (1971:128) one of the psychosocial stages corresponds with the adolescent developmental stage. Erikson (1971:211) postulates that the central psychological task of the adolescent stage involves establishing an own identity as a person. In his view (Erikson, 1971:119), the outcome of the adolescent stage greatly determines the adult personality: the adolescent or adult with a strong sense of ego identity, is someone who sees him or herself as a separate and distinctive individual. Erikson (1971:166) also refers to influences that may impair perceptions of oneself as separate and distinct from others and lead to "identity confusion". He describes "identity confusion" as the state that develops when there is not a clear sense of identity.

Rogers (1981:45) maintains that merely having a sense of identity is not enough. She states that an identity has to be healthy, because a distorted sense of identity can impact negatively on the activities of daily living. Rogers (1981:237) also maintains that another very important aspect in adolescence is the way adolescents are viewed by other members of society, and that establishing relationships with peers is particularly significant during this period (*ibid*, 246). While the period appears to create strain on parents and adolescents, a supportive family environment contributes significantly to the adolescent's preparation for adulthood.

Kimmel and Weiner (1995:342-343) present the perspective that adolescence is characterised by an increase in the intensity of sexual feelings, and the emergence of a sexual identity. Dacey and Kenny maintain that (1997:194): "sexual identity comes from the development of a cohesive sense of self as a sexual being in relation to culturally determined categories". They (Dacey & Kenny, 1997:278) maintain that sexuality is a normal and important aspect of adolescent development. Newman and Newman (1997:663), tie sexuality to rebellion, arguing that adolescents often engage in sexual relationships as "an act of rebellion and defiance against the family".

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Kimmel and Weiner (1995:365-376) cite research conducted in the United States of America, which suggests that up to 50% of adolescent participants in the studies cited were sexually active. According to this study, many of these adolescents do not use effective contraception, increasing the risk of unplanned pregnancy or contracting a sexual transmitted disease. According to Dacey and Kenny (1997:300) this risk-taking behaviour is often a source of stress in the individual.

Erikson (Papalia & Olds, 1989:227) like other proponents of psychoanalysis generally attributes great importance to the influence of childhood experiences in later development. As such they maintain that the strength of this perspective lies in its willingness to consider both the conscious and unconscious in its description and analysis of human development. Experiences of abuse such as rape in childhood and adolescence would therefore profoundly impact on the development of the individual. There are some reservations about Erikson's theory. Feldman (1999:422) states that although an advantage of utilising Erikson's theory is that it covers the entire life span, Erikson does not take sufficient account of development in women. Nevertheless as Papalia and Olds (1989:228) point out,

> [Erikson's] broad view of the issues of human development provides a helpful structure for interpreting behaviour at different stages throughout life.

2.2.3 Aspects of cognitive development

According to Piaget children's cognitive ability develops through a fixed sequence of stages, evolving from less to more logical thought (Papalia & Olds, 1989:360). Piaget's stages are known as the sensorimotor, preoperational, concrete operational and formal operational stages. Piaget argues that changes within the individual combined with environmental changes result in cognitive maturation. Papalia and Olds (1989:360) comment that during adolescence many individuals reach Piaget's highest level of cognitive development known as the formal operational stage. One feature of this stage is that the adolescent is fully capable of a high level of abstract, formal and logical thought. According to Erikson (1971:245): "such cognitive orientation forms not a contrast but a complement to the need of the young person to develop a sense of identity".

Feldman (1999:427) maintains that the increasing social and cognitive skills of adolescents may influence their understanding of sexual assault. However, he acknowledges that most contemporary theorists recognise that children's abilities vary.

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2.2.4 Aspects of moral development

Adolescents constantly have to make moral decisions that affect them and those around them. Rogers (1981:159) defines morals as:

> ... standards of right and wrong, determined for individuals by the values of the culture of which they are a part, and values as the relative worth attached to objects and behaviour.

Kohlberg has expanded the theory of moral development conceptualised by Piaget (Thompson & Rudolph, 2000:106). According to Papalia and Olds (1989:362) Piaget sees moral development as a function of cognitive development that occurs according to predictable stages. Nash *et al.* (1990:127) however, maintain that children develop their own moral standards, which do not necessarily come from parents or peers, but are the result of their interactions with their social environment.

According to Dacey and Kenny (1997:136-137), Kohlberg proposed that the development of moral reasoning occurs at three levels: the preconventional, conventional, and postconventional level. They maintain that most adolescents are at Kohlberg's postconventional stage of moral development and state: "At the postconventional level, the individual is concerned with moral principles that have been carefully thought about and chosen" (Dacey & Kenny, 1997:136-137). Feldman (1999:443) takes the view that adolescents are able to understand universal moral principles, because of their ability to think abstractly. Some adolescents have a tendency to question the way in which the world is run by adults, and are able to analyse the political philosophical theories of others, as well as construct their own theories.

Papalia and Olds (1989:382) maintain that adolescents delight in their new feelings of independence, since the feelings satisfy their own needs. This means that they often have a tendency to lose touch with reality and have a strong belief that they can make things come true without much effort on their part. For this reason adolescents tend to be argumentative, self-conscious, self-centred, indecisive and often hypercritical. Feldman (1999:449) states that this self-centredness, often results in self-injurious behaviour such as suicide among adolescents. Exposure to a wide variety of stimuli in society such as the media, in addition to rapid developmental changes, may also make adolescents vulnerable to risk-taking behaviour, such as experimentation with drugs (*ibid*, 447). Luster and Small (1997:131-143) conducted a study exploring the relationship between sexual abuse and two problem outcomes, binge

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drinking and suicidal ideation, in a sample of 42 568 adolescents. The results support findings of similar studies and indicated a link between sexual abuse history and suicidal ideation among adolescents.

According to Rogers (1981:159) Kohlberg's theory has not been without controversy. She states that he gathered data for his concepts by getting children to react to moral dilemma situations presented to them. She also states that certain morals or values are applicable to some societies and not to others. Feldman (1999:443) also maintain that though research indicates that moral development occurs in stages, some critique is levelled at Kohlberg's assumption that people move through these stages in a fixed order. He argues that many people will also never reach his optimal level of maturity.

Having discussed some aspects of adolescent development, the following section will include other concepts pertinent to this study.

2.3 OTHER KEY CONCEPTS

After a review of the literature I decided on the following key concepts which might be pertinent to this study. These concepts comprise rape, child sexual abuse, and features often associated with sexual trauma such as PTSD, Rape Trauma Syndrome, dissociation and depression in adolescence (Burgess & Holmstrom, 1974 cited in Hazelwood & Burgess, 2001:29-38; Barlow & Durand, 1995:223; Friedman, 2000:1).

2.3.1 Depression in adolescents

According to Tomb (1999:40) one of the main features of depression is a disturbance in the mood of the individual. This disturbance can be normal and/or appropriate, such as the reaction to grief or bereavement, but can also become pathological requiring treatment including psychotherapy (*ibid*, 52). Dacey and Kenny (1997:372) cite studies conducted in the United States of America, which suggest that depressive symptoms occur in up 35% of adolescents. They also maintain there are various factors which seem to put the adolescent at risk of developing depression, including the following: "hormonal changes and feelings about sexual maturation", "stressful life events such as parental divorce, loss of family support" and cognitive maturation which enable them "to reflect upon themselves and the future" (*ibid*, 373).

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Feldman (1999:346) maintains that child survivors of sexual abuse are at risk of developing depression. Beck (1967) cited in Dacey and Kenny (1997:373) identified four types of depressive symptoms that occur in individuals (see Table 2.1). According to Dacey and Kenny (1997:373) adolescents often display symptoms of depression similar to those in adults. Newman and Newman (1997:656) state that depression among adolescents is often a matter of concern for caregivers. They maintain that depression often results in poor scholastic performance and adolescents engaging in risk-taking behaviour such as suicide and drug and alcohol abuse. Dacey and Kenny (1997:227) maintain that adolescents who experience stressful events thrive in a supportive and nurturing family environment.

TABLE 2.1: SYMPTOMS OF DEPRESSION

SYMPTOMS OF DEPRESSION	
Emotional manifestation	Dejected mood, negative self-attitudes, reduced. Experience of satisfaction, decreased involvement with people or activities, crying spells, and loss sense of humour.
Cognitive manifestation	Low self-esteem, negative expectations for the future. Self-punitive attitudes, indecisiveness, and distorted body image.
Motivation manifestation	Loss of motivation to perform tasks, escapist; and Withdrawal wishes, suicidal thoughts, and increased dependency.
Physical manifestation	Appetite loss, sleep disturbance, decreased sexual interest, and increase fatigability.

(Source: Beck, 1967 cited in Dacey & Kenny, 1997:373)

2.3.2 Prevalence of rape

As stated earlier thousands of rapes or attempted rapes were reported to the South African Police Services annually between January 1994 and December 2002 (South African Police Services, 2003b). The true magnitude of the problem of rape among children and adolescents in South Africa cannot be determined, as the cases reported to the Child Protection Unit of the SAPS are included in the recent crime statistics.

Jaycox, Zoellner and Foa (2002:891-906) cite the figures of the National Crime Victimisation Survey, which suggest that more than 500,000 rapes and sexual assaults are reportedly annually by women in the United States of America. Even in a country such as the United States of America, with better financial resources than a country like South Africa, the number of cases reported annually reflects merely a fraction of the actual incidents of rape, since many cases are not reported (Burgess, 2000 cited in Hazelwood & Burgess, 2001:4-5).

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The National Survey of Adolescents in the United States of America done by Kilpatrick and Saunders in 1999 (cited in Hazelwood & Burgess, 2001:6) among 4023 adolescents aged 12 to 17 found that 8,1% of these adolescents had been victims of sexual assault.

2.3.3 The phenomenon rape

There are a number of developmental factors to consider in attempting to understand rape in adolescent victims, including the context in which the rape occurs, the level of social support and level of cognitive skills of the individuals involved, and their understanding of the concept rape.

Nash *et al.* (1990:492) define rape as an extreme form of violence which occurs when one person forces another to submit to sexual activity such as intercourse or oral-genital sex. They also maintain that power and anger often motivate this type of violent behaviour. Robertson (1989:4) states that under South African law this type of crime is regarded as rape only when a man forces a woman to have sexual intercourse against her will. All other rapes according to him including anal intercourse are defined as indecent assault, and sexual intercourse between an adult and a child under 16 years of age is regarded as statutory rape (Robertson, 1989:4).

2.3.4 Rape Trauma Syndrome

Different women respond to the trauma of rape in different ways, and may display a wide range of emotions, including responses commonly known as Rape Trauma Syndrome (Burgess & Holmstrom, 1974 cited in Hazelwood & Burgess, 2001:29-38). This syndrome or cluster of emotional responses that often occurs in survivors of rape or attempted rape, was identified by Burgess and Holmstrom (1974) cited in Hazelwood and Burgess (2001:29-38) in their study of rape survivors. Rape Trauma Syndrome is an acute and long-term emotional reorganisation process that occurs, and may last for months or years after the actual rape or attempted rape has occurred. They maintain it is a response to the profound fears of death that almost all survivor's experience during an assault. However, they state that some women might experience Rape Trauma Syndrome, while others might display few symptoms or none at all. The symptoms include physical, behavioural and psychological symptoms Burgess and Holmstrom (1974) cited in Hazelwood and Burgess (2001:29-38), and are briefly outlined as follows:

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2.3.4.1 Physical symptoms of rape trauma syndrome

According to Burgess and Holmstrom (1974) (cited in Hazelwood & Burgess, 2001:29-38), immediately after the rape, survivors may experience shock, are likely to feel cold, faint and may become disoriented, tremble, feel nauseous and sometimes vomit. Other symptoms include soreness and or bruising of the body, tension headaches and gynaecological problems such as vaginal discharges. Some survivors may also experience sleep disturbances and often have nightmares, while other may also experience eating problems.

2.3.4.2 Behavioural symptoms of rape trauma syndrome

Burgess and Holmstrom (1974) cited in Hazelwood and Burgess (2001:29-38), maintain survivors may cry more than usual, have difficulty concentrating, be restless, and agitated. They may also find it difficult to relax, feel listless and unmotivated and may not want to socialise. They may also not want to be alone, are easily frightened and very alert. Survivors may also experience relationship problems with family, friends, lovers and spouses. Some may behave as if the rape did not occur; attempting to live life as it was before the rape.

2.3.4.3 Psychological symptoms of rape trauma syndrome

Burgess and Holmstrom (1974) cited in Hazelwood and Burgess (2001:29-38), also state that survivors may experience increased fear and anxiety. Some may experience guilt and self-blame for not preventing the assault. Other symptoms often experienced include anger towards the perpetrator, legal system, family and friends, flashbacks, loss of memory, depression and suicidal ideation. Many survivors of rape lose or suppress memories of all or part of the rape. However, the memories might resurface later and the survivor will need to face them.

2.3.5 Child sexual abuse

According to Kinchin and Brown (2001:34) the abuse of children and adolescents takes many different forms, including physical, verbal, emotional and sexual abuse. According to Hill, Davis, Byatt, Burnside, Rollinson and Fear (2001:1283) there is empirical evidence which suggests a link between childhood sexual abuse and some mental health problems women experience in adulthood.

According to Webster (2001:535), the way children comprehend the sexual abuse and deal with it depends on their age and developmental level. They may often display a variety of

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behavioural signs such as sexual behaviour, which are not appropriate to their age and developmental phase (Robertson, 1989:41). Goldstein (1999:69-71) states that very young children may however not understand what happens to them. They may minimise the effects of the abuse because they have no comprehension of the consequences of the abuse. Other factors cited by Goldstein (*ibid*) impacting on the effect of abuse include the duration of the abuse, the reaction of parents and others close to the victim, resources available, the degree of violence and the nature of the sexual acts.

According to Robertson (1989:41-42) some of the short-term or long-term effects of sexual abuse include fearfulness and anxiety, sleep disturbances, insomnia, nightmares aggressiveness, somatic complaints and inappropriate sexual behaviour. Kinchin and Brown (2001:38) state that adolescents are often the victims of sexual assault, which may affect their psychological development. Adolescents may have difficulty in forming relationships with others. Field, Diego and Sanders (2001:241) have also noted low self-esteem, depression, dissociation, eating disorders, suicidal behaviours or self-injurious behaviour and drug and alcohol problems in adolescent survivors of sexual abuse.

2.3.6 Post-traumatic stress disorder

Friedman (2000:1) defines a trauma as an emotionally overwhelming or stressful experience. He states that an individual who has suffered trauma could display Post-traumatic Stress Disorder symptoms. Post-traumatic stress disorder (PTSD) is recognised by the Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 2000:463-464) as a mental disorder which arises from exposure to a severe traumatic event, such as rape, torture or exposure to war or a natural disaster.

Post-traumatic Stress Disorder symptoms include recurring memories of the traumatic event, emotional numbing, exaggerated startle response, sleep disturbance, memory impairment and difficulties with concentration (American Psychiatric Association, 2000:463-464). Yehuda (1998:1) suggests that people with PTSD often have difficulty in displaying affection towards loved-ones. They are also often hypervigilant and are easily startled, and typically re-live terrible experiences in the form of nightmares and recurrent disturbing recollections of the traumatic event. Scott and Stradling (1999:36) also state that intrusive thinking is one of the main characteristics of PTSD and De Silva and Marks cited in Yule (1999:162-163) maintain that they interrupt the stream of consciousness of the individual. See Table 2.2 for the criteria for the diagnosis of PTSD.

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A survey conducted in the United States of America on 2 181 participants between the age 18 and 45 years by Breslau, Kessler, Chilcoat, Schultz, Davis and Andreski (1996) (cited in Yehuda, 1998:5-16) found that the risk of PTSD as a result of rape and sexual assault was significant. Forty nine per cent of victims of this form of violent assault developed PTSD. Various factors, however, seem to influence the risk of PTSD following exposure to a traumatic event. Breslau *et al.* (1996:19) states that these factors include characteristics such as the individual's personality traits and whether there is a history of psychiatric disorders.

Other risk factors include the magnitude of the traumatic event, as well as, the level and nature of support provided to the individual exposed to the trauma.

TABLE 2.2: DIAGNOSTIC CRITERIA FOR POSTTRAUMATIC STRESS DISORDER

A. The person has been exposed to a traumatic event in which both of the following were present:

- The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
- The person's response involved intense fear, helplessness, or horror. In children, this may be expressed instead by disorganised or agitated behaviour.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. In young children repetitive play may occur in which themes or aspects of the traumas are expressed.
- Recurrent distressing dreams of the event. In children, there may be frightening dreams without recognisable content.
- Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated. In young children, trauma-specific reenactment may occur.
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- Physiological reactivity on exposure to internal or external cues that symbolizes or resembles an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
- Efforts to avoid activities, places, or people that arouse recollections of the trauma.
- Inability to recall an important aspect of the trauma.
- Markedly diminished interest or participation in significant activities.
- Feeling of detachment or estrangement from others.
- Restricted range of affect (e.g., unable to have loving feelings).
- Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

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D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- Difficulty falling or staying asleep.
- Irritability or outburst of anger.
- Difficulty concentrating.
- Hypervigilance.
- Exaggerated startle response.

E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if symptoms are at least 6 months after the stressor

(Source: American Psychiatric Association, 2000)

2.3.7 Traumagenic dynamics

Yehuda (1998:15) maintains that despite the fact that many people are exposed to traumatic events not all develop PTSD. He argues that some individuals seem to be more at risk than others are. With regard to those who seem to be unaffected by trauma, some schools within psychotherapy argue that mental scars will invariably be left, while others do not foresee future psychological problems Yehuda (1998:15). In the past twenty years, various models including the Post-Traumatic Stress Disorder (PTSD) model have been proposed to explain the trauma associated with sexual abuse (Finkelhor & Browne in Wyatt & Powell, 1989:64). They warn that the PTSD framework has serious limitations and have (1989:68) formulated a more comprehensive alternative to the PTSD model. This model proposes four Traumagenic dynamics to explain the impacts of childhood sexual abuse and offers a much broader explanation of the range of reported impacts of childhood sexual abuse.

According to Finkelhor and Browne (in Wyatt & Powell, 1989:68) a traumagenic dynamic is an experience that alters a child's cognitive or emotional orientation to the world and causes trauma by distorting the child's self-concept, worldview, or affective capacities. Papalia and Olds (1989:301) define self-concept as "our knowledge of what we have been and done", and further state that: "its function is to guide us in deciding what to be and do in the future".

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According to Barlow and Durand (1995:81), this (affect) "refers to the feeling state that accompanies what we say at a given point in time". The four traumagenic dynamics are traumatic sexualization, betrayal, stigmatisation and powerlessness. Table 2.3 provides an outline of the traumagenic dynamics. Finkelhor and Browne (*ibid*, 68) maintain the dynamics describe a variety of symptoms associated with sexual abuse and offer a much broader explanation of the range of reported impacts of childhood sexual abuse. The dynamics also incorporate elements of the PTSD model.

TABLE 2.3: TRAUMAGENIC DYNAMICS IN THE IMPACT OF CHILD SEXUAL ABUSE

I. TRAUMATIC SEXUALISATION	
Dynamics	• Child rewarded for sexual behaviour inappropriate to developmental level. • Offender exchanges attention and affection for sex • Sexual parts of the child fetishized. • Offender transmits misconception about sexual behaviour and sexual morality. • Conditioning of sexual activity with negative emotion and memories. • Psychological Impact • Increased salience of sexual issues. • Confusion about sexual identity. • Confusion about sexual norms. • Confusion of sex with love and care-getting and arousal sensations. • Aversion to sex-intimacy.
Behavioural Manifestations	• Sexual preoccupations and compulsive sexual behaviours. • Precocious sexual activity. • Aggressive sexual behaviours. • Promiscuity. • Prostitution. • Sexual dysfunction: flashbacks, difficulty in arousal, orgasm. • Avoidance of or phobic reactions to sexual intimacy.

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II. STIGMATIZATION	
Dynamics	• Offender blames, denigrates victim. • Offender and others pressure child for secrecy. • Child infers attitudes of shame about activities. • Others have shocked reaction to disclosure. • Others blame child for events. • Victims are stereotyped as damaged goods.
Psychological Impact	• Guilt, Shame. • Lowered self-esteem. • Sense of differentness from others.
Behavioural Manifestations	• Isolation. • Drug and alcohol abuse. • Criminal involvement. • Self-mutilation. • Suicide.
III. BETRAYAL	
Dynamics	• Trust and vulnerability manipulated. • Violation of expectation that others will provide care and protection. • Child's well-being disregarded. • Lack of support and protection from parent(s).
Psychological Impact	• Grief, depression. • Extreme dependency. • Impaired ability to judge trustworthiness of others. • Mistrust; particularly of men. • Anger, hostility.
Behavioural Manifestations	• Clinging. • Vulnerability to subsequent abuse and exploitation. • Allowing own children to be victimised. • Isolation. • Discomfort in intimate relationships. • Marital problems. • Aggressive behaviour. • Delinquency.
IV. POWERLESSNESS	
Dynamics	• Body territory invaded against the child's wishes. • Vulnerability to invasion continues over time. • Offender uses force or trickery to involve child. • Child feels unable to protect self and halt abuse. • Repeated experience of fear. • Child is unable to make others believe.
Psychological Impact	• Anxiety, fear. • Lowered sense of efficacy. • Perception of self as victim. • Need to control. • Identification with the aggressor.

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Behaviour manifestations	• Nightmares. • Phobias. • Somatic complaints; eating and sleeping disorders. • Depression. • Disassociation. • Running away. • School problems, truancy. • Employment problems. • Vulnerability to subsequent victimization. • Aggressive behaviour, bullying. • Delinquency. • Becoming an abuser.

(Adapted from Finkelhor in Wyatt & Powell, 1989)

2.3.8 Dissociation

Barlow and Durand (1995:223) describe dissociation as an abnormal psychological state in which individuals feel detached from themselves and or their environment. In addition, it is characterized by the splitting up of mental processes that are normally integrated and work together. This lack of integration of the personality is often related to traumatic experiences and may be a way of eliminating anxiety and avoiding disturbing memories. Friedman (2000:3) states that many of the features of PTSD are dissociative in nature, and as such may the individual be unable to remember important personal information, fail to remember past experiences or have a distorted sense of time.

According to Irwin (1998:1006) survivors of sexual abuse often dissociate from their feelings and from the memory of their abuse and the dissociative reactions become a coping mechanism during childhood and adulthood. Feldman (1999:240) mentions that dissociation is initially helpful because it enables the child to live without constantly feeling the pain and fear, which often are the emotional reactions to abuse. Irwin (1998:1006) however, states that dissociation can impact negatively on development resulting in dissociative disorders within the individual.

2.3.9 Therapeutic support to survivors of trauma

Tantam (2002:43) maintains that psychotherapy "requires the ability to respect and work with the values of other people, and to enter into the other person's emotional world, however bleak or frightening". Orlinsky and Howard in Bongar and Beutler (1995:9) state that psychotherapy offers individuals with mental health problems possibilities to receive support. They support can result in them living a more adaptive lifestyle.

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According to Friedman (2000:37-38) there are various approaches to the treatment for PTSD. While some of these approaches encourage the individual to focus on the traumatic event, others focus on increasing coping skills. The author however states that, whatever the therapeutic process, it has three essential steps (*ibid*, 38-39). These are:

- establishing trust and safety which provides the therapist access to the client's traumatic material,
- encouraging the client to explore the material in order to gain control and providing therapeutic support, and
- the integration or reconnection of the client with family, friends and society.

Kinzie (in Tseng & Streltzer, 2001:186) stresses the importance of allowing individuals to disclose the nature of their trauma in their own way. Friedman (2000:41) also states that normalisation is the sharing of intense personal information which enables the individual "to ventilate powerful feelings and learn that others have had similar reactions" to trauma. Kinzie (in Tseng & Streltzer, 2001:186) however, maintains:

> Patients often tell their stories in an incomplete, disconnected, and emotionally packed manner. They often feel relieved and unburdened by telling their stories and by having been listened to and understood. However many will find that the interview will stimulate memories and that there may be an exacerbation of nightmares and intrusive thoughts for a time.

Kinchin and Brown (2001:1-2) note that although much information had been gathered about the prevalence of trauma among adults from several studies, research on the effects of trauma on the lives of children is limited. Webster (2001:533) also maintains there is little research on the various types of therapies used to treat children who survive sexual abuse, as well as the effectiveness of such therapies. Kinchin and Brown (2000) suggest the following reasons for the limited research among children: the lack of appropriate screening instruments, the assumption by mental health professionals that the adverse reactions to trauma in children disappear very rapidly, as well as the difficulty to detect emotional numbing in children. Kazdin and Johnson (1994:233) however, cite various studies on child and adolescent psychotherapy conducted in the last two decades. These studies show an increase in research on psychotherapy in children, and also suggest that psychotherapy is effective.

Kazdin (1995) and Peterson and Bell-Dolan (1995) cited in Donenberg (1999:182), maintain that researching the outcome of therapy among adolescents can be very challenging.

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According to them the challenges researchers face include: identifying various influences that affect the functioning of adolescents and the outcomes of therapy, determining appropriate therapy outcomes and "considering developmental processes that influence therapeutic effectiveness (e.g., specific treatments may be more or less effective at different stages of development)".

Various studies cited in Van Beest and Baerveldt (1999:1993-201) and Malencki and Elliot (1999:473-481) highlight the importance of the relationship between adolescents and the social support they receive from parents and from friends. In their research, findings of a study done on 198 participants, Malencki and Elliot (1999:473-481) conclude that even perceived social support was crucial for adolescents and improve self-confidence. Similarly Luster and Small (1997:133) argue that having a supportive relationship with at least one parent, can assist the individual to deal effectively with for example, the depressive symptoms resulting from sexual abuse.

Luster and Small (1997:133) also cite literature that emphasises the importance of parental support for victims once the abuse is disclosed: "Parental support should decrease the likelihood that teens are suffering from depression and pondering the notion that life is not worth living". The findings support earlier research that indicated the benefit from having a supportive family context. The authors, however, stated that they could not verify the accuracy of the self-report survey. Other limitations included the lack of information about the abuse, such as the nature and duration, whether the abuse was disclosed and the response from the family. Feiring and Taska (1998:242) also acknowledge the need for social support for survivors, but argue siblings, as well as other adults and friends can also provide support.

2.3.10 Eye Movement Desensitization and Reprocessing

Shapiro and Maxfield (2002:934), proponents of Eye Movement Desensitisation and Reprocessing (EMDR), claim that it is successful in the treatment of people suffering from a variety of mental disorders. According to Shapiro (2002:1453) EMDR integrates elements of various schools of psychology including psychodynamic, cognitive-behavioural and person-centred principles. Shapiro (2002:1454) cites several studies indicating that EMDR is effective in treating people suffering from anxiety, depression, guilt, post-traumatic stress disorder and other emotional disorders.

According to Allen and Lewis (1996:254) EMDR is a simple technique that provides effective and long lasting relief from troubling memories that previously were difficult and

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time-consuming to treat. Shapiro and Maxfield (2002:934) postulate that it can also effectively be used to enhance emotional resources in clients such as self-esteem and confidence. According to Greenwald (1994:4) EMDR is also being used with effective results by "numerous child therapists" in the United States of America. He suggests that certain adaptations be made to the procedure recommended to accommodate children who may lack motivation or the necessary verbal skills. The adaptations include shortening the procedure and using tactile stimulation for children who may struggle to perform the eye movements. This section below will briefly outline some aspects of the EMDR procedure, and review some of the outcome evaluation studies.

McCullough (2002:1532) states that EMDR treatment involves the therapist guiding the client in concentrating on a troubling memory or emotion while using bilateral stimulation, such as moving the eyes rapidly or tactile stimulation, which repeatedly activates the opposite side of the brain. According to Shapiro (2002:1454) the treatment involves the utilisation of:

> an information processing model which addresses (i) the past experiences that have set the foundation for pathology and their manifestations (e.g. nightmares, physical sensation), (ii) the present circumstances that trigger and/or exacerbate the condition, and (c) the creation and incorporation of templates for appropriate future action.

Shapiro and Maxfield (2002:935-938) maintain that the treatment process consisting of eight phases and eye movements is used to process the traumatic memory and replace it with a more positive cognition. They state that these phases form the standard protocol for treatment and can be outlined as follows:

- The therapist takes a full history of the client, assesses the client's readiness for EMDR and develops a treatment plan
- Next there is a preparation or stabilisation phase that aims to establish a therapeutic relationship and set goals
- During the assessment phase the particular traumatic or troubling memory the client wants to process is determined
- The memory is gradually desensitised
- A positive cognition is installed

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- The body is scanned for any tension or unusual sensation
- The therapist determines whether the memory has been processed adequately
- The therapist evaluates the work done in the previous session.

During the preparation or stabilisation phase the therapist guides the client to create a "safe place" (Shapiro, 1995 cited in Shapiro, 2001:21). She regards this as an important part of the treatment and it is aimed at providing skills "to decrease distress when processing is incomplete at the end of a session", and to maintain stability between and during sessions (Shapiro, 1995 cited in Shapiro, 2001:21).

In addition to creating a "safe place" (Shapiro, 1995 cited in Shapiro, 2001:21), two subjective instruments, the *Subjective Units of Disturbance Scale* (*SUDS*) and the *Validity of Cognition* (*VoC*) Scale are also part of the standard administration of EMDR. Greenwald (1994:15) states that the purpose of these instruments is used to monitor the "progress of the processes". According to Shapiro (1995 cited in Shapiro, 2001:3), the *SUDS* measures the level of disturbance related to the memory. The *SUDS* ranging from 0- (Neutral) to 10- (highest possible disturbance imaginable) points, measures the level of emotional disturbance the client experiences while thinking about the specific traumatic event. A change in the *SUDS* level to a 0 or 1 is considered to be a good indication that sufficient desensitization has occurred to proceed with the rest of the EMDR (Shapiro, 1995 cited in Shapiro, 2001:78). The *VoC* (Shapiro, 1995 cited in Shapiro, 2001:3) measures a shift in the client's belief regarding the desired self-assessment or alternative positive cognition. The *VoC* ranging from 1- (completely false) to 7- (completely true) measures the client's degree of acceptance of the positive cognition. A rating of 6 or 7 is considered a strong indication that significant positive cognitive restructuring has occurred.

While some mental health professionals (Edmond, Rubin & Wambach, 1999:103-117) enthusiastically accepted these claims of effective results, others (Rosen, Lohr, McNally & Herbert, 1999:9-12) have been much more critical and sceptical. They dispute claims that EMDR produces rapid and effective results, and cite various studies on EMDR which have found insufficient empirical evidence for the dramatic successes claimed. They also argue that the effective results of EMDR are inconclusive, especially since it was found that the studies used small samples and were methodologically flawed. I will now present a review of some findings of EMDR research.

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In a controlled study Edmond, Rubin and Wambach (1999:103-117), examined the effectiveness of EMDR treatment for reducing trauma symptoms among female survivors of childhood sexual abuse. Fifty-nine women were randomly assigned to individual EMDR treatment (n=20), routine individual treatment (n=20) or a delayed treatment control group (n=19). In the post-test, both treatment groups performed better than the control group on measures of depression, state anxiety, posttraumatic stress symptoms, and distorted beliefs, but there were no differences between treatment groups. However, at follow-up three months later, the EMDR group performed better than the routine group on levels of depression and anxiety, and had better scores on subjective measures used during the treatment process, an emotional disturbance scale, and measure of cognitive beliefs about trauma. The researchers concluded that EMDR was effective to reduce trauma symptoms in the treatment of female survivors of childhood sexual trauma.

Rothbaum (1997:317-334) evaluated the efficacy of EMDR in the treatment of 21 adult female victims of sexual assault who all met the DSM-IV (American Psychiatric Association, 2000) criteria for PTSD. In a controlled study she found that, after three EMDR sessions, 90% of the participants no longer met the full criteria for PTSD. The measures used to evaluate results included the PTSD symptom scale, the *Impact of Event Scale*, *Beck's Depression Inventory* and *Dissociative Experiences Scale*. However, the improvement cannot be regarded as statistically significant. The sample size was small and no comparative treatment was available to participants.

Shepherd, Stein and Milne (2000:863-871) reviewed sixteen randomised controlled trials comparing EMDR with alternative psychotherapy treatments such as exposure therapies and relaxation therapy. Although the number of participants in these studies was small, the results indicated that EMDR was effective at reducing symptoms of PTSD. The results however, did not show conclusively that EMDR was more effective than other treatments. The researchers contend that EMDR holds potential as an alternative to other forms of treatment. They argue that not only is EMDR inexpensive, but fewer sessions in comparison to other forms of treatment are required to alleviate PTSD symptoms.

Richards (1999:16) states that alternative therapeutic techniques to EMDR in treating PTSD exist. These alternative techniques including exposure and cognitive restructuring, have been shown to be effective by various empirical studies. Devilly (2001:57-70) investigated the efficacy of Trauma Treatment Protocol (TTP), a cognitive behavioural technique, in two cases of victims of sexual abuse, who had previously been treated unsuccessfully with

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EMDR. The participants' symptoms were assessed pre- and post treatment times and the results indicated a significant improvement in scores obtained on the various measures used as therapy progressed. The improvement was also maintained until the 3-month follow-up. Although the results suggest that TTP is more effective than EMDR, the author acknowledged the limitations of the study, which included a small sample size and suggested a more complex design for future research (Devilly, 2001:57-70).

2.4 A SUMMARY OF THE CHAPTER

The literature reviewed in this chapter suggests that adolescence is a period of rapid change and that sexual trauma such as rape has a profound impact on their development. Wilkinson and O'Connor (1982:985) arguing from an ecosystemic perspective maintain that sexual trauma also impacts on the other systems the individual interacts with such as the family and school. The chapter also focused on aspects of physical, psychosocial, cognitive and moral development in adolescence and the impact of sexual trauma on the adolescent. Key concepts pertinent to this study including depression in adolescence, child sexual abuse, rape, PTSD, dissociation and EMDR were briefly discussed. The following chapter will outline the research methodology used in this study. It will focus on the methods used for data gathering, as well as a description of the various instruments used to gather data, and the method of analysing and interpreting the data.

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CHAPTER THREE

METHOD OF INQUIRY

3.1 INTRODUCTION

In this chapter the research design of this study will be outlined. The method of inquiry, the various instruments used in the data collection, as well as the method of data analysis and interpretation of data will be explained.

3.2 RESEARCH DESIGN AND METHODOLOGY

Babbie and Mouton *et al.* (2001:74) distinguish between research design and methodology. They refer to a research design as a: "plan or blueprint" that the researcher uses to show how the research will be done. In addition they regard research methodology as the "research process and the kind of tools and procedures" the researcher will use in the implementation of the study. In the section that follows, I will focus on the research problem and aims of this study. I also provide a profile of the participant, and explain the theoretical framework that underpins this study.

3.2.1 Research problem

According to Webster (2001:533) much research has already been conducted throughout the world on the topic of child sexual abuse. He states that the trauma of sexual abuse often results in painful and disturbing memories which, when left untreated, can keep their disturbing power over an individual, and impact negatively on activities of daily living (*ibid*, 536). Research cited by Kinchin and Brown (2001:40) and Friedman (2000:3) which was done in the United States of America shows that many individuals exposed to trauma such as sexual abuse develop mental health problems. Research cited in Bongar and Beutler (1995:4) indicates psychotherapy is beneficial to those with mental health problems. Thomson and Rudolph (2000:439) maintain sexually abused children in therapy "require extra consideration, understanding and support."

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McLeod (1994:122-123) states that there is often much criticism about the claims of the effectiveness of psychotherapy. Criticism relates to the manner in which research into psychotherapy is done. According to McLeod (1994:122-123), critics argue that research often lacks rigour and ignores the spontaneous recovery that occurs in individuals who experience a crisis. In this study, I attempted to select a research methodology that would provide sufficient rigour to obtain valid and reliable results. Babbie and Mouton *et al.* (2001:283) maintain there might be greater acceptance if studies are replicated, findings verified in order to build theory, before results are generalised.

I chose to use EMDR to provide support to a female adolescent sexual assault survivor. I was encouraged to do this study by the result obtained by Rothbaum (1997:317-334) with adult sexual assault survivors, especially since research with children is limited (Webster, 2001:533). As mentioned in chapter one, the research question formulated for this study was whether EMDR used in the support of a female adolescent sexual assault survivor could contribute to alleviating depressive and dissociative PTSD symptoms.

3.2.2 Aims of the study

Exposure to childhood sexual abuse may result in PTSD or other mental health problems in children and adults, which may impact negatively on their relationships and interactions with others (Kinchin & Brown, 2001:40; Friedman, 2000:3).

The aim of this study was to explore the use of EMDR as a therapeutic tool with a female adolescent survivor of sexual assault. Eighteen months prior to her involvement in this research, the participant had received psychotherapy. However, when this study commenced, she was reportedly still displaying symptoms of PTSD and depression. This study also aimed to contribute to an improved understanding of the challenges and hardships faced by female adolescents coping with sexual trauma. In addition it sought to raise awareness of EMDR as a means of treatment for female adolescent survivors of sexual trauma.

3.2.3 Theoretical framework

As mentioned in Chapter One I employed an ecosystemic perspective to explore the use of EMDR as a means of providing support to a female adolescent sexual assault survivor. According to Donald, Lazarus and Lolwana (2000:34-36) the ecosystemic perspective is concerned with the interactions between the individual and various other systems such as the family, school and cultural environment. O'Connor and Ammen (1997:1), argue that this

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perspective evolved from a combination of the ecology theory and systems theory. They argue that the ecology theory places the individual in the totality of his or her environment. Nash *et al.* (1990:171-172) maintain that ecosystemic theory views the world as consisting of systems, with each system comprising of subsystems. They state that a family may be seen as a system and the individual members of the family as subsystems.

Donald, Lazarus and Lolwana (2000:34-36) argue that the ecosystemic approach considers not only the individual when evaluating a problem, but includes the whole ecosystem within which the individual functions and interacts. Wilkinson and O'Connor (1982:987) hold a similar view: "Assessment and intervention in an ecosystemic perspective extend beyond the individual, to the interactions within the individual's ecosysystem". Combrink-Graham (1987:505) maintains that this perspective also views the therapist as part of the system. The therapist interacts with the client and the ecosystem within which the client functions. The interaction also affects the relationships between therapist and client.

In the data collection from and support provided to Mary, the participant of this study, I had to look at the systems she functioned and interacted in, and the interrelations among the systems. It could therefore be argued that the support provided to her extended beyond, and impacted on other systems, including her parent, siblings and peers (Wilkinson & O'Connor, 1982:987).

3.3 METHODOLOGY

3.3.1 Qualitative case study

This study involved a description of the process of support using EMDR with Mary, the participant in this study. The interactions between Mary and I were analysed and interpreted since the aim was to determine whether EMDR contributed to alleviating Mary's symptoms of PTSD and depression. Therefore a qualitative case study located within the descriptive-interpretative tradition seemed the most appropriate choice (De Vos *et al.*, 2002:109). According to McLeod (1994:104), case study research is not new and has been used by some of the pioneers of psychotherapy including Freud. In fact, case study research still forms the bases for some of the treatment techniques used today (McLeod, 1994:104).

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McLeod (1994:78) maintains that "the fundamental goal of qualitative investigation is to uncover and illuminate what things mean to people." Taking a similar view, Babbie and Mouton *et al.* (2001:278) describe the qualitative research process as follows:

> The qualitative researcher's emphasis on studying human action in its natural setting and through the eyes of the actors themselves, together with an emphasis on detailed description and understanding phenomena within the appropriate context, already suggest what type of designs will be methodologically acceptable.

In addition, Breakwell, Hammond and Fife-Schaw (1997:259) describe qualitative data as "descriptive material which may be collected by researchers from interviews or observations". Rosnow and Rosenthal (1996:24) report that case study research is used to describe and analyse the behaviour of people, and enables researchers to understand the causes of psychological disorders. The focus of investigation is usually on intensive analysis of an individual, a group, an activity or an event which according to De Vos *et al.* (2002:275-277), is "bound within a specific time and setting". The authors further describe various types of case studies each serving a different purpose. These include "intrinsic case study, instrumental case study and collective case study".

I decided upon an intrinsic case study because such studies aim to gather a better understanding of an individual case. It also tied in with the aims of my study. I wanted to explore the feasibility of EMDR as a therapeutic tool in the support of female adolescent sexual assault survivors. It was my task as a qualitative researcher to strive to provide a detailed description and understanding of the research topic and the participant in this study.

According to Breakwell *et al.* (1997:5), the aim of research is to generate theory, and case study research is often the initial step in theory building. They, however, also state that there are particular limitations in results obtained from case studies research. In the case of this study, there is just such a limitation. Only one individual participated in this study.

As stated earlier although this is a qualitative case study, I also made use of two self-report questionnaires: the *Beck's Depression Inventory* and the *Dissociative Experiences Scale.* Creswell (1994:174-175) maintains that qualitative and quantitative methods and designs can be combined in a single study as a means of triangulation. The concept triangulation, as it relates to this study will be described in 3.11. Creswell (1994:177) also proposes different models of combined designs including what he refers to as the "dominant-less-dominant design". He argues that "in this design the researcher presents the study within a single

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dominant paradigm with one small component of the overall study drawn from the alternative paradigm".

The data obtained from *Beck's Depression Inventory* and the *Dissociative Experiences Scale* are quantitative in nature, but forms only a "small component of the overall study" (Creswell, 1994:179), and complements the qualitative data. The data from the self-report questionnaires were also interpreted qualitatively. In addition I used self-report questionnaires in which the participant's mother provided details of Mary's overall development, including her physical, cognitive, motor and social development. This data from these self-report questionnaires were also interpreted qualitatively.

3.3.2 The participant

The participant in this case study was Mary (pseudonym) a seventeen-year-old female sexual assault survivor, who had symptoms of depression, low self-esteem, anger, and problems with social adjustment. Mary was sexually assaulted in November 1999 when she was in Grade 9. She was unable to attend school the year immediately following the incident since she having difficulty coping with the psychological effects of the trauma. At the time of this study she was in Grade Ten. Mary received psychological support from a psychiatric hospital in the period immediately following the incident. Prior to her involvement in this study she had been diagnosed with Post-Traumatic Stress Disorder (PTSD), attempted suicide twice and had been admitted to the adolescent unit at the hospital for psychotherapy.

Since the trial of the two alleged perpetrators was due to start before the end of 2002, the Child Protection Unit was approached by Mary's mother for psychological support. Since there is a collaborative relationship between the Child Protection Unit and Department of Educational Psychology at the University of Stellenbosch, the Child Protection Unit had approached the Department of Educational Psychology at the University of Stellenbosch for psychological support. Her mother had sought assistance because Mary was still struggling to cope with the psychological effects of the trauma.

Since there are few studies on the use of EMDR in South Africa I decided to use EMDR with Mary. She was selected because she was comfortable and agreed to participate in this study. Mary had no previous exposure to EMDR and was not receiving concurrent therapy. Although she exhibited some contraindications for the use of EMDR (i.e. suicidal ideation, asthma and inadequate ego strength), by the end of the intake interview the co-therapist and I, in collaboration with Mary and her mother, agreed that Mary would be a suitable candidate

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for my research. She did not appear to be in imminent danger to herself, and was requested to call in case of a crisis prior to the following session. The study could also indicate the feasibility of EMDR as a treatment tool for female adolescent sexual assault survivors.

3.4 DATA COLLECTION

Babbie and Mouton *et al.* (2001:281) argue that a detailed description can only really be obtained if a case is studied within its context. They also note the importance of the influence of other systems upon the individual being studied. It meant that I had to gather information about Mary from as many of the different systems with which she interacted as possible. I needed to obtain information to determine the impact of the sexual assault on her functioning. For the purpose of this study I interviewed Mary and her mother at the start and upon completion of the study. In addition I also conducted a psycho-educational assessment, and made use of observations, self-report questionnaires, field notes and video-recordings to gather information.

3.4.1 Psycho-educational assessment

3.4.1.1 Interviews

One of the instruments used for data collection in this research included a qualitative interview containing open-ended questions to determine Mary's functioning as well as the impact of the sexual assault on the family. Barker (2001:87) maintains:

> There are only two reliable ways of obtaining information about family relationships. One is to observe the interactions between family members; the other is to ask questions that bear on the relationships between the members, and study carefully the family's responses.

McLeod (1994:38-39) notes that interviews are useful to generate sensitive information. He further maintains that they require the interviewer to be neutral, and cautions that the personality or interpersonal style of the interviewer can influence the data obtained. However, Babbie and Mouton *et al.* (2001:261) suggest that participants may be reluctant to disclose inappropriate behaviours and attitudes in interviews.

In a multilingual society like South Africa it is important that participants in research are interviewed in a language they feel most comfortable with. Since Afrikaans was Mary's mother tongue, interviews were conducted in Afrikaans. However, it should be noted that for

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the purposes of this study verbatim responses were translated into English, which is my language of preference. Great care was taken with the translation to accurately reflect the responses provided during the various sessions.

South Africa is also a culturally and ethnically diverse society. According to Bongar and Beutler (1995:315) cross-cultural therapy is particularly challenging. Babbie and Mouton *et al.* (2001:251) consider that although it is desirable to match ethnic groupings and gender in interviews, it is not always possible in an ethnically diverse society. Some of the ethnic groupings in South Africa, however, do not have sufficient numbers of trained therapists. Although Mary and her mother are white and I am black they did not express a preference for a therapist of the same gender or ethnic group. It is not clear if this prevented her in any way from benefiting optimally from the therapy.

Although the initial interview was conducted in a way that was non-threatening, Mary and her mother Ms Snell (pseudonym) did not appear to be tense. This interview took place in the playroom at the offices of the Child Protection Unit of the South African Police Services in Goodwood, Cape Town. My role, as therapist as well as that of the co-therapist was explained. Mary and her mother were given the opportunity to ask questions. I explained the need to record sessions and assured them that recordings were to be used for supervision and research purposes only and would be dealt with in the strictest confidence. Ms Snell gave written consent for sessions to be videotaped.

3.4.1.2 Observation

Babbie and Mouton *et al.* (2001:282) emphasise the importance of using multiple sources to collect data in case study research. This they state does not only provide a source of thick description but also might ensure reliable results when studies are replicated. According to Breakwell *et al.* (1997:213-215) one method of obtaining information and that contributes to such thick descriptions in qualitative research is through the process of observation. They stress that observing non-verbal data is an equally important aspect of data collection process. Babbie and Mouton *et al.* (2001:293-295) suggest that the information obtained could include exterior physical signs, such as clothing, expressive movements such as facial expressions, bodily movements and the participant's language.

The type of observation used in this study was participant observation and involved my noting Mary's behaviour, including her interactions with me. Strydom (in De Vos *et al.*, 2002:280) describes participant observation as "a qualitative research procedure that studies

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the natural and everyday setup in a particular community or situation". One characteristic of special significance in participant observation is that the observer has "to be able to listen, to see, to inquire, to observe and to write notes" (*ibid*, 281).

3.4.1.3 Questionnaires

Mary was asked to complete the *Beck's Depression Inventory* and the *Dissociative Experiences Scale*. According to Babbie and Mouton *et al.* (2001:263), self-report questionnaires have the advantage over an interview in that they are quicker to administer and interpret. They note, however, that they require a certain degree of literacy on the part of the participant. McLeod (1994:65) suggests that participants might not always be honest in their responses. He furthermore maintains that responses might be influenced by the researcher's bias. Although the instruments used in this study, including the self-report questionnaires, had been validated in the United States of America, I was not able to determine whether they had been validated in South Africa. This fact was taken into consideration when the data were interpreted and analysed. The language of the various instruments was suitable for the South African context.

3.4.1.4 Video recordings

A video camera was used unobtrusively to record therapy sessions. Dialogues were later transcribed and together with the observations of behaviour coded and analysed. According to Breakwell *et al.* (1997:223-225) videotaping just like other forms of documentation has advantages and disadvantages. They state that an advantage is that recordings can be viewed several times, making the analysis more reliable and detailed. However, a disadvantage is that participants may often behave unnaturally in the presence of a video camera.

I could review data transcribed to verify the accuracy of information. The video recording was thus able to provide the most complete documentation of the dialogue between Mary and I. Cohen and Swerdlik (1999:57) note that individuals communicate verbally and non-verbally. The videotaping showed Mary's body language during sessions and provided indications of various emotions of distress or elation.

Reviewing videotapes was also a way in which I could critically evaluate my therapeutic techniques and could discuss limitations with the research supervisor. One cautionary note is that it is not clear whether the knowledge that sessions were being videotaped increased the pressure on Mary and impacted negatively on disclosure of sensitive or disturbing material.

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3.4.1.5 Field notes

Breakwell *et al.* (1997:223) state that field notes aim:

> to present the sequence of action and interaction but they are less concerned with describing behaviours and events and more with interpreting aspects of the situation which are of particular interest to the researcher.

De Vos *et al.* (2002:285) also suggest that not only should notes be made of everything that is seen and heard, but that such notes should be expanded "beyond immediate observations". The field notes that I made contain a description of my observations of the therapy sessions. I included my reflections, which described what I observed in the different sessions in Chapter Four. Mary was also asked to record issues that might occur between sessions, she wished to discuss.

3.5 SUPPORT PROGRAMME

As stated previously the EMDR protocol consists of eight phases and eye movements are used to process the traumatic memories (Shapiro & Maxfield, 2002:935-938). Before I used EMDR, I obtained Ms Snell's written consent to use the technique with Mary. I also took a full history of Mary, and in conjunction with my supervisor developed a treatment plan. Part of the support plan was to do a psycho-educational assessment to determine Mary's level of cognitive and overall functioning.

Mary's presenting problem and her *Beck's Depression Inventory* and *Dissociative Experiences Scale* scores suggested that the pace of the support needed to be slow. I initially utilised the "safe place", "container" and "light source" techniques to stabilise Mary (Shapiro, 1995 cited in Shapiro, 2001:21-51). The "safe place" technique provides the individual with skills to deal with disturbing memories between and during sessions. The "container" technique allows for the disturbing memories to be placed in a "box" to be dealt with at a time decided upon by the individual. Whereas the "light source" technique: "usually correlates with the disappearance of the upsetting feeling" (Shapiro, 1995 cited in Shapiro, 2001:51). "Eye movements" were used to install the techniques mentioned above. As the sessions progressed, I incorporated the other phases of the protocol. These included the gradual desensitisation of the disturbing memory, the installation of a positive cognition, the scanning of the body for any tension or unusual sensation, and the re-evaluation of the work done in the previous session (Shapiro, 1995 cited in Shapiro, 2001:51).

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3.6 THE SETTING

The environmental setting for conducting the research was the playroom of the Child Protection Unit. The advantage of using the setting was that it could easily be accessed by means of public transport. Mary could not always be transported by her mother and often had to make use of public transport. Both Mary's and my travelling costs were limited. She was also familiar with the surroundings, because she had previously been interviewed at the offices of the Child Protection Unit. Seating was arranged in such a way for the video-camera not to cause any distraction.

In consultation with Mary and her mother, I set the time for each session when it was convenient for us all to meet. They also gave me written consent to make field notes and have weekly discussions of the therapy process with my research supervisor.

3.7 THE THERAPIST

I was the only therapist who participated as researcher in this study. I was a master's (educational psychology) student, with very little experience of working with sexual assault survivors. Before this study commenced, I had completed level one of the two-level EMDR training. Level one training included an introduction to the theory that underpins EMDR as well as the EMDR protocol (Shapiro, 2001:1-51). The training involved practical demonstrations and the supervised implementation of EMDR protocol by participants. However, before I completed the level-two training, I wanted to explore the feasibility of EMDR as a means of support for a female adolescent sexual assault survivor. As an employee of the provincial education department, I also often receive requests to provide support to adolescent sexual assault survivors. I might then be able to use EMDR as a treatment tool. I received supervision once a week and discussed the therapy process in detail with my research supervisor.

3.8 TREATMENT PROGRAM

Before I could embark upon a program of support I had to do a clinical assessment to gather information about Mary's overall functioning. Barlow and Durand (1995:77) note that a clinical assessment is an important component of any form of intervention. They describe clinical assessment as: "a systematic evaluation and measurement of psychological, biological, and social factors in an individual presenting with a possible psychological

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disorder". O'Connor and Ammen (1997:76) also note that an assessment is important, because it guides the process of support given to a client. The first three sessions were used for the clinical assessment, and these and all the others took place at the Child Protection Unit, Goodwood, Cape Town.

The instruments used as part of the clinical assessment included the *Children's Apperception Test, Rorschach, Human Figure Drawing, Kinetic Family Drawing, BDI* and *DES.* At the start of the process of intevention and upon termination I used the *BDI* (Cohen & Swerdlik, (1999:184) to assess the severity of Mary's symptoms of depression and the *DES* (Carlson & Putnam, 1993 in Shapiro, 2001:116) to assess the probability of dissociative symptoms. The results of these instruments were interpreted qualitatively.

The treatment program consisted of eleven weekly individual sessions, which ranged from forty-five minutes to one hour each. In addition, there was an intake interview as well as a termination session. Ms Snell was present for these two sessions. The various instruments used to gather data are briefly explained below:

- The *Beck's Depression Inventory (BDI)* is a 21-item self-report questionnaire assessing symptoms of depression on rating scales that range from 0 to 3. According Cohen and Swerdlik (1999:184), this instrument has been validated for use with adults and adolescents. For each item the participant selects the statement that best fits the way he or she feels at "this moment". Scores between 0 and 9 indicate no or minimal depression; 10-18, mild to moderate depression; 19-29, moderate to severe depression, and 39-63, severe depression.

- The *Dissociative Experiences Scale (DES)* Carlson and Putnam, 1993 in Shapiro (2001:116) is a 28-item self report questionnaire assessing dissociative symptoms. Scores of 30 or greater indicate a probable dissociative disorder. The authors report good test-retest reliability, internal reliability (split-half) and validity of the *DES.*

- Subjective instruments (Shapiro, 1995 cited in Shapiro, 2001:78), which are part of the standard administration of EMDR to measure the disturbing emotion and the client's cognitive assessment, were also used during sessions. The *Subjective Units of Disturbance Scale (SUDS)* measures the level of disturbance related to the memory (*ibid*). The *Validity of Cognition (VoC)* Scale measures a shift in the client's belief regarding the desired self-assessment or alternative positive cognition (Shapiro, 1995 cited in Shapiro,

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2001:78). Very little information is available in the literature about the validity and reliability of the *SUDS*, although the *VoC* has face validity (*ibid*).

- Projective tests, including the *Children's Apperception Test* (Bellak & Bellak, 1991:2), *Rorschach* (Rorschach in Cohen & Swerdlik, 1999:437), as well as the *Human Figure Drawing* (Machover, 1949) and *Kinetic Family Drawing* were also used. For the *Children's Apperception Test* (Cohen & Swerdlik, 1999:444) the individual is provided with a series of projective plates and is then requested to make up a story. In the *Rorschach* (Cohen & Swerdlik, 1999:439) the individual is asked what he or she sees in each of ten inkblots. The *Human Figure Drawing* test and the *Kinetic Family Drawing* require the individual to draw a picture of a person, and his or her family respectively and questions are asked about the drawings. McLeod (1994:72) maintains that these pictures give access to personality and reveal how the individual feels about him or herself and the relationships among family members.

  McLeod (1994:71-72), states that psychodynamic theorists maintain that projective tests could be used to assess personality. According to him they assume that these tests reveal aspects of psychic functioning that cannot be expressed consciously. According to Miscel (1999:141) psychodynamic theorists regard projective tests as a way of assessing thoughts and feelings, the individual may regard as unacceptable and cannot express directly, as well as defences against such thoughts and feelings. McLeod (1994:71) however maintains that projective tests appear to lack adequate test-retest reliability. Cohen and Swerdlik (1999:448) state that despite this, a test like the *Rorschach* still remains a very popular projective technique used by practitioners in the United States of America.

- The *Senior South African Individual Scale-Revised (SSAIS-R)* is an individually administered, standardised test of thinking and reasoning abilities (Van Eeden, 1992:3). The test is divided into two sections, Verbal Scale and Non-Verbal Scale. The Verbal Scales are based on past, learned experiences, and together they provide a verbal Intelligence Quotient. The verbal test battery is a good indicator of academic performance. The Non-Verbal Scales are based on immediate problem-solving ability. The combination of results on the Non-Verbal scales provides a Non-Verbal IQ (*ibid*).

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3.9 DATA ANALYSIS

According to McLeod (1994:89-92) there are different approaches to and strategies that can be applied in the analysis of qualitative data. He states that these strategies depend on various stages including the immersion, reduction and triangulation. I used all of these stages in this study:

In the immersion stage I tried to understand the meaning of the data collected, by reading through the transcripts and going through my reflections of the various sessions. In the reduction stage (McLeod, 1994:89-92), I systematically worked through the data, assigning coding categories, which I developed. According to Miles and Huberman (1984:56-57) a code is used to indicate a segment of words that occur most frequently in data, in order to cluster segments that relate to particular themes. They state that such clusters of themes are used in the analysis and interpretation of the data. These authors furthermore, regard codes as astringent, meaning "they pull material together, permitting analysis" (*ibid*, 57). The coding system consisted of an "initial list" of codes, categories and themes. As such, were additional codes, categories and themes that emerged in the reduction stage added to this list. Included in the Addendum 1 and 2 is a list of the codes, categorises and themes used in this study.

Content analysis was used to analyse and interpret the qualitative data produced in this study. According to Breakwell *et al.* (1997:287-287) data collected from interviews can be content analysed. This means, that codes and categories that recur within transcripts of interviews can be clustered into themes that can be interpreted.

Having reviewed the literature I considered and selected the following tentative themes (see 3.10) that might emerge in my interactions with Mary and her mother. I decided upon these themes, because they could possibly indicate the impact of the sexual assault on Mary, and some of the systems within which she interacted. I also decided to use them as the basis for my discussion in pursuit of an answer to the research question: could EMDR contribute to alleviating symptoms of depression and dissociation and PTSD in a female adolescent sexual assault survivor?

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3.10 INITIAL THEMES

- **Developmental issues**

This theme dealt with aspects of development including physical, cognitive and moral development that might be issues of concern for Mary as an adolescent. More importantly issues of development Mary as an adolescent sexual assault survivor might display. Especially symptoms such as the physical, psychological and behavioural symptoms described by Burgess and Holmstrom (1974 cited in Hazelwood & Burgess, 2001:29-38).

- **Dissociative and PTSD symptoms**

As stated previously the literature reviewed suggests that dissociative and PTSD symptoms often occur in survivors of sexual trauma. Symptoms such as recurring memories of the traumatic event, emotional numbing, exaggerated startle response, sleep disturbance, memory impairment and difficulties with concentration (American Psychiatric Association, 2000:463-464). This theme focused on the reported symptoms of PTSD and dissociation present in Mary.

- **Social support**

This theme dealt with the experiences of support a sexual assault survivor and her family received from various sectors subsequent to the assault, including the health, welfare and legal sector. Support that might enable Mary to lead a more adaptive lifestyle (Orlinsky & Howard in Bongar & Beutler, 1995:9).

- **Symptoms of depression**

This theme indicated symptoms of depression a sexual assault survivor might display (Feldman, 1999:346). Symptoms include a depressed mood and diminished interest in activities of daily living and sleep disturbance (American Psychiatric Association, 2000:356).

3.11 THE SUPPORT PROCESS

The intake and termination sessions consisted of semi-structured interviews. Mary and her mother were present for both interviews. O'Connor and Ammen (1997:23) suggest that basic

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information such as the impact of the presenting problem on the family functioning, can be obtained by interviewing the primary caregiver.

From an ecosystemic perspective, however, I needed to obtain information from Mary and her mother's view of the impact of the assault on their family. During the initial session questions were asked aimed at obtaining as much information as possible about Mary. The questions were used to determine her family background, the impact of the sexual assault on Mary and her family. Questions asked included the school she attended, the grade she was in, her favourite subjects, overall functioning and her scholastic performance before after the trauma. The reason for the referral was also explored. The intake interview was followed by eleven individual sessions during which only Mary was present. The intervention program concluded with the termination interview. Mary's mother provided me with information about her perspective on Mary's level of functioning prior to and upon termination of the intervention. All the responses were carefully studied, coded and categorised into themes.

In the "reduction stage" (McLeod, 1994:89-92) the meanings or categories were questioned, i.e. I sought for other possible explanations. This was followed by the "triangulation stage" (McLeod, 1994:89-92) in which I sorted through categories to determine those that recurred and those, which were less significant or even invalid. According to Creswell (1994:174) triangulation refers to the use of a variety of methods in methodology to improve the validity of the research. He states that one assumption of triangulation is that bias inherent in data sources, the researcher and the methods used to gather and analyse information, will be eliminated when a variety of methods are used. Another assumption is that "triangulation of results will provide convergence about the "truth" of some social phenomenon" (*ibid*). I used different sources of information such as my field notes, interviews as well as, self-report questionnaires to collect data. In the final stage, I interpreted the data.

3.12 VALIDITY AND RELIABILITY OF RESEARCH INSTRUMENTS

Bongar and Beutler (1995:408) contend that "the aim of research is to reach valid conclusions about the effects of a given intervention and the conditions under which it operates". They maintain that there are various types of validity. The various types of validity each has a question they address, and Bongar and Beutler (1995:408) describe them as follows:

- Internal validity – to what extent did the intervention rather than extraneous factors influence the outcome of the intervention?

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- External validity – to what extent can the results be generalised?
- Construct validity- what is the conceptual basis underlying the change that results from the intervention?

Bongar and Beutler (1995:408) also maintain that there are threats to being able to draw valid inferences. An example of a threat is a research design that is methodologically flawed.

According to Breakwell *et al.* (1997) reliability refers to the consistency or stability of a research instrument. Reliability is primarily concerned with how well an instrument yields consistent results. Cohen and Swerdlik (1999:146), however, argue that "reliability is seldom an all-or-none matter; there are different types and degrees of reliability".

Except for the *Senior South African Individual Scale-Revised*, the instruments used in this study, including the *Beck's Depression Inventory*, *Dissociative Experiences Scale*, *Rorschach* and *Human Figure Drawing* have been constructed and validated in the United States of America. The practical limitations of using them on South African participants are recognised. De Vos *et al.* (2002:341) note that a researcher could, by the process of triangulation ensure more trustworthy results. In the absence of other assessment instruments, I used different sources of information (as mentioned before), including a psycho-educational assessment, interviews, field notes, and self-report questionnaires to gather data.

Although the intention was and consent obtained to have a co-therapist present during sessions, it was not always practical. The role of the co-therapist was to supervise sessions and to provide feedback to the therapist at the end of the session. However, the data were video-recorded and could be reviewed by the research supervisor during the weekly supervision sessions. The supervision sessions were also used to plan the ongoing support.

3.13 ETHICAL CONSIDERATIONS

Certain ethical guidelines govern the behaviour of those involved in psychological assessment and research (Cohen & Swerdlik, 1999:62). In South Africa, all practising psychologists must be registered with the Health Professions Council of South Africa (HPCSA), which through the Professional Board for Psychology governs the practices of psychologists (HPCSA, 2001:1-43). According to the ethical code for practitioners (HPCSA, 2001:1-43), participants in research must be protected from physical and mental harm, and informed consent must be obtained. Where the application of specialised techniques are

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involved, therapists must be certain that their training is sufficient for them to use the technique in question. Since some techniques such as EMDR raise special emotional questions, therapists should be sensitive to issues raised by the individual and discuss them along with the implications of such issues (Allan, 1997:17).

Mary's safety and anonymity were assured and written consent was obtained to record sessions and use information for research purposes. Information about EMDR as a therapeutic tool was also provided. Although I had been granted consent to use EMDR, I emphasised at the onset and end of the treatment that Mary could scrutinize and verify information obtained. The study did not involve any deception. At the end of the study Mary was debriefed to remove any misconceptions and anxieties.

3.14 A SUMMARY OF THE CHAPTER

In this chapter the aims, research problem and theoretical framework were provided in detail. Details of the research design and methodology, including the various instruments used to gather data and the method of data collection were given. The concept case study was defined and the reason for this choice of enquiry explained. In addition, information given about the participant was expanded. Data were obtained from the participant by means of interviews, observation, and self-report questionnaires. Finally information was given on the method of data analysis, the therapeutic setting and ethical issues considered in this study. In Chapter 4 the implementation of the study will be outlined.

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CHAPTER FOUR

IMPLEMENTATION OF THE STUDY

4.1 INTRODUCTION

This chapter describes the implementation of this study. It contains information obtained from the intake interview, the individual therapy sessions and the termination interview. The intake interview as well as the second and third sessions were also used for a psycho-educational assessment, and formed part of the clinical assessment. The aim of the clinical assessment was to determine Mary's level of functioning. The instruments used included the *Beck's Depression Inventory*, *Dissociative Experiences Scale*, *Rorschach*, *Human Figure Drawing* and *Kinetic Family Drawing*. This chapter also contains a summary of the therapy sessions including the therapist's reflections. The process of data analysis will also be explained.

4.2 THE PSYCHO-EDUCATIONAL ASSESSMENT

Full details of Mary's assessment are provided below to contextualise the case study.

4.2.1 Reason for the referral

Mary was a sexual assault survivor and reportedly displayed depression and PTSD symptoms. There was also concern about her scholastic performance.

4.2.2 Background

- ***Family*:** Mary lived with her mother, older brother and younger sister. Her parents were divorced when she was fifteen. Her father had a drinking problem and the information provided suggested a history of family violence. After the divorce her father had stayed in regular contact with the family, and had been very supportive and even moved back in with the family after she was sexually assaulted. Mary and her father reportedly used to be close, but since the divorce of her parents, this relationship had deteriorated rapidly.

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No reasons were provided for the deterioration of their relationship. Since the incident she reportedly had a much closer relationship with her mother. Mary brother was unemployed and her sister was in primary school. The siblings lived with their mother and reportedly got along well. However, since the perpetrators were her brother's friends, the incident caused tremendous tension between Mary and her brother. Their relationship had initially deteriorated, but gradually improved later.

- ***Birth and development*:** The pregnancy was reportedly normal, but she was born by caesarean section when foetal distress was diagnosed. Her developmental milestones were all age-appropriate, but she became an asthma sufferer after the assault. Asthma attacks are reportedly anxiety-related.

- ***Behaviour*:** Emotionally Mary was described as secure and confident and as a child that mixed well with other children. Ms Snell expressed some concern regarding her behaviour, reporting that Mary could become aggressive and at times tearful. Mary was also described as an intelligent, honest, obedient, yet moody sensitive child. She was further described as being a quiet, obedient and well-behaved child. Prior to the assault she seemed happy with no tearful or depressed episodes, and never presented any significant behaviour problems. However since the incident she displayed symptoms of depression and PTSD. She was easily frightened, aggressive, developed crying spells and insomnia, became socially withdrawn, bit her nails, and became afraid of the dark. Mary also experienced nightmares, and found contact with her perpetrators very disturbing.

- ***Socialization*:** Before the incident she used to socialise easily and got on particularly well with her friends. However, after the assault she had become withdrawn.

- ***Scholastic*:** Prior to the incident Mary had reportedly progressed quite well academically. However, since the incident her emotional state had a detrimental effect on her scholastic performance. She could not cope emotionally with the academic demands of school and was unable to return to school for an extended period of time. She displayed symptoms of depression, regularly missed classes due to ill health, was having difficulty with concentration at school, and experienced academic difficulties.

- ***Previous help*:** Mary had been admitted to hospital subsequent to the assault. She was admitted to Tygerberg Hospital, but reportedly struggled with the nature of support because therapists rotated on a regular basis. Prior to her participation in this study she

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had received intensive psychotherapy after two suicide attempts. During her stay in hospital she made another suicide attempt. Mary's inability to function adequately in school suggested the need for medium to long-term treatment. The duration of her history of depression following the sexual assault and her repeated suicide attempts suggest risks of relapse and it might have been more desirable to explore a different therapeutic approach such as EMDR.

4.2.3 Behaviour during assessment

During the assessment Mary appeared slightly anxious. She answered questions tentatively and initially spoke only when asked a question.

4.2.4 Observations

- ***Impression of the client*:** Mary became withdrawn and provided very little information when pressed for information about the incident.

- ***Mother*:** Ms Snell seemed willing to share information about the family and the incident and also appeared very supportive of her daughter.

4.2.5 Findings of the assessment

4.2.5.1 Qualitative

A measure of initial performance anxiety was present when Mary was asked to do the *Human Figure Drawing*. She commented she could not draw and seemed reluctant to do so. She also stated she disliked drawing and always relied on her brother to draw for her. Her drawing was below par for her age. It reflected feelings of inadequacy, insecurity and helplessness. Additionally, her drawing suggested difficulty reaching out into the world, and instead a tendency to withdraw and turn inward toward herself and to inhibit her impulses. The *Kinetic Family Drawing* possibly indicated a desire for the family to be re-united as she included every member of her nuclear family. Mary's responses to the *Rorschach* and *Children's Apperception Test* indicated a lot of resistance possibly to sensitive issues around the assault that she still needed time to work through. There were also possible indications of threats from her environment (*Children's Apperception Test*).

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4.2.5.2 *Quantitative*

- ***SSAIS-R***

  It should be noted that the test has only been standardised for children between the ages 7 years to 16 years 11 months (Van Eeden, 1992:1). Since the norms were not appropriate for her age group, the results could not be regarded as a true reflection of Mary's level of cognitive functioning. The *SSAIR-R* was merely used qualitatively. Qualitatively Mary persevered and was co-operative throughout the assessment, and engaged actively with me. She seemed less shy, but this could be attributed to the fact that this part of the session was not video-recorded. Although Newman and Newman (1997:656) maintain that depression often results in poor scholastic performance, it was unclear to what extent the sexual trauma affected her performance during the completion of the *SSAIR-R*.

- ***Beck's Depression Inventory*** and ***Dissociative Experiences Scale***

TABLE 4.1: SCORES OF SELF-REPORT QUESTIONNAIRES

	Before intervention	**Upon termination**
Beck's Depression Inventory (BDI)	24	3
Dissociative Experiences Scale (DES)	33	11

Table 4.1 shows the scores Mary obtained for the *BDI* and *DES*. The scores of the *BDI* indicate that before Mary received support she displayed moderate to severe depression, but that these had changed to minimal depression (Cohen & Swerdlik, 1999:184) upon termination of the intervention program. Similarly, the scores of the *DES* show that the probability of a dissociative disorder decreased upon termination (Carlson & Putnam, 1993 in Shapiro, 2001:116).

4.2.6 Diagnosis

In view of the above-mentioned findings it seems that the symptoms of depression and dissociation Mary displayed, might be contributing to poor scholastic progress. For psychologists who wish to obtain information about clients the DSM-IV (American Psychiatric Association, 2000:27-34) also makes provision for an assessment on several axes representing different domains. The information obtained from the different domains,

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provides a holistic picture of the individual and facilitates the planning of any intervention. The information obtained during Mary's assessment is as follows.

AXIS I - This axis is used for reporting the major condition or disorder that is the presenting problem (2000:27). In Mary's case it is the sexual assault she suffered, which caused PTSD as well as parent-child relational problems.

AXIS II - This axis is used for reporting personality and mental retardation (2000:28). In Mary's case there was no diagnosis on this axis.

AXIS III - This axis is used for reporting current medical condition (2000:29). Mary was diagnosed with asthma after the assault, and the asthma attacks were reportedly anxiety related.

AXIS IV - This axis is used for reporting psychosocial and environmental problems that may affect the diagnosis, treatment and prognosis (2000:31). The parental divorce caused a disruption in primary support.

AXIS V - This axis is for reporting the psychologist's judgement of the individual's overall level of functioning using the Global Assessment of Functioning (GAF) scale (20001:34). The individual's functioning is rated on a scale of 0 to 100. Mary was given a GAF score of 50 which indicates "*serious symptoms (e.g. suicidal ideation) or any serious impairment in social, occupational, or school functioning*" (2000:34). Based on the information provided by her mother, Mary's GAF would have been greater before the sexual assault. This would have indicated a higher level of functioning. Since the assault she had made three suicide attempts and was progressing poorly scholastically.

4.2.7 Recommendations

Individual therapy was recommended to support Mary and assist her to overcome her traumatic experience and to improve her overall level of functioning. Therapeutic support was also recommended for Mary's mother, her primary caregiver. She, however, preferred not to use the services made available by the Unit for Educational Psychology.

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4.3 A SUMMARY OF THE THERAPY SESSIONS

Each therapy session and my reflections of the session are briefly outlined below.

SESSION 1

The intake interview took place at the Child Protection Unit, Goodwood, Cape Town. Her mother Ms Snell (pseudonym) accompanied Mary (pseudonym). After the initial introductions and an explanation of the team approach to therapy followed by the university, consent was obtained to video record sessions and use recordings for weekly discussions with the research-supervisor and for research purposes. The goal of the session was to obtain information about Mary including biographical details as well as the reason for the referral, family structure, support structure, and general functioning to facilitate planning of the therapy. Information about EMDR was provided and consent obtained to use it. The number of sessions, the timeslot as well as the venue were negotiated and agreed upon. Mary and her mother were allowed an opportunity to raise questions or concerns. The purpose of a psycho-educational assessment was also explained.

THERAPIST'S REFLECTIONS

I raised the issue of cross-cultural therapy with my supervisor, since I had felt uneasy during the session. I had a sense that neither Mary nor Ms Snell had expected this. I felt competent to handle the situation as a therapist, because of my prior experience in cross-cultural therapeutic situations. Yet I became aware that as a therapist I was not as comfortable as I had thought within a cross-cultural therapeutic setting. I was not sure to what extent this influenced the support provided to Mary. It did, however, become a serious matter to reflect upon especially since my future work as a psychotherapist would involve cross-cultural support. I was not sure whether Mary would show up for the follow-up sessions.

SESSION 2

The session took place three weeks after the intake interview, because Mary had to reschedule the session. She completed the first part of the psycho-educational assessment. The goal was to determine her general level of functioning to assist with the planning of intervention. During the interview part of the session she struggled to maintain eye contact, and sat with her arms folded and legs crossed. Efforts were made to put her at ease. I was

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aware of time constraints and the activities that needed to be completed during the session. Mary needed lots of encouragement to complete the *Human Figure Drawing* and *Kinetic Family Drawing*. Mary seemed to be quite anxious about the pictures of the *Children's Apperception Test*. After a long pause she mentioned that she could not think of a story to go with the first picture or what the characters might be feeling. She provided a similar response for the second picture, and became visibly upset while looking at the third picture. She put it down and responded: *"I really can't do this*." After she was given time to gain her composure, she completed the *Beck's Depression Inventory* and *Dissociative Experiences Scale*.

THERAPIST'S REFLECTIONS

I was relieved that Mary had showed up for session. I thought that perhaps after the intake interview her mother would decide not to send her for therapy after all. Mary seemed quite anxious, lots of probing was needed to obtain information from her, as well as lots of encouragement to complete the tasks. Her reaction to the *Children's Apperception Test* took me by surprise, as I was unprepared for it. I realised she needed time to work through issues and perhaps found the *Children's Apperception Test* too threatening. The fact that she had been given the space to gain her composure during the session and not forced to complete the *Children's Apperception Test* possibly enabled her to proceed with the rest of the assessment. The issue of allowing clients to dictate the pace of therapy was raised with the supervisor. It was agreed that Mary would have to be paced carefully.

SESSION 3

The session was aimed at completing the assessment. Mary seemed more at ease, and mentioned that she had been absent from school once the previous week due to ill health. She had also been having difficulty sleeping at night and was having nightmares. She completed the *SSAIS-R* and *Rorschach*. The session was also aimed at creating and installing a "safe place". In addition she had to identify a "container" in which disturbing memories could be stored until she was ready to deal with them, as well as "light source" to strengthen her ability to cope with disturbing memories or thoughts. The "safe place, container and light source" were all installed with "eye movements".

THERAPIST'S REFLECTIONS

The session proceeded well. Although Mary had initially seemed reluctant, she eventually co-operated well, and completed every activity given. She struggled to maintain eye contact, but

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seemed to grasp what was expected when we did the "*eye movements*". Since EMDR was new to me, the session did not go as smoothly as I expected. I struggled to follow the EMDR protocol, as Mary seemed unresponsive. Mary also seemed to have lots of unfinished issues that had to be processed at her own pace. Since there had been several suicide attempts it was important to for me to be alert to any indication that she was in distress. In accordance with ethical guidelines for psychologists I had to ensure that Mary was protected from physical and mental harm (HPCSA, 2001:1-43). The contact and the discussion with the supervisor were important because it gave me some direction as to how to deal with Mary. The supervisor and I agreed that Mary would determine the pace of support. Mary was also encouraged to make telephonic contact with me or the supervisor between sessions should a crisis arise. It was also essential that I obtain additional information to equip myself with some knowledge to deal with the issue of suicide should it arise in therapy.

SESSION 4

The aim of the session was to continue to work on Mary's ego-strengths or resilience and to allow her to determine the pace of therapy. Nash *et al.* (1990:439) note that ego strength is the ability the individual has "to cope with the demands and challenges of everyday life". Thompson and Rudolph (2000:4) also state that children often show great resilience and their development is seldom stunted even in the face of life threatening situations. "Eye movements" were used to reinstall strategies such as the "safe place, container and light source" she might use during and between sessions. Mary seemed troubled as she discussed the events of the previous week. She described a typical week and mentioned that her mother had given up her job to provide additional emotional support. She also mentioned having a disturbing thought about coming face-to-face with her perpetrators, but was able to access her "safe-place" which helped her not to focus on the disturbing thought. Mary expressed concern about the court case and inquired whether I knew when it would be heard in court.

THERAPIST'S REFLECTIONS

Mary's seemingly uncooperative behaviour was a matter of concern. She seemed very troubled during the session and provided only very brief responses. She seemed particularly quiet and needed a lot of encouragement to participate. The probing and long pauses between responses resulted in my feeling awkward. Although the session was carefully planned, I did not make provision for an alternative plan of intervention. I struggled through the session and again felt that I was not adequately equipped to deal with the magnitude of the case. My

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concerns were discussed with the supervisor. She encouraged me to slow the pace of support and to go with what Mary brought to the session, since she might not be ready to deal with disturbing issues.

SESSION 5

The aim was to try to process what Mary brought to the session by means of EMDR. She still seemed very quiet and seemed to have a worried look on her face. She mentioned the previous week had been "*hectic*", her mother had been on holiday in Johannesburg. She had chosen to stay with her boyfriend and his mother, because she "*wanted to be away from home*". She said she still had difficulty sleeping at night, and this made her very tired during the day. She claimed she had had no need for any of the therapeutic techniques explored during the previous two weeks. Mary was visibly reassured not to feel obligated to use any of the techniques or disclose any information. I explained that she might find some techniques useful and others not, and that therapy was aimed at supporting her, as well as strengthening her skills to cope with painful memories and emotions. Mary revealed that she occasionally went through periods of worry about the court case, although there had also been times when she did not think of the case at all. She said she was too busy with schoolwork to worry about the case. She expressed concern about the possibility of her family moving to Pretoria. She said she had not felt well the previous week, and would have preferred being at home and visiting a doctor rather than coming for therapy.

Mary mentioned how upset she was that the court case could not be finalised. She did not want to testify in-camera. It also disturbed her that one of her perpetrators had befriended one of the girls at her school, and remained unsure whether to warn her or not. She also reported having mood swings and how negatively these impacted on relationships with family members and friends. Eye movements were used to access the "*safe place*". Mary seemed uncooperative and had a blank stare on her face. She mentioned she wanted to talk about the sexual assault and matters that bothered her, but did not know how. I suggested that she focussed on verbalising feelings rather than feeling obligated to talk about the actual incident since this might be easier.

THERAPIST'S REFLECTIONS

Mary did not seem particularly co-operative. She also seemed to have great difficulty verbalising her feelings and thoughts. I had the sense that she felt rushed and was distracted. The session took the form of a dialogue with not much time for eye movements. It seemed as

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if she needed time and space to work through whatever it was that was disturbing or distracting her. She also seemed desperate to have the court case finalised, before she could move on with her life. This was to be understood. However, I was left with the sense that the therapy was not proceeding as I planned it.

SESSION 6

The aim of the session was to establish which of the techniques used in therapy Mary found meaningful and was actually using. It was also aimed at exploring her coping skills, her picture of her "*ideal self*", as well as the nature of her relationship with her mother. She looked troubled and visibly tired. She said she had not felt well the previous week, but had not visited a doctor. She had also been absent from school once the previous week, had difficulty sleeping at night, and expressed concern about the pending court case.

Mary mentioned that she was looking forward to her mother's return. She mentioned that she was still on holiday. She said she had seen one of her perpetrators, which had caused "*her heart to beat faster and legs to become lame*". Mary seemed worried and mentioned having difficulty falling asleep and being very restless at night. I explained that traumatic experiences often remained in an individual's memory, and could be processed with psychotherapy, and that EMDR could be used to process her traumatic memories. I used the image of a movie to illustrate how when one kept looking disturbing scenes eventually went away. Before the session was terminated Mary mentioned her concern about being pregnant, because she stopped using contraceptives. Her boyfriend shared her concern, but they could not afford a do-it-yourself pregnancy kit. She also did not want to approach the local day-hospital.

THERAPIST'S REFLECTIONS

Mary seemed uncooperative and troubled. She did not seem at ease, and clung to the garment on her lap. Long pauses and lots of probing, with brief responses, characterised the session. I was relieved when the session finally ended, because she really seemed to have difficulty in expressing her feelings and thoughts and was unable to verbalise what was troubling her. She struggled to come up with anything she wanted to discuss in the session, but spoke about her concern about being pregnant.

The therapy also seemed to be progressing very slowly. I also had an uncomfortable feeling, because I was not sure how to proceed with the session without letting Mary feel obligated to

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talk about what was troubling her. Mary's disclosure about probably being pregnant put aspects of her behaviour during the past few weeks in perspective. The probable pregnancy might have been of greater concern to her now, than having to work through the trauma of the sexual assault she suffered three years back.

SESSION 7

The session was aimed at exploring and processing Mary's fears about a possible pregnancy and the implications of motherhood. The EMDR protocol was used to address some of her fears. She seemed relaxed, but was reportedly still having trouble falling asleep. She said that her mother had returned from holiday. She mentioned she had not informed her mother about her suspicions, but was worried how being pregnant would impact on her life. She was concerned about what her mother's response would be. She was also concerned about having to leave school, but expressed the hope of returning after the birth of the baby. Mary agreed to process her concerns with EMDR. Role-play was used to assist Mary to discuss her suspicions with her mother. She also had not sought confirmation from a medical doctor because she did not have the financial means. "Eye movements" were used to process Mary's concerns and ambivalent feelings about the pregnancy.

Mary also mentioned that her once close relationship with her father had deteriorated since before the incident, but she would not to elaborate. She also indicated that she wanted to continue with therapy, but had difficulty talking about issues that troubled her. There had however been other things such as preparing for the examination that had kept her from thinking about the sexual assault. She mentioned being glad her mother had given up her job to play an even more supportive role. Eye movements were used to install this positive feeling and to access her "safe place, container, and light source".

THERAPIST'S REFLECTIONS

Mary struggled to maintain eye contact, and stared at the floor as she mentioned how helpful it had been to talk to me about some of the things that troubled her. The fact that we did not follow EMDR protocol exactly during the session and seemed to have done very little EMDR was a major concern to me. Mary also seemed very distracted, and although she smiled shyly at times, a very serious and worried look remained on her face throughout the session. I had a sense I was not making sufficient progress and that she did appear to understand the value of therapy fully. She also seemed particularly tired and anxious.

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SESSSION 8

The session was again aimed at addressing Mary's fears about the pregnancy. This time she was to engage in a conversation with her baby. We would also work on whatever issues she raised in the session and to process them using EMDR. We used role play to help her tell her mother about her suspicions.

She still seemed troubled and worried, but reported that not much had happened in school during the previous week, other than the examination. Mary reported that although her sleeping patterns had improved since she had started therapy she kept thinking about how much she wanted to tell her mother about her suspicions. She mentioned that her relationship with her father had been strained and that her mother had become the one she confided in since the incident. Her mother reportedly had also asked her father to leave the family home, which did not seem to bother Mary at all. She said she had told her brother's girlfriend that she suspected she was pregnant, and desperately wanted to tell her mother about it. She lacked the courage, and preferred to confirm the pregnancy before broaching the matter with her. She said she was sad about having to quit school, but expressed the hope again that she might "*return after the birth of the child* ".

Mary disclosed that she had been able to cope with a previous pregnancy, because of the emotional and material support her mother provided. She was sixteen-years old at the time, but the pregnancy was not as a result of the sexual assault. She acknowledged her mother would be disappointed but supportive just as with the previous pregnancy. Mary spoke sadly of the loss of her first baby, and mentioned preparing with excitement for his arrival. She sat with her arms folded, legs crossed and maintained good eye contact. When I referred to the sad look on her face, she smiled shyly but seemed uncomfortable with the attention given to her. She requested assistance in talking to her mother about her suspicions and also inquired about the number of sessions that remained. We agreed that she would decide during the course of the week whether her mother was going accompany her to the following session.

THERAPIST'S REFLECTIONS

The session proceeded well, but took the form of a therapeutic interview, which focussed on Mary's concerns. Her mood during the session seemed to fluctuate between periods of joy and sadness. I was more at ease with the way therapy was proceeding, as the dialogue seemed to suit the therapeutic situation and seemed less threatening to her than when we followed EMDR protocol. The fact that she did not seem obligated to come up with feelings or

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thoughts, seemed to facilitate the flow of the interview. The arrangement that it would be her decision to allow her mother to accompany her to the following session reaffirmed to her that she had control over what happens in therapy.

SESSION 9

The session was planned for Mary to inform her mother about her suspicions about being pregnant. My role was to provide support and act as facilitator. Mary's mother did not, however, accompany her to the session. Mary seemed quite at ease and mentioned that she had been on holiday for a week, which she particularly enjoyed. She also reported that she had not done as well as expected in the examinations. She had, however, been pleasantly surprised to receive an award for English. She reported feeling and sleeping well, and had attended school regularly during the previous two weeks. She initially did not seem to know what had contributed to her different outlook on life, but mentioned "*I'm enjoying it.*"

Mary said she had told her mother about her suspicions, but a pregnancy test had proved negative. Her mother had initially reacted with shock, but had been very supportive. She expressed relief, and acknowledged she would have to take measures to prevent falling pregnant, saying, "*I am extremely happy, I'm not pregnant.*" Although her mother prohibited her from seeing her boyfriend, they still saw each other at school. Mary struggled to come up with any matter to process with EMDR. The interview shifted to inquiries about her ways of coping with the sexual assault. She maintained good eye contact as she recalled having difficulty adjusting after the incident. She reported being sad about missing out on school for a whole year, but had to some extent moved on with her life by making new friends when she eventually returned. Her goal was to complete school and become a social worker. Mary was asked to focus on the qualities that helped her cope with previous stressful life events. She mentioned she believed there was "*a purpose with everything that happened in my life.*"

Mary also mentioned she had found it more and more difficult to come for therapy. She said it had become easier for her to cope emotionally with what had happened as therapy progressed. She also reportedly wanted the court case to be finalised, because "*it had been going on too long*". She described her overall functioning in terms of school, relationships with parents, siblings and peers as "*much better than before the start of therapy*". "*Everything is better.*" "*Everything we have done here was helpful*", and gave herself a rating of 9 on a scale of 1 to 10.

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THERAPIST'S REFLECTIONS

The session took an unexpected twist with Mary confirming she was not pregnant. She seemed elated about the news. Pregnancy might have impacted adversely on her relationship with her mother. Mary also seemed rushed, wanting to get the session over and done with as soon as possible. I had the sense that she was preparing herself to terminate therapy. She seemed much more at ease than on previous occasions and co-operated well.

SESSION 10

The aim was to get Mary to suggest the issues that she wanted to process using EMDR. She reported that the previous week had been "*fine*". She seemed very relaxed and smiled throughout the session. She expressed concern about her poor examination results, but said she hoped to perform better in the finals. She mentioned that various things including her poor relationship with her father, concern about being pregnant, and concern about the family moving to Pretoria all contributed to her poor performance in school. Furthermore her mother, her source of support had been on holiday during a crucial period. Although she was determined to do well in school, she had not started preparing for the final examination. Mary also expressed amazement at how she at times surpassed her wildest expectations and managed to achieve academic success.

Mary reported she wanted to qualify as a social worker, in order "*to work with children*". She seemed confused when asked about the qualities she thought she possessed that had led to this particular choice of career. She was requested to explore the job of a social worker to help her make an informed decision.

Mary was asked to describe her level of functioning. She mentioned that she was "*much more sensible now*", but struggled to expand on what she meant by the description. She seemed rushed. When probed she reported that "*everything is better*", and *"my concentration at school is better*." She reported being moody after the incident, having difficulty trying to sleep at night, as well as having her poor eating habits. She said everything had improved "*significantly*" since she had started therapy. She reported seeing two of her perpetrators during the previous week. She mention that in the past she used to find meeting them very disturbing, however, it was less disturbing than before. She claimed she had been coping better and did not wish to continue with EMDR. She expressed confidence in handling the court case, but did not to think of it too much, preferring rather to focus on the final

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examination. She also mentioned that she preferred dealing with issues around the assault closer to her court appearance.

THERAPIST'S REFLECTIONS

Mary seemed rushed and despite lots of probing her participation was limited to a few responses. She seemed distracted and did not seem interested in suggesting issues to be processed with EMDR. She also seemed visibly tired and made poor eye contact. The session was marked by periods with long pauses. She also seemed particularly quiet at the end of the session.

SESSION 11

Mary seemed very relaxed and spoke frankly about the latest developments in the case. The investigating officer had been in contact with the family, but it remained unclear when the case would go to court.

Although she reportedly had many different issues at the start of therapy process, she said she had none to process with EMDR during this session. "*There's really nothing I can think of.*" After some probing, Mary reported that arrangements had been made for her to testify in-camera. She however, preferred to face her perpetrators in court. It was suggested that the image of a film producer be used in preparation for her court appearance. "*Eye movements*" were used to install this image.

THERAPIST'S REFLECTIONS

Having struggled to explore the use of EMDR more fully during the previous sessions, it was a relief to work through a significant part of the therapy session using the technique. She seemed more willing to co-operate and seemed to have a better understanding of the potential use of EMDR. I also realised that lots of practice was needed in EMDR to ensure more effective results in therapy. There was also the realisation of Mary's need to work through issues at her preferred pace.

SESSION 12

Mary reported that although she had thought about the previous session, nothing out of the ordinary had happened since then. She also mentioned she had decided not to pursue a career in social work any longer, but had opted to do missionary work instead. She seemed quite

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excited about the prospect of leaving school, and smiled happily about the possibility of working overseas. She claimed she had become convinced about this career path after discussions with her mother and several members of her church. Her mother had been very supportive.

She reported that "*everything is fine*" and said she had nothing specific to process during the session. She believed she was adequately prepared for the court case. She also described her emotional state as "*very good*" in comparison to what it was at the start of therapy, and mentioned that coming for therapy contributed greatly to her emotional state. Mary mentioned that although some of her friends had been supportive, the techniques learnt during therapy had been of some use. She had also not been troubled much when she encountered one of her perpetrators in the previous week.

When Mary's ability to cope with previous stressful life events was acknowledged, she concurred that she possessed a strong will to succeed. She mentioned she wanted therapy sessions to be terminated, so she could only have the court case to focus on. She mentioned she just wanted "*everything to go away*". The picture she had of herself was that of someone who was successful. The session concluded with Mary talking enthusiastically about her plans to do missionary work.

THERAPIST'S REFLECTIONS

Mary seemed very quiet at the start of the session. The session took the form of a therapeutic interview, since Mary felt strongly that she had nothing to process with EMDR. She seemed very enthusiastic about doing missionary work, and seemed to have her mother's support. It was agreed that therapy would be terminated during the following session. Throughout the processing of the information Mary seemed to co-operate well and seemed much more focussed than at the start of the therapy process.

TERMINATION INTERVIEW

Ms Snell accompanied Mary to the session. The goals of the session included the following:

- To make certain Mary had no pressing issues;
- To make Mary realise that issues might occur at another stage of development for which help might have to be sought; and

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- To provide an opportunity for Mary and Ms Snell to evaluate the therapy process.

Ms Snell mentioned that she saw a "*big improvement in Mary's overall behaviour since she started therapy*". She felt Mary seemed to possess "*better self-control, was less likely to have anger-outbursts, and was emotionally more stable*". She also reported that Mary was sleeping well, was less restless at night, and was less troubled by nightmares. Ms Snell mentioned she believed that therapy had contributed greatly to Mary's level of functioning. Mary seemed less troubled when coming into contact with her perpetrators. It did not seem to have the same disturbing influence and she seemed better able to handle them. The therapy had reportedly also helped her to discuss concerns about the incident more easily with her mother. Mary completed the BDI and DES.

THERAPIST'S REFLECTIONS

There was a sense of relief that the therapy had come to an end. Although sessions did not always proceed as anticipated, allowing greater flexibility seemed useful as it enabled Mary to determine the pace and direction of therapy and to discuss what she preferred. Mary reportedly benefited from being in a situation in which she could disclose what she wanted to.

4.4 THE USE OF EMDR DURING SESSIONS

EMDR formed an integral part of the intervention program. During the intake interview Mary and her mother were provided with information about EMDR. However the EMDR protocol was only introduced during session three after the completion of the clinical assessment. I taught Mary the "safe place" exercise and installed it with "eye movements". The "safe place" exercise was intended to provide Mary with skills to decrease distress at the end of and between sessions. She was asked to practice the "safe place" exercise between sessions. Mary was also introduced to the "light source" and "container" metaphors which could also be used to deal with disturbing memories. The fourth session started with a re-evaluation and a consolidation of the work done in the previous session, and further consolidation occurred in session five. The metaphor of "being in a movie" when using EMDR to process trauma was also used.

It was only during session eleven that the standard EMDR protocol could be followed for the first time. Mary was asked to rate the intensity of the distressing emotion on a 0 to 10 *Subjective Units of Disturbance* (*SUD*s) scale and the validity of the positive cognition on a

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7-point *Validity of Cognition* (*VoC*) scale. She reported a *SUD* of 7 and a *VoC* of 5. She was asked to concentrate on the image, negative belief, and body sensation associated with the image, and then to follow my fingers with her eyes. The set of eye movements consisted of Mary tracking my fingers moving horizontally from side to side, at a speed that was comfortable for her. After the set of eye movements had been completed, I asked her to take a deep breath. She was then asked: "*What came up for you*?" She was instructed to follow up that thought, and then I followed it up with another set of eye movements. The process of "eye movements" was followed by my exploring with Mary what had come up until her *SUD* level was 2, indicating that the memory had been desensitized. She also reported a *VoC* of 7.

4.5 DATA ANALYSIS

As mentioned in Chapter 3, several tentative categories and possible themes based on a review of the literature were selected for discussion in this study. Mary and her mother were both present for the intake interview. The themes that emerged from Mary's mother input can be seen in Table 4.2, while Table 4.3 shows the themes that emerged from Mary's input during the same interview.

Upon the completion of the support process and the coding of the transcripts, several additional themes emerged. The themes are briefly outlined below and were also included in the discussion (also see Table 4.4 to Table 4.6) of the findings.

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TABLE 4.2: THEMES WHICH EMERGED DURING THE INTAKE INTERVIEW WITH MS SNELL

CATEGORIES	THEME
• Divorce • Marital relations • Parent child Relations • Impact of sexual assault • Relations with siblings	Turbulent family dynamics
• Social withdrawal • Anger outburst	Volatile emotional state
• Judicial and health system • Psychotherapy and pastoral support • Parental support • Support from siblings and friends	Need for social support
• Diminished interest • Suicidal ideation • Depressed mood	Symptoms of depression
• Avoidance of stimuli associated with trauma • Re-experiencing the trauma i.e., memories or dreams • Flashbacks	PTSD symptoms
• Moral • Physical	Developmental issues
• Activities of daily living	Overall functioning

TABLE 4.3: THEMES WHICH EMERGED DURING THE INTAKE INTERVIEW WITH MARY

CATEGORIES	THEME
• Relations with siblings	Turbulent family dynamics
• Resistance	Volatile emotional state
• Therapy	Need for social support
• Memory loss • Avoidance of stimuli associated with trauma	PTSD symptoms
• Activities of daily living	Overall functioning

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TABLE 4.4: THEMES WHICH EMERGED DURING THERAPY SESSIONS WITH MARY

CATEGORIES	THEME
• Relations with siblings • Parent child relations • Marital relations	Turbulent family dynamics
• Resistance • Self-confidence • Anger outbursts • Social withdrawal • Fear • Coping skills • Anxiety • Motivation • Disturbing thoughts, worries, indecision	Volatile emotional state
• Parental support • Support from siblings and friends • Psychotherapy and pastoral support • Judicial and health system	Need for social support
• Sleep disturbance • Depressed mood • Memory loss	Symptoms of depression
• Avoidance of stimuli associated with trauma • Flashbacks	PTSD symptoms
• Cognitive • Physical • Moral	Developmental issues
• Activities of daily living • Sleeping habits • Eating habits	Overall functioning

TABLE 4.5 THEMES WHICH EMERGED DURING TERMINATION INTERVIEW WITH MS SNELL

CATEGORIES	THEME
• Motivation • Anger outburst	Turbulent emotional state
• Judicial and health system • Psychotherapy and pastoral support • Parental support • Support from siblings and friends	Need for social support
• Avoidance of stimuli associated with trauma • Re-experiencing the trauma i.e., memories or dreams	PTSD symptoms
• Activities of daily living	Overall functioning

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TABLE 4.6 THEMES WHICH EMERGED DURING TERMINATION INTERVIEW WITH MARY

CATEGORIES	THEME
• Motivation	Turbulent emotional state
• Therapy	Need for social support
• Activities of daily living	Overall functioning

This study is my account of what happened during the intake and termination interviews, the therapy sessions, as well as the experiences reported by the Mary and Ms Snell. McLeod (1994:107) maintains that a high degree of trust between the researcher and the participant is essential and might ensure more authentic and complete data. He further states that a skilled researcher is also able to listen attentively and understand what is being communicated. I used several techniques including one-to-one interviews, observations, questionnaires and field notes to obtain information for this study. All 13 sessions were recorded on videotape, and recordings transcribed. Once data was collected I as the researcher was faced with the task De Vos *et al.* (2002:286) describes as: "*data reduction, presentation and interpretation*". Once I drew up a coding system, all sessions were closely examined, word by word to identify themes. Units of behaviours were defined and labelled or coded. Codes were clustered to determine what themes emerged.

The codes, categories and themes in the start list and additional lists were used to identify the themes that emerged. The themes emerged from the interviews with Mary and her mother, Ms Snell. Both Mary and her mother were present for the intake and termination interview, whilst Mary was the only one present for the therapy sessions. Additional information including information about Mary's overall development was obtained from self-report questionnaires completed by Ms Snell. Addendum 1 and 2 show the tentative themes and additional themes that emerged respectively. Addendum 3 shows an example of part of the transcript that was coded. The themes emerging from the various sessions form the basis for my discussion can be summarised as follows (included are some verbatim responses):

- **TURBULENT FAMILY DYNAMICS**

This theme dealt with the dynamics of the Snell (pseudonym) family, and indicated the impact of Mary's assault on the family. It also dealt with her relationship with her parents and

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her siblings. The information provided indicated that Mary's assault had a profound impact on her relations with her parents and her siblings:

At that stage we just got divorce ... it was a difficult time (Mary's mother)

I saw something was wrong, but she would not say anything to me (Mary's mother)

I didn't speak to my brother for quite a while (Mary)

It's strange, before the incident she really was daddy's girl (Mary's mother)

I think it was the most difficult for her sister (Mary's mother)

Initially it was very difficult for me to accept (Mary)

I'm just thinking, how am I going to tell my mother (pseudo-pregnancy)(Mary)

- **VOLATILE EMOTIONAL STATE**

This theme described Mary's emotional state before and following the incident and upon the completion of the therapy process. Mary's mother provided a lot of information about her emotional state. Mary seemed to have experienced an emotionally turbulent period following the assault:

Or she has terrible anger outburst for no apparent reason (Mary's mother)

... when she starts becoming aggressive, when she starts to cry (Mary's mother)

Sometimes I think it will be better if I could know what happened so that I can let go (Mary)

This exam she is particularly motivated to learn (Mary)

The thing is, I'm so used to coping (Mary)

I'm going to study. I spend the whole day in my room to study (Mary)

I look forward to finishing school. I definitely want to finish school (Mary)

- **NEED FOR SOCIAL SUPPORT**

This theme refers to the support Mary and her family received subsequent to the assault. It also dealt with the supposed ineffective support they received from the health and judicial sector. The nature and level of support varied, but contributed in a meaningful way to an improvement in her overall functioning:

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Every time she got used to someone (therapist), someone else (another therapist) walked in (Mary's mother)

... she had to go weekly (to hospital), after she was admitted (Mary's mother)

The thing is, I don't want you to think I don't want to co-operate (Mary)

Usually I wake my mother. Then we make coffee and talk (Mary)

The court case is coming up, I don't know when, but it bothers me (Mary)

When I get home, all my friends are there (Mary)

I can really state that I notice a big change (Mary's mother)

- **SYMPTOMS OF DEPRESSION**

This theme dealt with the reported symptoms of depression Mary displayed following the incident, including sleep disturbance, depressed mood, and diminished interest and memory loss. These are the same symptoms mentioned in the DSM-IV as characteristic of depression in individuals (American Psychiatric Association, 2000:352). Mary displayed a variety of symptoms characteristic of depression, and there reportedly seemed to have been an alleviation of symptoms as therapy progressed:

She then tried again. She was admitted and the third attempt (suicide) was in hospital (Mary's mother)

... she has again become very, very tearful... (Mary's mother)

There are times that she withdraws herself completely (Mary's mother)

The previous evening I was awake almost the whole night (Mary)

It's really at night that it gets really bad. (Mary)

I sleep very well. In the beginning I used to wake up a lot... (Mary)

- **PTSD AND DISSOCIATIVE SYMPTOMS**

This theme was related to the reported symptoms of PTSD and dissociation Mary displayed following the incident. Symptoms of PTSD and dissociation were present following the incident, including flashbacks, avoidance of stimuli associated with the incident and memories of the incident. The symptoms correspond with DSM-IV symptoms characteristic of individuals who were exposed to traumatic events (American Psychiatric Association, 2000:466). Some alleviation of symptoms was, however, reported:

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She will example have nightmares. They are chasing her... (Mary's mother)

... she has great difficulty when she comes face-to-face with them (Mary's mother)

... it's just that I don't like talking about it (Mary)

Then I was somewhat scared to go to sleep (Mary)

Just the thought of what happened to me – I see their faces (Mary)

- **DEVELOPMENTAL ISSUES**

These are issues that could be more intense during the adolescent stage of development. This theme dealt with developmental concerns that became evident in my interactions with Mary:

They say that the asthma is anxiety related (Mary's mother)

... one of them (perpetrators) is going out with one of the girls at school. I feel like telling her and warning her (Mary)

The thing is there is something (pseudo pregnancy), I don't know how... I'm not sure (Mary)

Look I had been pregnant before. It was a miscarriage (Mary)

- **OVERALL FUNCTIONING**

This theme indicated Mary's overall functioning before and following the incident. It described how she dealt with activities of daily living, as well as her sleeping and eating habits. Mary's overall functioning reportedly improved as the therapy progressed.

I eat a little bit, then I've had enough (Mary)

I had been to school every day this week (Mary)

This afternoon, I going for a modelling session (Mary)

I had such a hectic week, there was no time to think about it (Mary)

I also started a casual job where my mother is working (Mary)

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4.6 A SUMMARY OF THE CHAPTER

This chapter explained how the study was implemented, indicating the procedure used to generate data. Clinical assessment was an important component of data production. This included a psycho-educational assessment which, together with the self-report questionnaires provided information about Mary's overall functioning. The process of data analysis was also explained. During the process of data analysis the themes that emerged included the impact of Mary's assault on her relations with her parents, siblings and peers. It also showed the impact on her overall functioning. The following chapter will provide a general discussion of the themes that emerged during the data gathering process.

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CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 INTRODUCTION

As previously stated, this study explores the use of EMDR with an adolescent female sexual assault survivor. In this chapter I will focus on a general discussion of the themes that emerged from this study. These themes will once again be located within an ecosystemic framework. I will also outline the limitations of the study, recommend suggestions for future research and end with some concluding remarks.

5.2 DISCUSSION OF THEMES

The themes that emerged from this study, and mentioned in Chapter 4 form the basis of my discussion follow below. The themes are:

- The turbulent family dynamics
- Mary's volatile emotional state
- The need for social support
- Symptoms of depression evident
- PTSD and dissociative symptoms displayed
- Developmental issues she might have
- Mary's overall functioning

5.2.1 Turbulent family dynamics

Donald, Lazarus and Lolwana (2000:34-36) maintain that the interaction between an individual and his or her immediate surroundings is dynamic and reciprocal. In addition to Mary's assault, a number of factors affected the relations among the various members of the Snell household. Mary's assault happened a few months after her parents' divorce. The family home had also been sold and the search for alternative accommodation possibly led to instability in their lives. Mary's assault had a profound impact on her relations with her

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parents and her siblings. While Dacey and Kenny (1997:372) postulate that parental divorce is a major source of depression in adolescents, Mary's assault temporarily re-united the family. Her parents had been very supportive following the assault, her mother especially. They had sought assistance from the police, health and legal sectors. Although her reportedly once close relationship with her father had deteriorated since the divorce, the assault led to an improvement in mother-daughter relations. Mary found it beneficial and could more easily discuss issues around the assault with her mother. This supports Luster and Small's (1997:133) argument that parental support is important to help the child cope with the psychological effects of sexual trauma.

5.2.2 Volatile emotional state

Ms Snell's description of Mary before the incident was of a child who was secure, confident, happy, quiet and well behaved. She reportedly also mixed easily with friends and had a good relationship with her siblings. Following the incident, however, she displayed many of the symptoms suggested by Burgess and Holmstrom (1974) (cited in Hazelwood & Burgess, 2001:29-38) characteristic of survivors of sexual trauma. Mary cried more than usual, had difficulty with concentration, became agitated and her relationship with her siblings and peers deteriorated. However, another picture of Mary emerged as the therapy progressed: one of an individual with ego-strength, motivation and determination who, for example, could face her perpetrators in court and achieve the vocational goals she set for herself. The therapeutic support and the support she received from her mother seemed to contribute to an improvement in her emotional state.

5.2.3 Need for social support

Kazdin and Johnson (1994:217-226) maintain that early intervention is important to prevent the debilitating effects of trauma in adulthood. Mary's disclosure of the assault to her cousin was significant in that it got various sectors involved. It resulted in her parents seeking assistance from various sectors including the judicial, health sector, police and the Unit for Educational Psychology. The nature and level of support varied, and was reportedly not always effective. Yet, as both Mary and Ms Snell acknowledged, meaningful contributions were made by the police, the church and the therapeutic support she received during her involvement in this study.

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5.2.4 Symptoms of depression

Mary as a sexual assault survivor displayed a variety of symptoms characteristic of depression including sleep disturbance, depressed mood, diminished interest and suicide ideation. Mary's symptoms of depression show aspects of what Beck (1967) (cited in Dacey & Kenny, 1997:373) describes as emotional, cognitive, motivation and physical manifestation (also see Table. 3). She always used to have close friends but had become socially withdrawn. Her symptoms support what Feldman (1999:346) maintains about the risk of developing depression, following sexual trauma. However there reportedly seemed to have been an alleviation of symptoms as the therapeutic support progressed and upon termination. Mary had re-established contact with some of her friends and was more socially active. This improved her self-confidence.

5.2.5 PTSD and dissociative symptoms

Mary reportedly displayed several symptoms of PTSD and dissociation following the incident. Although her symptoms did not meet the criteria for a diagnosis of PTSD (American Psychiatric Association, 2000:463-464) they were sufficient to cause nightmares, sleep disturbance, memory impairment and concentration problems. In addition she experienced intrusive thoughts about the incident (Scott & Stradling, 1999:36). Although Robertson (1989:3) suggests that it is advisable to use definitions recognised by South African courts of law when referring to acts of crime, Mary never used the concept sexual assault or rape during her interactions with me. This might have been an attempt to avoid stimuli associated with the trauma. However, there did seem to be some alleviation of symptoms as the therapy progressed and towards termination. During the termination interview Ms Snell mentioned that Mary had been requested by the police to return to the scene of the crime days prior to termination of therapy to gather evidence for their investigation. She experienced some sleep disturbance after this, but her recovery was reportedly quicker than would have been the case soon after the incident. She attributed the improvement in her functioning to the work done during the sessions with me.

5.2.6 Developmental issues

Several developmental issues became evident during my interactions with Mary. According to Piaget (Feldman, 1999:425) abstract and logical thinking is a feature evident in adolescents. Yet it seemed as if Mary did not fully comprehend the implications of an unplanned pregnancy. Her reactions to the pseudo-pregnancy seemed to fluctuate from

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excitement about having a baby to concern about having to give up her leisure activities. She was quite prepared to leave school and give up her goal of becoming a social worker. She was also not too concerned that her boyfriend could not support her and the baby financially.

Newman and Newman (1997:663) state that adolescents often rebel against or defy their parents, by displaying risk-taking behaviour. Although Mary's mother encouraged her to use contraception, she was sexually active without using effective contraception. This also seems to support research cited by Kimmel and Weiner (1995:365-376) suggesting that many adolescents often engage in this kind of practice and risk unplanned pregnancy. The pseudo-pregnancy was also as Dacey and Kenny (1997:300) postulate, a major source of stress for Mary. It also impacted on her relationship with her mother in that Mary had to deal with the anxiety of a pseudo-pregnancy, but she could not tell her mother.

The knowledge that one of her perpetrators was having a relationship with a peer posed a serious moral dilemma for Mary. Her dilemma was whether to warn the learner or not. This self-awareness and indecision Papalia and Olds (1989:382) describe as common features in adolescents. In this case the situation had a profound impact on her. It was an issue that concerned her and which she raised during the support sessions in order to gain clarity as to what she should do.

5.2.7 Overall functioning

The assault impacted negatively on Mary's overall functioning and following the incident she had great difficulty with activities of daily living. As mentioned previously, she experienced sleep disturbance, had poor eating habits, struggled with the academic demands of school, and became socially withdrawn. Her overall functioning however gradually improved to the extent that she was able to attend school more regularly, participated more freely in activities at school and in church, and even found herself part-time employment. Mary's overall functioning reportedly improved gradually as the sessions progressed.

5.3 LIMITATIONS AND RECOMMENDATIONS

Methodological limitations must be considered in interpreting the findings of this study. Firstly, the study was limited to a single adolescent girl and can therefore not be generalised to all adolescent girls in similar situations. Secondly, although every effort was made to follow EMDR protocol, my lack of experience, and the apparent difficulty with and

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resistance to the process Mary at times displayed possibly influenced the effectiveness of support. Although "eye movements" were used during several sessions to process Mary's issues of concern, the standard EMDR protocol was really limited to one session.

The results of the *Beck's Depression Inventory* and *Dissociative Experiences Scale* seemed to suggest the feasibility of EMDR as a treatment strategy. However, further research using a larger sample is recommended. This research could also include adolescent male sexual assault survivors.

5.4 CONCLUDING REMARKS

The issue to be considered was whether after thirteen sessions of support, including sessions in which EMDR was used, there was evidence that Mary's symptoms of depression and dissociation had been alleviated? The issue of measuring the impact of EMDR in the support provided to Mary can be done in several ways. One way, arguably, is to examine the results of the *Beck's Depression Inventory* and *Dissociative Experiences Scale*, which upon completion of therapy seemed to indicate an alleviation of symptoms of depression and dissociation. Another way would be to examine reported experiences of the participant in this study, as well as the reported experiences of her mother.

Ms Snell's description of Mary before and at the point of termination seemed to indicate that the support, including EMDR Mary received, contributed to more improved overall functioning than before her involvement in this study. McLeod's (1994:122-123) criticism about the claims of the effectiveness of psychotherapy, seem relevant here. Whilst there were indications that some of Mary's depression and PTSD symptoms had been alleviated and her overall functioning reportedly improved, not all of it could be attributed to EMDR and the support she received. Mary seemed to exhibit resilience and the motivation to overcome the traumatic event she experienced. The EMDR and support reportedly contributed to the identification and "building-up" of her inner resources. I would argue that the support Mary received from her mother, the youth pastor and the support she received during her involvement in this study in combination with EMDR resulted in an improvement in her overall functioning. She had a more positive outlook on life.

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ADDENDUM 1

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CATEGORIES, CODES AND THEMES (INITIAL LIST)

CATEGORY	CODE	THEME
• Physical	PHYS	Developmental issues
• Cognitive	COG	
• Psychosocial	PSYC	
• Moral	MOR	
• Re-experiencing the trauma i.e. memories or dreams	RE-EX	Dissociative symptoms and Symptoms of PTSD
• Avoidance of stimuli associated with trauma	AVOI	
• Persistent symptoms of increased arousal	AROU	
• Flashbacks	FLAS	
• Memory loss	MEM	
• Derealization and depersonalisation	DEP	
• Parental support	PAR	Social support structure
• Support from siblings, friends and others	SIB	
• Psychotherapy and pastoral support	THER	
• Judicial and health system	JUID	
• Depressed mood	DEPR	Symptoms of depression
• Diminished interest in activities of daily living	DIMI	
• Sleep disturbance	DIST	
• Fatigue or loss of energy	ENER	
• Decrease or increase in appetite	APP	
• Suicidal ideation	SUIC	

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ADDENDUM 2

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CATEGORIES, CODES AND THEMES

(ADDITIONAL LIST)

CATEGORIES	CODE	THEMES
• Divorce	FAD	Family dynamics
• Marital relations	MAR	
• Parent child relations	PAC	
• Impact of sexual assault	IMP	
• Relations with siblings	REL	
• Activities of daily living, e.g. school, sport, etc.	ADL	Overall functioning
• Eating habits	EAT	
• Sleeping habits	SLEE	
• Emotional state	EMO	Emotional state
• Resistance	RES	
• Social withdrawal	WITH	
• Anger outburst	ANGE	
• Self-confidence	SELF	
• Fear	FEAR	
• Motivation	MOT	
• Anxiety	ANX	
• Coping skills. Ego strength	COP	
• Disturbing thoughts, worries, indecision	DIS	

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ADDENDUM 3

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SAMPLE OF CODING

Me. N[1] Ek het hier gewoon. En het ek die huis verkoop. Ek is op soek na 'n huis, maar al wat ek kon kry is in Bellville. Maar ek is op soek na weer in die omgewing	FAD
T.1[2] U wil weer terug kom na die area toe. En jy is van Gr. 8 af al by Goodwood Kollege. Watter graad is jy nou?	
M[3] Graad tien.	
T.1 Graad tien.	
Me. N M. moes eintlik in Gr 11 gewees het. Maar as gevolg van die storie is sy byna 'n jaar uit die skool was. Sy het glad nie weer terug gegaan.	ADL DIMI
T.2[4] Watter jaar was dit?	
Me. N St. 7, Ja. St. 7	
T.1 Gr. 9. Dit is graad 9. Sy is nou in Gr 10. Gee vir ons 'n idee wanneer het dit gebeur?	
Me. N Dit was Nov 1999. Sy was besig met eksamens te skryf vir Gr 8. Sy het in begin van Gr 9 terug gegaan, maar toe het sy uitgeval .	ADL
T.1 So sy was in daardie stadium in Gr 8.	
Me. N Ja, toe dit gebeur het	
T.1 Toe gaan sy terug in 2000 vir Gr 9	
Me. N Umhh! Umhh! Maar dit was net 'n rukkie in die skool. Seker net vir 'n maand. Dit was Februarie. Toe het dit haar regtig begin vang.	

[1] Ms Snell
[2] Therapist
[3] Mary
[4] Co-therapist

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M	Dus toe dit begin het.	
Me. N	Ja. Sy het begin selfmoord pleeg en hulle het haar opgeneem in	SUIC
	Tygerberg. Sy was omtrent vyf of ses weke wat sy daar opgeneem is.	THER
T.1	Umhh! Ek weet dit is dalk moeilik om te praat, maar ek dink dit is vir ons belangrik dat ons 'n idee het van wat gebeur het. So miskien as M. vir ons in haar eie woorde kan vertel. So dat ons kan weet in terme van terapie en ons begin met die beplanning daarvan, waarmee ons te doen het. M.	
M	Moet ek vertel wat gebeur het.	AVOI
T.1	Daar het 'n insident gebeur in 1999. in Nov. sê jy,	
T.2	Sal jy gemaklik voel om daaroor te praat. So ver as wat jy gemaklik voel. Jy is verplig om nie oor enige iets te praat nie. As sy voel jy wil nie nou nie maar wel later. Jy kan net vir ons breed weg 'n idee gee.	
M	Umhh! Dit die Vrydag gewees…toe ek en my broer en twee vriende. Toe sou ons na die Club toe gaan. Op pad daarna toe het hulle 'n bottel gekoop. Toe is hulle na 'n Sportgrond toe hier agter. En toe het ons daar gedrink. Toe besluit hulle, hulle gaan nie, dus te vol. Umhh…. Ek weet dat A het sy hand in my broek probeer steek. Ek het by my broer gaan sit. Ek weet my broer het opgestaan en saam met sy vriende geloop. En dus al wat ek onthou. Ek weet nie hoe ek by die huis gekom het nie. En die volgende oggend toe sien ek dat my "pantie" is vol gras.	MEM
T.1	En na dit, het sy terapie ontvang? Wanneer het dit gebeur? Kan ek net gou een stap terug gaan. Daar was nou die voorval, en toe sy die oggend wakker skrik toe sien sy haar " klere" is vuil. En toe, het sy dit aan u genoem?	
Me. N	Nee. Ek dink dit was iets soos twee, drie weke wat sy doodstil gebly het	AVOI

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	beter kan hanteer as wat voorheen die geval was?	
Me.N	Ek wil graag se die terapie het 'n groot impak op haar gehad dat sy dit beter hanteer. Wat julle natuurlik gesels het, gesels ek en M. nie. Ek aanvaar dus haar deel van die lewe. As sy wil praat, dan praat ons. Maar ek wil graag glo dat die terapie vir haar gehelp om dit beter te aanvaar, ja Sy praat ook makliker. Sy is net vir my 'n bietjie gemakliker oor die situasie nou.	THER ADL THER ADL
T.	Is daar iets anders behalwe die terapie. Ek dink dus ook vir ons belangrik vir ons wat u sou dink vir haar moontlik 'n bydraende faktor was, die afgelope twee maande.	
Me. N	Wat ek kan aan dink is dat ons huis is rustiger? Ons het by 'n nuwe kerk aangesluit. Dit is vir ons lekker om kerk toe te gaan. Ons gaan omdat ons wil gaan . M. geniet dit ook vreeslik. Dit is ook waar sy die begeerte gekry het om sendingwerk te gaan doen. Ons wil nou Sondag met die pastoor gesels, dat sy aansluit by die skool daar.	ADL THER MOT
T.	Wanneer het julle aangesluit by die kerk?	
Me. N	Dus nou maand en 'n half wat ons nou daar aangesluit het	
T.	M. jyself, wat was jou ervaringe. Wat sal jy graag met ons wil deel? Hoe het jy die proses ervaar, die sessies. Jy kan net deel dit waaroor jy gemaklik mee voel.	
M.	Die sessies het my amper laat praat daaroor. Dit het my beter laat voel, elke keer wat ons daaroor gepraat het.	THER ADL AVOI
Me. N	Ja, ek dink aan die begin het sy vir my gesê dit was moeilik om daaroor te praat, dit was ongemaklik. Dit lyk vir my asof dit al hoe makliker geraak het vir haar. Ook omdat een persoon wat vir haar die sessies gegee het, waar dit by Tygerberg was dit gedurig nuwe mense.	ADL THER
T.	Wat sou jy sê, is daar iets wat vir jou uitgestaan het van ons tyd saam	

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	sedert Augustus. En in hoe 'n mate was dit vir jou betekenisvol ?	
M.	Net die feit dat ek iemand gehad het om mee te praat as 'n persoon.	THER
T.	En as ons moet dink aan die pad vorentoe.	
Me. N	Sy het haarself voorgeneem sy gaan nie nou bekommer oor die hofsaak of enige iets in daai lyn nie. Ons het gesels daaroor. Voorheen was dit maande voor die tyd begin sy al "panic". Sy moet eers die eksamen agter die rug kry. En wanneer hulle sê daar is 'n hof datum dan sal ons dit hanteer.	JUID PAR ADL
N.	Ek wag eers vir my eksamen om verby te kom.	PAR
T.	Is daar iets spesifiek, en ek wil hê dat jy eerlik moet wees, wat nie vir jou betekenisvol was nie, iets wat nie werklik vir jou betekenis was nie.	
M.	(skud haar kop). Daai "safe-place" het ook baie gehelp.	THER
T.	Die rede waarom ons ook gevra het dat u moet kom, is dat ons wil hierdie proses op die regte manier afsluit. Net soos aan die begin daai eerste onderhoud belangrik was, net so is die onderhoud ook belangrik. Op hierdie stadium is die pad vorentoe onseker soos u self se. U weet nie wanneer die hofsaak gaan plaasvind nie. M het ook vir haar self sekere dinge ten doel gestel. Die eerste ding soos sy gesê het is om eers deur hierdie eksamen te kom, en kyk of sy dan by die kerk skool sal in kom.	