

Derailed by a sugar daddy: An investigation of the failed treatment of an adolescent township rape survivor with PTSD

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Abstract

This study investigates the transportability of an evidence-based psychological intervention to local contexts by documenting the treatment process with an isi-Xhosa speaking Black South African adolescent. She was sexually assaulted on two separate occasions, the second incident involved a gang rape by several perpetrators and was diagnosed with post-traumatic stress disorder (PTSD) and depression. She was treated using Ehlers and Clark's (2000) cognitive therapy (ECCT). Systematic case study methodology was used. Treatment was partially successful as Lulama prematurely terminated after 11 sessions. Nevertheless, her case study highlights some of the challenges in working with adolescents from disadvantaged backgrounds characterised by dysfunctional home environments, parental psychopathology, community violence and the presence of perpetrators. The study identifies some of the obstacles that can be encountered when implementing trauma- focused interventions in local South African contexts and serves to sensitise practitioners to some of the conditions necessary for treatment to be effective.

Introduction

Despite the emergence of effective manualized treatments for posttraumatic stress disorder (PTSD), it is erroneous to conceptualize PTSD as a discrete medical problem requiring a specific treatment that is somehow independent of the life context of the traumatized individual. This is illustrated by the case of Lulama (16), an isi-Xhosa speaking Black South African adolescent who had been sexually assaulted on two separate occasions during the course of a single day. One assault involved a gang rape by several perpetrators. Lulama was referred to the first author, a counselling psychologist, who treated her as part of a research project investigating the transportability of Ehlers and Clark's cognitive therapy (ECCT) for PTSD to South African conditions. ECCT is an evidence-based treatment that has been demonstrated to be very effective and its application in various South African settings was examined in a series of case study projects over several years (Edwards, 2009; 2010; 2013).

Observations from systematic case studies from this project and other published case studies generated in South Africa and other countries, led to the development of an integrative model (Edwards, 2013). This situated the specific procedures involved in

treatment within a broader framework of necessary conditions for treatment to be deliverable and effective. This included a basic physical infrastructure (shelter, food), a basic social infrastructure (family and social support), client motivation, the establishment of a therapeutic alliance, and a capacity in the client for self-regulation and resourcefulness. In Lulama's case, these conditions were not adequately met and the treatment of her PTSD was only partially successful. This article presents a systematic case study of Lulama and her treatment that allows for an in-depth interpretative enquiry into what necessary conditions were not met and what, if anything, might have been done to address this.

Child sexual assault in South Africa and risk for PTSD

In South Africa, the sexual assault of children is pervasive with 40% of reported cases involving girls below the age of 18 (Richter & Dawes, 2008). Childhood sexual assault (CSA) is typically opportunistic and girls who are neglected or live in communities with high levels of poverty are particularly susceptible to victimisation (Padmanabhanunni & Edwards, 2012). Parents living in disadvantaged settings often have to commute long distances to work leaving children unsupervised for extended periods of time, and enhancing their risk of victimisation. Poverty is also widespread in South Africa with 71% of children living in households where no adult is employed and where the normal processes that provide protection to children are placed under significant strain (Richter & Dawes, 2008; Smith, Bryant-Davis, Tillman & Marks, 2010). Abuse of alcohol and other substances by parents or caretakers can further impede their exercise of appropriate responsibility with respect to engaging in protective behaviour and identifying when abuse is occurring (Padmanabhanunni & Edwards, 2015).

Exposure to CSA is associated with increased risk of problems with reproductive health as well as adverse mental health outcomes including substance abuse (Hager & Runtz, 2012), self-harming behaviours (Jones et al, 2013), suicidal ideation and depression (Lopez-Castroman et al, 2013). PTSD represents the most common psychological consequence of exposure to rape and various South African studies have confirmed the prevalence of PTSD among child survivors (Kaminer, Grimsrud, Myer, Stein & Williams, 2008; Walker, Carey, Mohr, Stein & Seedat, 2004; Padmanabhanunni & Edwards, 2012). PTSD is a debilitating condition where memories of the trauma intrude into consciousness uninvited, resulting in marked distress. If unaddressed, the disorder can persist into adulthood and compromise survivors' daily functioning and their capacity to maintain meaningful relationships (Padmanabhanunni & Edwards, 2013).

For children and adolescents, recovery from sexual trauma is dependent on the quality of social support available particularly within the context of the family (Vranceanu, Hobfoll & Johnson, 2007). Healthy parenting practices that have been identified as beneficial include believing the child, taking active steps to protect them from the perpetrator and creating an environment where they feel able to speak about the trauma and receive care (Salmon & Bryant, 2002). These responses communicate to the child that they are still loved and valued, correct negative appraisals ascribed to the

trauma (e.g. self-blame) and promote the regulation of threatening emotions (Hyman, Gold & Cott, 2003). Parents can also support recovery by increasing the predictability of family routines, appropriately monitoring the child's activities both inside and outside the home, ensuring that there are clear household rules and that appropriate roles and responsibilities are set for family members (Madu & Peltzer, 2001; Smith et al. 2010). This can promote a felt sense of security and stability in children within the home environment and prevent further exposure to trauma. However, many families in South Africa live in dangerous and disadvantaged settings characterised by poverty, community violence and substance abuse, and, in such circumstances, such stabilising factors within the family are severely compromised (Meinck, Cluver, Boyes & Ndhlovu, 2013). Poverty and high rates of unemployment leave parents helpless and frustrated and can result in punitiveness towards children. The impairments in family functioning that can arise from adverse social circumstances have implications for the child's ability to make effective use of structured treatment approaches and can limit the effectiveness of treatment (Nock & Photos, 2006).

In South Africa, girls are also vulnerable to transactional sexual exchanges with much older men, called "sugar daddies" (Zembe et al, 2013). In these relationships, young girls trade sexual favours to obtain material goods (Potgieter et al, 2012). In many instances these relationships represent poverty-related survival strategies and some families living in impoverished circumstances have been known to encourage young girls to engage in such relationships as a means of supporting the family (Potgieter et al, 2012). These relationships can also provide a means of obtaining expensive commodities such as jewellery or fashionable clothes that denote social status. These "sugar daddy" relationships fall outside local and Western definitions of prostitution as the girls involved are considered "girlfriends" and the exchange of gifts for sex is part of a broader set of obligations that may not involve predetermined payments (Zembe et al, 2013). Nevertheless, these transactional sexual relationships place girls and young women at risk of exploitation and domination by older, wealthier men. They also increase vulnerability to physical and sexual abuse and the risk of unplanned pregnancies and sexually transmitted infections (Leclerc-Madlala, 2008).

Lulama: A neglected adolescent

All of the above mentioned factors impacted on Lulama. She lived in an impoverished setting with her mother (Thando), grandmother and sister. Her mother abused alcohol and behaved unpredictably within the home, often lashing out violently at her children. The family relied on the grandmother's pension for financial support as her mother was unable to find work because of her alcohol abuse. At home there were few daily patterned routines, an absence of fair and consistent discipline, and the roles and responsibilities of family members remained ambiguous. Outside the home, Lulama was rarely supervised. She had no curfew and was not required to inform her caregivers of her whereabouts when she was not at home.

Lulama was raped on two separate occasions during the course of a single night after she had run an errand for a neighbour late one evening. Her mother responded to the rape by blaming Lulama and, in the following weeks, Lulama received similar negative reactions from her peers. She was eventually referred for therapy by her school teacher who had seen the research advertisement. Lulama was suffering from PTSD and depression and therapy had limited impact even though she attended 11 sessions. The case narrative provides an opportunity to examine how some of the factors summarized above contributed to this and to consider what would be required for someone in her precarious position to be able to fully engage with and benefit from a trauma-focused, evidence-based treatment.

Methodology

This is a systematic case study (Eells, 2007; Fishman, 2005, Fishman, 2013) that formed part of a larger series in which the implementation of ECCT for PTSD was investigated in a range of local South African conditions. Systematic case studies can provide nuanced insights into clinical phenomena that are of significant practical utility to clinicians but which are not typically accessible in group comparison or survey research. In the development of evidence-based approaches, they play an important role as a complement to randomised-controlled trials (RCTs) (Fishman, Messer, Edwards & Dattilio, 2017). Systematic case studies are practitioner-oriented: they take into account the personal and contextual features of the client's life and how these impact on the complex processes involved in building a therapeutic alliance and the clinician's capacity to be responsive to the client, through the stages of assessment, case formulation, treatment planning and treatment delivery (Eells, 2007, 2013; Fishman, 2005; Edwards, 2010, 2013). While RCTs allow us to determine whether a treatment works, systematic cases studies allow for an examination of how it works and the value of the rationale on which treatment is based (Dattilio, Edwards & Fishman, 2010).

Client recruitment and selection

The project was advertised to community organisations and by placing posters in public spaces. Lulama's teacher noticed one of these and referred her for treatment. Initial interviews were used to determine whether volunteers met inclusion criteria (age >14, meet DSM-IV-TR [APA, 2000] criteria for PTSD related to the rape, understand English) and did not meet exclusion criteria (psychosis or mental retardation). Following ethical procedures approved by Rhodes University, Lulama signed informed consent for assessment and treatment. She also consented to information obtained being used in research reports and publications, in which pseudonyms would be used, and limited identifying information provided. Lulama was assessed and treated by the first author, under the supervision of the second author who was familiar with the treatment model. ECCT is a flexible, formulation-driven trauma-focused model that focuses on tailoring treatment to suit the individual needs of the client (Ehlers & Clark, 2000; Ehlers et al, 2005; Clark & Ehlers, 2005). It has two phases, namely the assessment and treatment phase. The assessment phase focuses on uncovering the nature of the trauma memory, identifying the main cognitive themes (i.e., problematic appraisals of the traumatic event

and/or its sequelae), and detecting problematic cognitive/behavioural strategies that need to be targeted. Psycho-education about PTSD and a rationale for treatment is also offered. The treatment phase involves modifying negative trauma-related appraisals, reducing intrusive re-experiencing through elaboration and contextualisation of the trauma memory and, dropping safety behaviours/problematic cognitive strategies.

Data collection

The case study is based on the following data sources:

Session records: After each assessment and treatment session, the therapist created a session record from memory summarising the events of the session, including her experience of the session and the client's process and observations relevant to the research project.

Audio recordings and verbatim transcripts: All sessions were voice recorded and verbatim transcriptions were made. One transcript, randomly selected by an independent assessor, was evaluated against the audio recording. No distortions or omissions were reported.

Supervision notes were made on the issues discussed and suggestions made during case supervision.

Self-report measures: Although self-report measures were used with many of the cases in the series, they were not given to Lulama. Although Lulama spoke English, she was unable to grasp the nuances inherent in some of the questions and this limited the utility of these measures.

These above data sources were drawn on to write several data condensations (Miles, Huberman & Saldaña, 2014): A comprehensive assessment narrative and case history, a case formulation and an initial treatment plan, and a narrative of the treatment process, written as a first person account by the therapist. These are presented more fully by Padmanabhanunni (2010) and have been shortened for this article. The detailed information and rich chronological narrative allow for the investigation of interpretative questions of social and clinical relevance. Assessment sessions are referred to as A1, A2 etc. while therapy sessions are T1, T2, etc.

Assessment narrative and case history

Lulama was seen twice weekly during five sessions of assessment of 40-60 minutes each.

Sessions A1-A3: Building a narrative of the trauma

Lulama, unfamiliar with the profession of psychology, was offered psycho-education regarding the role of a psychologist and what treatment entailed. I explained that therapy was a space for her to share her experiences and that I would work with her to alleviate distress. I also explained issues related to confidentiality and the practicalities of therapy (i.e. that I would see her once a week at a mutually agreed time, that sessions were for 60

minutes and that she needed to notify me if she could not make an appointment). Lulama appeared to understand this.

I explained that her teacher had informed me about the rape and invited her to share her story. She offered a brief factual description of the trauma and smiled and giggled throughout, attempting to minimise her distress. Late one evening, after visiting a store to purchase groceries for a neighbour, she was accosted by an acquaintance who insisted on accompanying her. He made unwanted sexual advances, including groping her. Feeling distressed and seeing a police car in the near vicinity, she shouted for the police officers to assist her. When the police officers arrived, the perpetrator told them he was involved in a domestic dispute with his girlfriend and there was no need for them to intervene. He then pulled Lulama away and forced her to his house where he raped her. He released her much later that night and she fled in the direction of her home. Two other men accosted her and dragged her to an empty warehouse where they repeatedly raped her. After the assault, Lulama ran to a friend's house where her friend's parents notified the police and she was taken to hospital and later to the police station where she opened a case. She was later escorted home by the police and disclosed her ordeal to her mother (Thando), grandmother, and sister. Thando responded reproachfully, telling Lulama that she had probably done something to provoke the attacks and that "it would have been better if [she] had died that night". Deeply hurt, Lulama withdrew from her family. Two days later, she spotted the perpetrators of her gang rape walking along a street near her home and, feeling afraid, alerted her grandmother who called the police. The rapists were arrested but released on bail while the case was being investigated. Lulama visited the police station regularly to enquire about the progress on her case. I reflected on the trauma she had endured and her courage in being able to share her story with me. Lulama said she had feared I would blame her for the rapes as her mother had done and I reassured her that she was blameless and had done nothing to deserve such abuse. I offered psycho-education around some of the common reactions survivors experienced following rape including PTSD, guilt and shame. Lulama found this helpful in normalising her experiences, reporting that she had been experiencing flashbacks and believed she was "going crazy".

I sought Lulama's consent to include her mother, Thando, in her treatment process but she refused. She did not perceive this as beneficial as Thando abused alcohol, was unreliable and frequently lashed out at her. However, Lulama did consent to my sending her mother a letter introducing myself as her therapist. I explained the treatment process and invited Thando to contact me, but she never did.

Lulama missed her next appointment without notice and I was not able to reach her by phone. When I saw her at A4, a week later, I gently encouraged her to notify me if she could not make a scheduled appointment. She apologised and agreed to do so. Lulama disclosed that she felt deeply ashamed and believed that the perpetrators' semen was still inside her body and that she was contaminated. Through close questioning, it also became evident that her assumptions were fuelled by negative responses from those close to her. After hearing about her rape, some of Lulama's peers at school had started taunting and

marginalising her. As a result, she found it difficult to concentrate in class and was feeling increasingly alienated and worried that she would not be able to maintain her grades. Her boyfriend had also distanced himself from her after she disclosed the trauma to him. I empathised with her and obtained her consent to speak with her school teacher (Zamiwe) around how to address the hurtful behaviour of her class mates. I provided Zamiwe with psycho-educational material about the impact of rape on the survivor that she later used to explain to Lulama's peers about the effects of their behaviour. Lulama subsequently reported that she felt somewhat safer in the school environment as she was no longer being openly taunted.

Case formulation and treatment plan

Lulama was raised in an unstable and unstructured home environment. Her parents divorced when she was 7 years old and her mother started consuming alcohol excessively and behaved in a punitive and rejecting way towards her children. Her moods became unpredictable and she would shift from being calm one moment to being highly aggressive the next. She regularly beat Lulama. Lulama coped by avoiding her as much as possible believed that she could not trust others to care for her or support her. These assumptions were reinforced by the negative reactions she received following her rape.

Lulama had been intensely afraid during the assaults and believed that each of the perpetrators intended to kill her after they raped her. These peri-traumatic appraisals contributed to the development of symptoms of PTSD. Lulama also felt permanently contaminated and believed that the trauma meant she would not be able to attain her goals in life. As a result she felt sad and despondent. The negative reactions of her mother, peers and boyfriend led her to expect that others would be rejecting if she disclosed her distress and so she increasingly isolated herself. This aggravated her depressed mood by inhibiting her from having opportunities to correct these appraisals. The treatment plan involved continuing to work to enhance her social support and use trauma-focused work to address her PTSD and depression.

Therapy narrative

T1-T4: More social interventions, addressing negative appraisals, and a dangerous relationship

Lulama appeared markedly distressed when she arrived for T1, reporting that her mother had been intoxicated and had cast her and her sister (Lindiwe) out of the home, telling them that they were to fend for themselves. She was afraid that they now had nowhere to go. A pre-requisite for trauma-focused treatment is safety and support in the external environment. As such, to promote her security, I contacted the Department of Social Development and accompanied Lulama to an appointment with a social worker who arranged for her and Lindiwe to stay with a relative. The social worker subsequently met with the family and Lulama and her sister moved back in with their mother. To monitor the home environment, the social worker encouraged the family to meet with her on a weekly basis for the next three months but these appointments were often not kept. Lulama's caregivers were also encouraged to take a more active role in facilitating her

recovery from the trauma by consulting with me and by monitoring the progress of the police investigation. Lulama's mother did not make any subsequent contact with me.

At T2, I focused on addressing Lulama's appraisal that she had been tainted by the rape. I offered her psycho-education, explaining that semen did not remain in the body indefinitely but was expelled if fertilization did not occur. Surprised, Lulama reported that she had not known this and had assumed that she was permanently contaminated. I used guided discovery to try and help Lulama realise that she was not tainted, but she appeared sad, saying she did not understand why those close to her had responded so hurtfully if she was still good. I validated the hurt she felt and emphasised that it was wrong of her mother and peers to react in such an insensitive manner. I offered psycho-education about rape myths and explained that their responses were reflective of their prejudices and problematic assumptions rather than reflecting on her worth. I encouraged Lulama to enhance her social support by identifying people in her environment who were still supportive and seeking support from them. Although she identified her sister and two friends, she remained hesitant, fearing that she would be hurt and rejected again. Lulama was twenty minutes late for T3, saying she had been doing chores at home. Concerned that this limited the time available for active treatment, I again offered Lulama psycho-education about psychotherapy and the time-limited nature of treatment. She apologised and indicated she would try to be more prompt. Lulama was increasingly experiencing feelings of anger which I encouraged her to express in the session. She was angry with her mother for not supporting her and for blaming her for the rapes. She now realised that she had done nothing wrong and did not deserve what had happened. She was also feeling angry at the perpetrators for hurting her and disrupting her life. Lulama appeared sad and forlorn after this and I empathised with her sadness. She lowered her head and cried softly. Later, I encouraged her to continue monitoring the progress of her case at the police station and she indicated that she would do so because she wanted the perpetrators to be held accountable for the harm they had caused.

At T4, Lulama appeared distressed and told me how she had skipped school the previous day because she had not been able to find her textbook and had been severely reprimanded by her school principal. She also disclosed that she had been involved in a romantic relationship with a 43 year old man (Sipho) in her neighbourhood for the past three weeks. He had bought her expensive clothes and jewellery on a regular basis during this time. She reported that she had not engaged in sexual activity with him and believed that he only wanted her friendship. She also told me that her grandmother had heard about the relationship from a neighbour and, accompanied by two police officers, had visited Sipho's home to warn him not see her again. Although Lulama indicated that she did not intend to see Sipho again, I was aware that the neglect and deprivation she experienced in her home environment rendered her vulnerable to such potentially exploitative relationships. I therefore used Socratic questioning and guided her to explore the dangers inherent in a relationship of this nature. Lulama was able to recognise that the relationship was problematic due to the age discrepancy. She knew that Sipho had other

“girlfriends” in her community and was a father of four children. She concluded, therefore, that it was not in her best interests to pursue a relationship with him.

Lulama then informed me that she had been invited to spend the weekend at her friend’s (Mandisa’s) home in another city and, believing that her mother and grandmother would not consent to the visit, intended to abscond from home for the weekend. Concerned about her decision, I guided Lulama to explore the consequences of this for herself and her caregivers. I also offered her psycho-education on the possible dangers of travelling alone to an unfamiliar city and she was able to recognise that it was important that her caregivers know of her whereabouts. She decided to have Mandisa’s parents contact her grandmother, notify her of the invitation and provide her with their contact details.

T5: Interruption of the therapy

Therapy was then interrupted as Lulama arrived two hours late for T5. I explained that I could only see her at specified times during the week as I had other commitments and encouraged her to make the next appointment. Lulama missed her next session but her teacher reported that she had been attending school. However, four weeks later, Lulama unexpectedly arrived to see me. She was cheerful and indicated that she wanted to continue with therapy. I explained that I was very worried about her inconsistent attendance and that it impacted on my ability to help her and she was apologetic. As I briefly touched base with her, I learned that she had sought her mother’s consent to visit Mandisa and that, during the weekend, she had disclosed the rapes to Mandisa. To her relief, Mandisa had responded with affection, care and support and encouraged Lulama to share the trauma with her (Mandisa’s) family. Despite fearing that they would react as her mother had done, Lulama did so. To her further surprise and relief, Mandisa’s family had been genuinely concerned for her welfare and responded to her with kindness and warmth and encouraged her to share her story. This prompted Lulama to share her experience with them in detail and to reveal how scared and hurt she had felt. After her retelling, Mandisa’s family offered her comfort and reassurance and explained that the trauma was in the past and that she should focus on achieving her goals for the future. Lulama’s mood had considerably improved since the visit and she was much happier. To reinforce the gains that she had made and consolidate the cognitive restructuring of these maladaptive beliefs, I emphasised that the responses of Mandisa and her family were evidence that she had not been tainted by the rapes. Lulama could now accept this.

She also reported that, despite the gains that she had made, she continued to experience distressing intrusions related to the gang rape and this troubled her. One of the CT methods used to facilitate processing of the trauma memory is encouraging the client to provide a written account of the trauma (Resick, Suvak, Johnides, Mitchell & Iverson, 2012). This can be done at home and the client is then invited to read out the narrative in the next session to facilitate emotional processing. I believed this would be particularly helpful, given Lulama’s sporadic attendance in therapy, and Lulama reported that she felt able to accomplish this.

T6-T7: Promoting safety

Lulama appeared sad at T6 and, after close questioning, disclosed that she had renewed her relationship with Siphos and, three days previously, he had physically assaulted her when she refused to visit him after school. After this, she had decided to end all contact with him. She did not want to tell her grandmother as she feared being reprimanded. I expressed my sadness that Lulama had been hurt and, to promote her safety, firmly advised her not to meet with him in the future. Another distressing event was that one of the men involved in her gang rape had behaved in an intimidating way towards her sister while she was walking home from school and this had left her feeling frightened. To enhance her safety, I encouraged Lulama to inform her grandmother and notify the police. She indicated that she had visited the police station on an almost weekly basis for the past five months and each time was informed that the police were awaiting the results from the forensic lab before they could take action.

At T7 there had still been no developments from the police. However, her mood had lifted as a result of having received two awards for academic excellence at her school's prize-giving. I congratulated her and used these achievements to further challenge her negative appraisals that her life had been permanently damaged by the trauma. She was able to recognise that she was gradually reclaiming her life and expressed hope that this meant that, despite the trauma, she would still be able to achieve her goals in life. Lulama had found it difficult to write down her experiences of the gang rape because of the distress it evoked, and I judged it would be beneficial to do graded trauma-focused work based on what she had written. I prepared her to imaginatively relive the events by explaining the rationale behind the procedure. The explanation made sense to her but she was afraid that if she relived the memory, the perpetrators would magically appear and try to harm her. She recognised that this was an irrational belief but still felt threatened. I therefore proposed that we test her belief by reliving a less threatening part of her ordeal and then checking to see if the perpetrators did appear. She agreed to this and, after the reliving, accepted that the perpetrators had not magically appeared and that it was unlikely they would do so. However, she still felt very afraid and I used safe space visualisation to calm her. She engaged well with the exercise, visualising a memory from childhood where she had felt safe and protected.

Premature termination, unexpected visit and follow-up

Lulama missed her next appointment and I attempted to contact her without success. Five weeks later, she arrived unexpectedly and reported that she had not been able to make her sessions because of a part-time job she had obtained at a local retail store. I experienced a sense of frustration and enquired about her reasons for not notifying me of this and she shrugged. I subsequently invited her to meet with me at a mutually convenient time but she did not come for that appointment either. About 6 months later, I contacted her school teacher who told me that Lulama had dropped out of school after it became apparent that she was pregnant and that she was currently living with a much older man. She did not return.

Discussion and conclusion

Most treatment outcome studies document the successful application of interventions and it is seldom that cases where treatment was unsuccessful are discussed. However, in the case series of which the present study is a part, Swartz (2007) examined three cases of PTSD where there was a failure to engage with the therapy process. She identified several factors, including lack of social support, an inadequate understanding of the nature of psychological services, practical problems (e.g. financial) interfering with attendance, exposure to multiple traumas, avoidance of the distress evoked by engaging with traumatic experiences, cultural beliefs, and failure of the criminal justice system. The case of Lulama offers the opportunity to examine the extent to which these and/or other factors contributed to Lulama's dropping out of therapy.

Poor family functioning

Regular attendance is one of basic requirements for the provision of treatment. Poor attendance for psychotherapy is common among adolescents. Bettmann and Jaspersen (2009), for example, reported that 40-60% of youth prematurely terminated treatment. Many adolescents with untreated psychological problems behave in ways that interfere with engagement in treatment such as dropping out of school, alcohol and drug abuse, engaging in unsafe sexual practices and running away from home (Nock & Photos, 2006). Lulama's story is therefore not unique.

The quality of support provided by parents and the quality of functioning of the family play a significant role in promoting engagement with treatment. In two South African case studies, Leibowitz- Levy (2005) and McDermott (2005) both identified the importance of having a caring relative who supported and motivated a child/adolescent who was being treated for PTSD. Parents have been shown to positively influence treatment of adolescents by monitoring attendance, applying consequences for non-attendance and encouraging the completion of homework tasks (Nock & Photos, 2006). Parental warmth, empathy and willingness to speak about the trauma can play an important role in helping the child/adolescent come to terms with what has happened. Talking with parents about trauma-related distress can assist adolescents in correcting misinterpretations (e.g. self-blame) of the trauma and its sequelae and thereby promote healthy processing of the trauma memory (Salmon & Bryant, 2002). By contrast, disinterest, hostility and blaming impede recovery by aggravating existing negative appraisals and leaving the adolescent feeling alienated and uncared for (Salmon & Bryant, 2002).

Lulama's family failed to provide the kind of support she needed and there was an absence of family routines. Her home environment was chaotic and dysfunctional. Her mother, who was abusing alcohol regularly, had no capacity to empathize with her daughter or express meaningful care. She induced guilt by blaming Lulama for the rapes, and failed to respond to the therapist's invitation to meet her. She was unpredictable and often abusive to the extent that at one point she threw her two daughters out of the house. Her elderly grandmother at times played a protective role, for example by getting the police to

confront Siphso, but she clearly did not have the authority or consistency to follow this through. So Lulama had no responsible adult who was interested in her welfare or her recovery to whom she could turn for support in a consistent way, or who would motivate her to attend therapy.

Lack of social support

Limited social support outside the family was a second obstacle to treatment delivery. Lulama was well able to respond to empathy, care and support, as shown by many of her responses to the therapist and her willingness to share her experience with Mandisa and her family. Sadly, Mandisa lived in another town so this support was not available consistently and she had no similar friends locally. Instead, her peer group mocked and mistreated her when it was learned that she had been raped. The intervention of having the teacher speak to the class did ameliorate this and attests to the value of this type of intervention (for an earlier example, see Edwards & Bailey, 1991).

The absence of meaningful support from within or outside the family made Lulama vulnerable to the inducements of the 43 year old Siphso. Emotionally deprived, neglected and accustomed to abuse, Lulama was an easy target as these types of relationships offered some form of validation of her worth. Prior to the rapes, Lulama had performed consistently well academically, was often at the top of her class and had received merit awards throughout high school. Her involvement with Siphso led to an unwanted pregnancy and probably deprived her of the opportunity to achieve her academic potential, leaving her dependent and vulnerable.

An insufficient therapeutic alliance?

In the context of the deprivation and poor family functioning discussed above, building a therapeutic alliance with a client such as Lulama is a challenge. On the positive side, despite the practical difficulties of attending at a place quite far from her home, Lulama came for several sessions, during which she confided sensitive information and experienced significant vulnerability. She appeared to experience the therapist as a caring, trustworthy person and a credible mentor. Even when she missed sessions, she would return to see the therapist, though often not at a scheduled time.

The indicators of a strong therapeutic relationship include the client's willingness to share experiences, collaborate with the therapist in formulating treatment goals, and actively participating with the tasks of therapy (e.g. attending therapy, completing homework assignments, engaging with reliving, etc.) (Edwards, 2009). Despite the positive factors identified above, the lack of support and routine in her family almost certainly contributed to the failure to establish regular attendance. The fact that she and others in her community would not have been familiar with the idea of regular attendance over weeks and months probably also played a role.

Lulama dropped out of therapy after the therapist used a trauma-focused intervention and perhaps with hindsight, this was premature. On the other hand, trauma-focused work can

bring significant relief and increase motivation for engagement in therapy as described by Payne and Edwards (2009). It seems more likely that the major contributing factor to the breakdown of the therapy was the relationship with Siphso, her pregnancy and her dropping out of school.

Failure of the criminal justice system

One of the prerequisites for treating survivors of trauma is the establishment of safety (Briere & Lanktree, 2008). For someone who has been raped this means knowing that the perpetrator(s) are no longer at large in the community. In Lulama's case, the perpetrators were identified but not arrested and were still at large. For five months after the rape, Lulama continued to visit the police station once every two weeks, to enquire after her case and monitor the investigation. She never received any information that suggested that the matter was being taken seriously or that some meaningful action against the rapists was likely to follow. Unfortunately, this kind of unsatisfactory functioning of the criminal justice system is widespread in South Africa (Jewkes et al, 2009; Payne & Edwards, 2009) and contributes to the further victimisation of those exposed to sexual trauma.

Implications for clinical practice

What does this mean for clinicians who are confronted with similar cases in the future? What may have been done differently to ensure that Lulama would be able to complete treatment? Some of the factors that interfere with treatment are potentially malleable and if identified and addressed early on in treatment can promote successful outcome (De Haan, Boon, De Jong, Hoeve & Vermeiren, 2013; Taylor, Kaminer & Hardy, 2011). However, in Lulama's case there were significant limitations to what could have been done about her dysfunctional family situation or the failure of the criminal justice system.

It is interesting to compare the outcome of this case with that of Zinhle (19) who had been raped by a neighbour at the age of 10 (Padmanabhanunni & Edwards 2015). She was assessed and successfully treated for PTSD in 9 sessions. She began with very little social support but had a functioning family (in another town) who were not living in poverty or dealing with alcohol abuse. During the therapy process her alienation from family members was addressed and repaired. She was also living on a university campus so did not have far to go to see her therapist. As a student she was able to understand the value of committing to a treatment process. This allowed her to respond rapidly to trauma-focused work.

What else might have been done for Lulama? The therapist offered a significant amount of psychological education to promote greater understanding of the role and function of the therapist and worked to increase her motivation to remain in treatment, so it seems unlikely that by itself more focus on this would have prevented her dropping out. Perhaps more could have been done to generate support in her environment. The therapist's involvement of the teacher and social worker did have a positive impact. However, it was not sustained and perhaps more could have been done through educating and motivating

her grandmother to encourage Lulama's attendance and limit the damaging impact of her mother's behaviour. The reality is that limited services were available and the resources of the Department of Social Services were under considerable strain. The availability of significantly more social work resources might have made a difference.

Realistically, though, it seems improbable that these changes alone could have provided Lulama with the kind of protection she needed to prevent her involvement with a sexual predator such as Siphon and her dropping out of school as a result of an unplanned pregnancy. At very least, she would have needed to be relocated to a foster family in which there were responsible adults able to understand her predicament and provide the structure, support and protection she needed. Her experience with Mandisa's family shows that she might well have responded to this. Another solution would be an inpatient programme for adolescents that provided appropriate trauma-focused treatment within a secure, stabilising environment, and group support. No such programme was available for Lulama in the treatment setting. Another option would be a community health care centre located close to her home.

In conclusion, far more resources would be needed than those currently available to address the needs

of those suffering from PTSD in South African communities, a condition that is so tragically widespread and endemic (Kaminer et al, 2008; Walker et al, 2004; Watt & Dadds, 2007) There are plenty of indications from the narrative that Lulama might well have had the personal resources to be able to build a relationship with the therapist and engage effectively in trauma-focused treatment had the necessary conditions been met. But the absence of a stable family or any reliable caretaker, her background of emotional deprivation and abuse, living in a precarious township community where rapists remain at large and visible, and where police services offer inadequate protection, all meant that those conditions were not met. However, this case study does point to the limitations of offering treatment only in the form of individual sessions of psychotherapy and the importance for therapists of taking whatever steps they can to promote support and protection for the client in the contexts of their everyday lives.

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