Psychological Management of Rape Survivors Suffering from Post-Traumatic Stress Disorder: Practitioners' Perspectives

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Abstract

South Africa has consistently had high reports on the prevalence of rape, and post-traumatic stress disorder (PTSD) is the most common mental healthcare problem associated with rape. However, it seems that the provision of mental healthcare services for rape survivors is an acute challenge in the North West province and South Africa in general. Thuthuzela care centres provide care for rape survivors and these centres are located in public hospitals that mostly have mental health institutions that are well equipped with mental healthcare practitioners to assist rape survivors. This study explored and described the perceptions of mental healthcare practitioners regarding the psychological management of rape survivors suffering from PTSD in the North West province in South Africa. The study used a qualitative exploratory, descriptive and contextual research design to explore and describe the perceptions of mental healthcare practitioners regarding the psychological management of rape survivors suffering from PTSD. Data were collected using the purposive sampling method among mental healthcare practitioners through focus group discussions. Tesch's method was used to analyse perceptions obtained from the participants. Five themes emerged: barriers to the psychological management of PTSD, assessments confirming diagnosis of PTSD, the use of various psychotherapeutic interventions, psychopharmacological management, and the involvement of various stakeholders. Therefore, recommendation is made for the implementation of effective psychotherapies such as debriefing, supportive

UNISA university of south africa PRESS

Africa Journal of Nursing and Midwifery
https://upjournals.co.za/index.php/AJNM/index
Volume 21 | Number 1 | 2019 | #4264 | 22 pages

https://doi.org/10.25159/2520-5293/4264
ISSN 2520-5293 (Online)

counselling, trauma-focused cognitive behavioural therapy, the provision of selective serotonin reuptake inhibitors, and brain working recursive therapy for the management of PTSD from post-rape experiences. Recommendations for the development of psychological management guidelines for rape survivors suffering from PTSD are also made for future research.

Keywords: PTSD; psychological management; rape survivors; mental healthcare services for rape survivors; mental healthcare practitioners

Introduction and Background Information

It is estimated that close to 35 per cent of women worldwide experience rape and sexual assault (WHO 2016, 1). South Africa is known as the one country that reported a high prevalence of rape with 39 828 cases of rape per 100 000 citizens within the period March 2016 to March 2017 (SAPS 2017, 18). Among the nine provinces of South Africa, the rape cases in the North West province (NWP) increased relatively with the highest percentage of 5.3 per cent compared to the reported percentage in the year of 2015 to 2016 (SAPS 2017, 18). Therefore, these reported statistics call for investigations into the effects related to rape ordeals in this province.

Rape is associated with post-traumatic stress disorder (PTSD) more than any other mental health problems (Yehuda et al. 2015, 57). In order to confirm the diagnosis of PTSD, mental healthcare practitioners must have the knowledge of both conducting history taking and the use of a diagnostic scale aligned in accordance with the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) known as the Posttraumatic Diagnostic Scale for DSM-5 (PDS-5) (Foa et al. 2016, 1). When the PTSD diagnosis is confirmed, there is a need for employing early management of PTSD to promote healing among rape survivors (NICE-UK 2015, 13). The management of rape-related ordeals in South Africa is provided by various professionals such as nurses, doctors, social workers, psychologists, victim advocates and police officers at the Thuthuzela care centres (TCCs) (Hazelwood and Burgess 2016, 18).

TCCs are mostly located in institutions providing mental healthcare services that can be used either as their referral system or as work in collaboration with the TCCs when they have survivors who require psychological management of PTSD. In addition, the TCCs are also located either in the urban and rural provinces such as the one in the NWP. In this instance, the role of mental healthcare practitioners such as counsellors or psychologists and psychiatrists is to provide counselling and management in the aftermath of traumatic events such as rape (Gordon 2016, 31). However, based on the researcher's personal experience, there is a challenge with regard to the lack of PTSD assessment and offering PTSD-related management for rape survivors at the TCCs in the NWP.

Furthermore, in the context of South Africa, Abrahams and Gevers (2017, 6), and García-Moreno et al. (2015, 1579) state that there are various reasons that hinder mental healthcare provision. These reasons include not seeing mental health as an emergency, the lack of clinical coordination of services, and healthcare providers lacking the knowledge of providing mental healthcare management such as the psychological management of PTSD. In addition, Abrahams and Gevers (2017, 6), and Greeson, Campbell and Fehler-Cabral (2016, 100) also illustrate that other reasons that hinder mental healthcare provision in South Africa entail the manner in which rape is handled by various stakeholders and their attitudes such as blaming the survivor, the lack of resources as well as survivors' responses to rape experiences such as self-blame, feelings of shame, fear, guilt, and late reporting.

However, in an attempt to deal with rape-related mental health problems in South Africa, the existing guidelines and protocols (Lin, Dean, and Ensel 2013, 23; Ochberg, 2013, 34) list social support and crisis interventions as mental healthcare interventions practically applicable to post-rape care for survivors. Therefore, such interventions cannot cater for PTSD because the cure of PTSD symptoms needs at least eight to twelve sessions with a therapist (NICE-UK 2015, 17).

Furthermore, evidence has shown that psychological management methods such as cognitive behavioural therapy (CBT), specifically exposure therapy, behavioural techniques and cognitive restructuring techniques, and eye movement desensitisation and reprocessing (EMDR) were effective in the management of PTSD, other than supportive counselling and group CBT (Foa and McLean 2016, 24). In spite of evidence about the effectiveness of psychotherapies, the researcher deemed it necessary to conduct this study to generate further insights into the psychological management of PTSD among rape survivors, particularly in the NWP, South Africa.

Problem Statement

Rape-related services in South Africa are conducted in only one station called the TCCs (Jina and Thomas 2013, 19). The care commonly provided by a multidisciplinary team (MDT) to rape survivors in those TCCs encompasses HIV- and AIDS-related services, and forensic and medical examinations without the collaboration of other services such as mental healthcare. In relation to this, several barriers including all the problems related to the shortage of staff, the lack of specialisation in mental healthcare and the lack of knowledge with regard to the management of PTSD in South Africa also pose a challenge to the management of PTSD post-rape (Abrahams and Gevers 2017, 6; García-Moreno et al. 2015, 1579; Greeson, Campbell, and Fehler-Cabral 2016, 100). The shortage of staff, the lack of specialisation and/or the management of PTSD in TCCs located in South Africa are supported by anecdotal evidence observed by the researchers where there are possibilities of rape survivors who are seen by nurses only while those aged 14 years and above are seen by social workers only in the TCCs located in the NWP.

The other anecdotal evidence observed by the researchers is that other TCCs facilities of the NWP do not have resident clinical psychologists nor social workers, except those hired by the lifeline centres. In this instance, the shortage of staff, the lack of knowledge as well as the lack of coordination of TCCs services may contribute to poor assessment and management of PTSD among the TCCs in South Africa, including the one in the NWP. Furthermore, PTSD is associated with comorbid mental healthcare problems such as substance use and depression (Armour et al. 2014, 422; Ullman et al. 2013, 2221). Therefore, this information clearly shows that the management of PTSD cannot be ignored in the provinces of South Africa, including the NWP. Hence, the researcher deemed it necessary to conduct the study that explored and described the perceptions of those managing PTSD, mostly in their work routine with the aim of improving mental healthcare service delivery to rape survivors by developing guidelines specific to post-rape care of PTSD that can be adopted and implemented in the context of South African TCCs.

Aim of the Study

The present study aimed to explore and describe the perceptions of mental healthcare practitioners regarding the psychological management of rape survivors suffering from PTSD in the NWP of South Africa in order to make recommendations for mental healthcare practitioners regarding the development of psychological management guidelines of PTSD for rape survivors within the province.

Research Methodology

Research Design

The study used a qualitative, exploratory, descriptive and contextual research design in order to explore the research problem and to identify possible solutions (Grove, Burns, and Gray 2013, 694). This design was appropriate for this study since the perceptions of mental healthcare practitioners regarding the psychological management of rape survivors suffering from PTSD emerged from their own submissions in the context of TCCs, allowing for thick descriptions of the emerging themes.

Study Setting

The study was conducted at four public mental healthcare institutions in the NWP. These four public mental healthcare institutions were purposively selected because this is where mental healthcare practitioners such as nurses, clinical psychologists, doctors, psychiatrists and social workers assigned to provide mental healthcare services to survivors who went through any traumatic experience and who were diagnosed with PTSD could be found.

Population

The study targeted mental healthcare practitioners working in four public mental healthcare institutions in the NWP.

Sampling

The purposive non-probability sampling technique was used to collect data from mental healthcare practitioners employed in four public mental healthcare institutions in the NWP. The study sampled the mental healthcare practitioners who specialised and worked in mental healthcare institutions and who provided the psychosocial mental healthcare management in the NWP. All of the mental healthcare practitioners who participated in this study were identified through the help of the clinical manager of the MDT, the nursing manager, the manager of social workers, and the manager for psychology. The reason for choosing those that are working and that are specialised in mental healthcare is that they provided relevant and first-hand information with regard to the psychological management of PTSD that can be used among rape survivors.

Sample Size

Data saturation is defined as the number of accomplished interviews or elements for the data that is actually collected (Brink, Van der Walt, and Van Rensburg 2012, 145). The sample size of this study was therefore determined by the data saturation which was reached after four focus group discussions (FGDs).

Data Collection

The researchers collected data by conducting four semi-structured FGDs with six participants per group that included nurses, doctors, psychologists and social workers. This led to a total number of 21 participants for all the conducted FGDs. An FGD is a process of gathering a group of people who have similar backgrounds or experiences with the aim of discussing a specific problem of interest (Brink, Van der Walt, and Van Rensburg 2012, 152). Therefore, FGDs were appropriate for the study as the researchers targeted a specific group of people knowledgeable about mental healthcare, treatment and rehabilitation services. During the FGDs, the participants were asked about their perceptions regarding the psychological management of PTSD among rape survivors. The researchers adhered to the ethical principles of data collection such as tape recording, bracketing and making field notes.

Data Analysis

Tesch's method of qualitative data analysis as explained by Creswell and Plano Clark (2017, 44) was used to analyse all FGDs' perceptions obtained from the participants. Before the data analysis, the researchers transcribed the data from the recording tape verbatim. That was followed by grouping data from all the FGDs through quotations of the participants in each FGD.

Trustworthiness

The researchers adhered to the five criteria of trustworthiness: credibility, conformability, neutrality, dependability, and transferability, to ensure data quality (Moule, Aveyard, and Goodman 2016, 104). In the interests of credibility, the

researcher built trust and rapport with the participants and wrote a valid report that presents the true perceptions of the participants. With regard to conformability, the researcher embedded the direct words of the participants to ensure authenticity and to avoid bias. In the interest of dependability, data coding and categorisation were done and given to a supervisor and a co-coder to cross check. Transferability was determined by data saturation of each FGD and applying the findings to other contexts in PTSD research.

Ethical Considerations

The researchers presented the study to the School of Nursing Science Board and the Human Research Ethics Committee of the Faculty of Agriculture, Science and Technology of the North-West University (NWU), ethics number (NWU-0477-17-A9) for ethical clearance. The researcher sought permission from the Department of Health in the NWP to conduct the study. The researcher presented the ethical clearances to the hospital managers for approval to collect data from the participants.

The researchers wrote an invitation letter to the participants requesting anonymous participation, and those interested signed informed consent forms concerning their participation in the study. In the interest of respect for the persons, the consent form clearly specified the rights of the participants to terminate their participation in the study at any stage and to be ensured that they would not be penalised or discriminated against by the researchers (Grove, Burns, and Gray 2013, 694). The principle of beneficence is defined as an act of assistance, compassion and gentleness with a strong association of doing well to others, including moral commitment (Grove, Burns, and Gray 2013, 694). In this study, the principle of beneficence with regard to compassion, gentleness, doing well to others as well as moral obligation was applied through informing the participants that they should inform the researcher when they experienced any form of physical and emotional discomfort so that the researcher can refer them for debriefing sessions with the mental healthcare practitioner. The arrangements were made with the hospital management and the mental healthcare practitioner who could offer debriefing sessions for those in need of those services for free. However, during the data collection of this study, none of the participants experienced or reported emotional or physical discomforts.

Furthermore, the principle of justice in this study was ensured through selecting the participants who are knowledgeable about the research problem at hand, which is the psychological management of rape survivors suffering from PTSD. The appointment date and time for data collection that the researchers had with the participants were honoured. During the FGDs, the participants and the hospitals were given code names used during the data collection to ensure confidentiality. However, at times, the participants used the real names of the hospitals and then the researcher recoded those names to make sure that the data remained anonymous. The names of the hospitals where the interviews were conducted as well as the interviews of the FGDs were coded

and kept in a password-protected computer. Only the researchers could access the transcripts and in this manner, privacy and confidentiality of the data were ensured.

Results and Discussions

This paper focused on the perceptions of mental healthcare practitioners regarding the psychological management of rape survivors suffering from PTSD in the NWP and the findings are discussed below.

Demographic Data

The study focused on 21 mental healthcare practitioners working in different public mental healthcare institutions and units consisting of nine nurses, four psychologists, four doctors and four social workers to represent all categories in one group. The FGDs were based on the perceptions of mental healthcare practitioners regarding the psychological management of PTSD and the results of this study are presented under themes, sub-themes as well as literature control to support the results of this study as proposed in Table 1.

Table 1: Perceptions of mental healthcare practitioners regarding the psychological management of PTSD

Themes	*Sub-themes*
Barriers to the psychological management of PTSD	• Disappearance of the rape survivors from the health system • Lack of human resources such as mental healthcare practitioners • Centralised psychosocial services • Inadequate training of mental health practitioners • Lack of school health programmes that deal with PTSD • Blame by various stakeholders
Assessments confirming diagnosis of PTSD	• History taking • Good clinical interviews or application of the PCL scale • Laboratory tests
Use of various psychotherapeutic interventions	• Debriefing (e.g. using the Rogerian approach) • Counselling in a TCC • Supportive counselling • Trauma-focused CBT • Brain Working Recursive Therapy (BWRT) • Family therapy
Psychopharmacological management	Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine (Prozac)
Involvement of various stakeholders	• Family, community and police involvement • Acceptance by family and community • Strengthening of collaboration among MDT members • Proper training of mental health practitioners and other stakeholders

Theme 1: Barriers to the Psychological Management of PTSD

Sub-themes that emerged from the barriers to the psychological management of rape survivors suffering from PTSD were the disappearance of the rape survivors from the health system, the lack of human resources such as mental healthcare practitioners, centralised psychosocial services, inadequate training of mental health practitioners, the lack of school health programmes that deal with PTSD, and blame by various stakeholders. These sub-themes, which emerged from barriers to the psychological management of PTSD, are supported by the literature control below.

Disappearance of the Rape Survivors from the Health System was a barrier emphasised by the mental healthcare practitioners. The participants added that rape survivors have a tendency of reporting rape and then disappearing from the health system. Confirmation of this result is captured in an FGD with participants as indicated below:

> … there are those instances that the doctor will indicate that he has examined the patient. So after that rape survivors usually go home and disappear from the healthcare system.

Another participant added:

> Most of them will tell you that 'I went to see the psychologist in the hospital two or three times, he never called or made follow up and that was it'.

Kantor, Knefel and Lueger-Schuster (2017, 57) concur with these findings of this study, indicating that rape survivors have a tendency of being reluctant to seek services from healthcare systems. This is because rape survivors are uncomfortable with being asked about the type of clothes they were wearing during their rape incidences and their sexual history. Rape survivors also do not have adequate information about follow-up visits and many indicate a lack of warmth and a welcoming atmosphere when consulting in rape care centres (Chacko et al. 2012, 6). Therefore, the findings of this study indicate that negative interaction of mental healthcare practitioners with rape survivors could be regarded as a significant barrier to survivors using rape care services. This in turn could affect the health of rape survivors negatively and they consequently develop PTSD as they are intimidated and unable to consult for proper management specific to the rape conditions suffered possibly because of such post-rape experiences.

The lack of resources such as mental healthcare practitioners was emphasised in most of the FGDs as one of the barriers to providing adequate care needed by rape survivors. This finding is confirmed by the following direct quotation:

> We are unable to assist those people effectively in psychiatry because of a shortage of mental health experts who specialise in the management of those people, for example in Hospital A we don't have psychologists in rape care centres. Sometimes we use social workers to counsel the patient or alternatively refer the patients to hospital X which is 200 to 250 kilometres from us, where counsellors are available.

This submission supports the findings by García-Moreno et al. (2015, 1579) who indicate that some rape survivors come from rural areas and have to travel long distances to reach rape care services. The National Prosecuting Authority and the Department of Health staff lack the skills of performing vital assessments of problems related to mental health as well as referrals of survivors to psychologists and psychiatrists because those staff members claim that there are no available psychologists and psychiatrists, and that waiting lists for referrals are long (García-Moreno et al. 2015, 1579). Therefore, these results confirm that the lack of access to healthcare, unskilled professionals, and poor coordination of available resources break the continuity of rape therapy which could possibly predispose survivors to certain development of PTSD.

Centralised psychosocial services was stated in an FGD as one of the barriers to providing optimum care to rape survivors. To support this perception, the participants gave an example of the decentralisation of services to primary healthcare (PHC) as an option that could be used to promote access to psychosocial services for rape survivors. One of the participants said:

> … because of our limited resources, I think rape issues can be decentralised to PHC level where the patient can be assisted to prevent complications such as depression, e.g. previously the patient was admitted with depression and at a later stage, it was picked up that the patient had been raped …

The findings of this study confirm that resource-constrained countries, such as South Africa, are unable to pay highly qualified mental healthcare practitioners (Becker and Kleinman, 2013, 72). Instead, Lund et al. (2012, 1359) and Petersen et al. (2011, 42 suggest that it is advisable to appoint dedicated but less skilled community mental healthcare (CMHC) providers who would focus on basic counselling. However, the limitations of these CMHC providers are that they cannot perform the best available interventions for PTSD, for example CBT (NICE-UK 2015, 4) implying therefore that rape survivors diagnosed with PTSD would still be referred back to the hospital for care from skilled mental healthcare practitioners who can perform such interventions.

Furthermore, Abrahams and Gevers (2017, 7) have proven that mental healthcare in rape centres is not well-integrated nor even regarded as a priority. Deriving from these discussions, the results of this study point towards the decentralisation of mental healthcare services at the rape care clinics because most of them are embedded within the hospitals. This would ease the burden for mental healthcare practitioners to schedule appointments with rape survivors at their clinics that is at the same hospital where the service provider works. Alternatively, the mental healthcare practitioner working with mental health-related disorders such as PTSD could empower other mental health providers to obtain formal training in mental health work in rape clinics to integrate the services provided at such sites with mental healthcare from an acute phase to a chronic phase of rape.

Inadequate training of mental health practitioners emerged in an FGD as one of the barriers to providing treatment to rape survivors diagnosed with PTSD. In support of this result one of the participants in an FGD stated that:

> … but if you have mental health practitioners that are not trained adequately you are going to get the poor services.

The results of this study, along with the findings of Abrahams and Gevers (2017, 7), suggest that the majority of staff working in rape clinics for counselling had no official training in mental healthcare, treatment and rehabilitation services because they had no understanding of the differences between mental illness and mental health. Their knowledge about rape care was based on acute phases, focusing strictly on forensic examinations, legal advocacy and the collection of biomedical data (Abrahams and Gevers 2017, 6). Therefore, the results suggest that mental health-related problems should be dealt with by mental healthcare providers who have formal training in mental health and they ought to start providing mental healthcare from the onset.

The lack of school health programmes that deal with PTSD was emphasised in an FGD as another barrier to the psychological management of PTSD. The participants indicated that these programmes are needed for proper, effective and efficient management of PTSD among learners. This finding was emphasised through a direct statement from an FGD. A participant said:

> Even our schools should have a health programme that addresses rape and that can also assist learners with PTSD in schools. A programme that educates our girls about reporting these incidents of rape and so forth.

It seems there is no current evidence to support these findings. However, these results are in line with those of a study by Kataoka et al. (2003, 316) who found that programmes like school trauma-focused CBT interventions have played a positive and significant role in meeting present unmet mental health needs of learners who were diagnosed with PTSD. Therefore, if these programmes are developed in schools and practised accordingly, they would increase access to healthcare for communities that need such programmes.

Blame by various stakeholders was emphasised as a serious barrier to the effective management of PTSD. In an FGD a participant offered an example in support of this barrier as quoted below:

> Blame game by various stakeholders stresses the client and prevents her from reporting the cases and which will prevent them from getting help from the onset and sometimes they only come when they are sick.

Greeson, Campbell and Fehler (2016, 1) also support this submission by indicating that being blamed by others was one of the reasons women do not report rape.

These results suggest that everyone who is involved with a survivor should avoid acting in a manner that makes the survivor undergo the blame game, which could result in a total dissuasion from mental health services that aim either to prevent or to manage PTSD.

Theme 2: Assessments Confirming Diagnosis of PTSD

Sub-themes that emerged from assessments to confirm diagnosis of PTSD before the management of PTSD were history taking, good clinical interviews or a PCL scale and laboratory test results. The sub-themes that emerged from assessments confirming diagnosis of PTSD are discussed in tandem with the literature control below.

History taking emerged as a diagnostic procedure that could be conducted among rape survivors in a second session for diagnostic purposes of PTSD. In support of this result, one of the participants in an FGD said:

> In psychiatry, history taking should be conducted in a second session and it is a very important component for diagnosis of conditions such as PTSD. History taking can also assist you to know if the patient is at risk or not.

This perception, along with the results of a study conducted by Kilpatrick et al. (2013, 547), reveals that events of rape experiences can predict signs and symptoms of PTSD. Therefore, the results of this study suggest that history taking of rape events should be conducted specifically during the follow-up visits by rape survivors in order to assess and establish the warning signs of PTSD.

Good clinical interviews or PCL scale emerged as one of the diagnostic criteria that could be used to diagnose PTSD among rape survivors. In support of this result the direct statement from a participant is presented verbatim below:

> … if there are possibilities of PCL test it can be done but we should just make sure that people have great information, specifically for those that are still going through training and working with those types of patients.

In support of this result, Foa et al. (2016, 1) illustrated that the diagnostic scales aligned with the DSM clinical interview guide were also found reliable and valid in the diagnosis of PTSD. For example, the recent PDS-5 aligned with the structured clinical interview (DSM–5) for possible assessment of diagnosing of PTSD in rape is a most convenient tool (Foa et al. 2016, 1).

Laboratory tests, particularly taking blood samples such as full blood counts (FBCs) emerged as one of the diagnostic criteria that could be used to exclude other infectious diseases for differential diagnosis of PTSD caused by rape. However, other participants felt that it would be unnecessary to take blood samples of rape survivors if the diagnosis of PTSD is made through a PCL test and in-depth clinical interview. This contradiction

indicates that more research is needed on this topic. In support of this result, one of the participants in an FGD said:

> We can take blood such as FBC because it can show elevated white blood cells and sometimes stress could be caused by electrical imbalances or some of the illness the client had previously and not knowing that she has those illnesses.

The other participants rejected the test as unnecessary and the statement below conveys their negative perceptions from another FGD:

> I think the good clinical interview can give you the information you need. It's not necessary to conduct tests on patients.

Apparently, there is no recent literature to support this statement. However, contrary to these findings, literature is not clear if there is a need for conducting FBC for differential diagnosis of PTSD among rape survivors. Kendall-Tackett (2009, 35) found that rape survivors reported high levels of the C-reactive protein from IL-6 and above suggesting that they had high levels of inflammation compared to those that were not raped. However, the results of Kendall-Tackett (2009, 35) are not linked to taking blood with the aim of differential diagnosis of PTSD. Therefore, these results from other studies cannot offer conclusive justification for this finding in this study. It could suggest that other diagnostic criteria such as good clinical interviews as advocated by other participants could be used as a diagnostic tool of PTSD since the tool has a proven efficacy to diagnose PTSD. The other reason is that we cannot confirm if survivors had infections before the experiences of rape or not. That means even if they showed elevated inflammation in their blood results after the rape, one cannot categorically account if the infection is due to other diseases or rape. Therefore, the differential diagnosis of PTSD among rape survivors could be difficult to establish in this instance.

Theme 3: Use of Various Psychotherapeutic Interventions

Sub-themes that emerged from the use of various psychotherapeutic interventions were debriefing (for example using the Rogerian approach), counselling in a TCC, supportive counselling, trauma-focused CBT, BWRT and family therapy. These sub-themes are described with the literature control below.

Debriefing (for example using the Rogerian approach) was singled out as one of the various psychotherapeutic interventions that mental healthcare practitioners such as nurses and psychologists could use from the time the rape is reported. This is supported through a direct quotation from a participant as indicated below:

> As a mental healthcare worker I will perform debriefing particularly using Rogerian approach when they first report the incident and if the incident is still fresh from the onset have now to be cognisant of the clinical observations then will take that information to therapy at a later stage.

Qi, Gevonden and Shalev (2016, 20) confirm that one non-delayed session of debriefing has been proven to reduce the intensity of acute stress among clients who went through traumatic experiences. Therefore, this suggests that any mental healthcare practitioner such as nurses, psychologists or medical doctors should perform debriefing immediately when survivors report rape.

Counselling at TCCs was equally identified as one of various psychotherapeutic interventions that could be used in managing rape survivors before they are diagnosed with PTSD. A participant from the FGD is quoted below:

> It's important for all rape survivors to receive counselling in TCC before developing PTSD because it is an after complication of acute stress disorders.

Bougard and Booyens (2015, 29) support this observation of counselling for rape survivors. However, the study conducted by Bougard and Booyens (2015, 29) only confirms HIV and AIDS counselling as having been received by survivors in a TCC. Therefore, based on this finding, assumptions could be made that counselling related to mental health is not given to survivors consulting in a TCC when reporting rape. This suggests that healthcare workers working in a TCC should give counselling related to HIV and AIDS as well as for mental healthcare needs, for example, crisis interventions (Gordon 2016, 36).

Supportive counselling was identified as one of the psychotherapies that could be used to manage PTSD among rape survivors. In support of this finding, one of the participants said:

> We can also give them supportive counselling especially when you have observed that this client is very withdrawn and doesn't keep up.

Foa et al. (2013, 2650) apparently do not share the same views as illustrated in their opinion that supportive counselling was identified as ineffective in the management of PTSD. However, since we do not have evidence of effective supportive counselling in the management of PTSD post-rape in the context of South Africa, the results of this study only tentatively suggest that studies focusing on supportive counselling ought to be conducted in order to consider its efficacy or otherwise for the management of PTSD post-rape in South Africa.

Trauma-focused CBT was specified as a psychotherapeutic intervention that could be used to lessen PTSD symptoms among rape survivors. In support of this result, one of the participants from an FGD said:

> … depending on how the survivor responds to treatment, I think six to seven sessions of trauma-focused CBT which is the best individual therapy can be used to treat PTSD.

These results concur with the results of the study by Foa and McLean (2016, 24) which revealed that PTSD was successfully treated with CBT particularly CPT and EX among adult rape survivors after the therapist had given them seven to twelve sessions. Therefore, this advocates for the use of CBT as one of the psychotherapeutic interventions in treating PTSD post-rape for a minimum of six to twelve sessions. However, the progress of the survivor needs to be taken into consideration to allow the continuation of more than twelve sessions or changing to another type of CBT if the survivor has still not yet responded to the treatment of choice offered by a therapist.

Brain working recursive therapy (BWRT) was identified as another psychotherapeutic intervention that could be used to lessen PTSD symptoms among rape survivors. To support this finding about the use of BWRT, participants in a FGD stated:

> We can also give them BWRT which is the new therapy that can be implemented post trauma.

According to reviewed literature, BWRT is the latest therapy developed in South Africa for the treatment of conditions such as PTSD resulting from traumatic situations (Bellchambers-Wilson 2016, 6). Unfortunately, the literature is silent about confirming the efficacy of this therapy among rape survivors, even to other populations who experienced trauma. The efficacy of this therapy is only evident in testimonials in non-accredited websites. Therefore, such a gap calls for further studies to confirm the efficacy of this therapy in a group of people who have experienced rape trauma.

Family therapy is a sub-theme that emerged as one of the various psychotherapeutic interventions to manage PTSD among rape survivors. To confirm this result one participant in an FGD gave an example:

> We will engage into family reconstructive work therapy. If maybe now the family will be starting to take her as a black sheep in the family.

Ochberg (2013, 34) concurs with these findings in that engaging family members in post-trauma therapy has a direct influence on the healing process of a rape survivor. For example, the behaviours, myths and cultural beliefs of family towards the survivor can either assist the healing process or not. Therefore, based on these findings, Ochberg (2013, 34) suggests the use of family therapy in situations whereby the family gets directly involved in the healing of rape survivors. The involvement of the family should be suggested as an alternative therapeutic process, especially making them appreciate the trauma of the survivor and calling upon all the coping mechanisms embedded in their belief systems. Therefore, the results of this study also confirm the importance of family therapy in cases where the healing of a survivor is negatively influenced by their attitudes, belief systems and myths attached to rape experiences.

Theme 4: Psychopharmacological Management

A sub-theme that emerged from the psychopharmacological management was SSRIs such as fluoxetine (Prozac). This sub-theme is supported by the literature control below.

Selective serotonin reuptake inhibitors (SSRIs) emerged as one of the psychopharmacological management tools that can be used to treat PTSD. Participants in this study gave examples of drugs such as fluoxetine (Prozac) as an SSRI used to treat PTSD among rape survivors. A direct quote to support this finding from the FGD is as follows:

> From pharmacological treatment, we will give SSRIs to help the patient for example Prozac, with fluoxetine starting with a low dose to help with mood elevation, insomnia (to sleep at night) and reduce levels of stress.

Kirkpatrick and Heller (2014, 342) concur that SSRIs such as fluoxetine and amitriptyline are effective in the management of rape survivors diagnosed with PTSD. However, owing to intolerance and side effects, some rape survivors are likely to disappear from the health system. It is suggested that these SSRIs be used by those survivors who can tolerate the side effects of these drugs or only those that present with extreme levels of PTSD (Kirkpatrick and Heller 2014, 342). This study suggests that these drugs should be administered to rape survivors who have extreme PTSD and those that are admitted for the first few weeks in order to assess their tolerance to these drugs with the aim of stopping or considering other drugs or other effective non-drug management of PTSD.

Theme 5: Involvement of Various Stakeholders

Sub-themes that emerged from the involvement of various stakeholders were family, community and police involvement, acceptance by family and community, strengthening collaboration among MDT members, and proper training of mental healthcare practitioners. The aforementioned sub-themes are discussed with reference to what has been established in the literature below.

Family, community and police involvement is one of the sub-themes identified by the participants, suggesting that there is a needed for involvement of these stakeholders in the psychological management of PTSD among rape survivors. In support of this finding, a participant in an FGD said:

> So we need to involve the family because it is forever giving full support and in most cases in mental health the involvement of the family and community is very important.

Gordon (2016, 32) concurs that the inclusion of social support stakeholders in the care of rape survivors diagnosed with PTSD lessens the symptoms of PTSD because they assist them to cope with trauma experiences as well as to build long-lasting relationships with them. This clearly shows that rape survivors diagnosed with PTSD cannot manage

on their own without the support from their loved ones. This goes to say that even if the rape care centre offers the best available treatment options, social support plays the bigger role in the recovery of rape survivors diagnosed with PTSD.

In support of this finding on the involvement of police officers, other participants gave an example about one reported case in their hospital as quoted below:

> She was referred for mental healthcare this side after finding out that she was raped but rape was not reported. So I think the police officers should be involved in the management of these people when these cases were not reported to them.

Conversely, Mason and Lodrick (2013, 36) in their study revealed that police officers do not investigate rape that is reported late because they argue that there is no physical or forensic evidence. In addition to the evidence needed to prove rape, Mason and Lodrick (2013, 36) state that police officers are unable to consider factors that could make the rape survivors report rape late, for example issues of shame, self-blame, and just the readiness about reporting.

Therefore, the results of this study advocate for the inclusion of police officers from the time the rape is reported to healthcare services regardless of whether evidence can be established or not. Furthermore, police officers should also get trained about taking into consideration factors that cause delays in reporting rape in order for them to avoid blaming the rape survivors.

Acceptance by family and community is an important milestone that stakeholders should strive to reach in dealing with rape survivors and in their management of rape in general and PTSD. In an FGD a participant stated that:

> So acceptance by community members and the family, especially close relatives, as it is a tool that we can use to minimise the symptoms of PTSD.

The study by Wangamati et al. (2016, 249) confirms that the involvement of family and community is a critical component in the rehabilitation of rape survivors who are often rejected by their families as well as their communities. Such rejection and alienation engender feelings of isolation.

Strengthening collaboration among MDT members emerged as a sub-theme wherein various stakeholders need to be involved and work together when caring for rape survivors. A participant gave an example of an MDT in providing mental healthcare:

> We have MDT in this hospital side, I mean nurses, psychologists, social workers and doctors to participate there, so this side we all work together to assist our clients by giving feedback during our MDT meetings and TCCs can do the same like us this side.

Wangamati et al. (2016, 249); Moylan and Lindhorst (2015, 165) concur with the results of this study as the involvement of mandatory caring for rape survivors without coordination, cooperation, collaboration and promotion of an MDT approach is reported in their findings. Therefore, the results of this study suggest that an MDT working with rape survivors need to be considered through benchmarking in mental healthcare institutions to promote coordination, integration and cooperation through meetings and discussing the progress of their patients. This approach engenders collaborating with other healthcare services such as psychiatry to maximise the care of the patients who need psychiatry for admission and continuity of care.

Proper training of healthcare practitioners and other stakeholders was stated in an FGD suggesting that people who care for rape survivors need to be adequately trained on how to handle rape cases and caring for rape survivors. In support of this result a direct quotation from an FGD is reported as follows:

> Training is also important for the people who are going to see the patient at first, for example nurses, doctors, psychologists, social workers and police officers have to be trained on how to conduct interviews as well as provision of privacy when reporting rape, the crime statement needs to be taken privately in police stations.

According to Campbell, Patterson and Bybee (2012, 240) rape survivors are victimised by mental healthcare practitioners and police officers who take on an impersonal approach in the questioning over rape experiences. The lack of sensitivity among doctors and nurses when performing examinations for forensic evidence, taking time before attending to the rape survivors as well as blaming them because of what happened were cited as critical factors. Based on this finding, Maier (2011, 172) suggested that training on the questioning of rape survivors should be provided by rape survivor advocates to the affected police officers as well as healthcare practitioners such that they are tutored to comfort and support survivors and reduce waiting times.

When victims feel protected rather than victimised, they are bound to experience closeness and consequently take on cooperative stances. Those charged with receiving this report should minimise secondary victimisation. The training on the emergency management of rape survivors was also achieved through the implementation of Sexual Assault Nurse Examiners (SANE) programmes because it has been reported that nurses who underwent such programmes exhibit more knowledge on emergency management of rape survivors as compared to doctors and non-SANE nurses (Campbell, Patterson, and Bybee 2012, 240; Maier 2011, 172). From the above discussion, this suggests that rape survivors advocate for training to be implemented in rape care centres as well as the development and implementation of SANE training programmes in order to offer skills for those who care for rape survivors at emergency level. The training suggested might play an important role in minimising the development of PTSD.

Conclusion

The psychological management of PTSD in public mental healthcare institutions needs to be prioritised like any other effects of post-rape such as HIV and AIDS. The psychological management of PTSD should start with the assessment of PTSD using history taking or conducting clinical interviews with a rape survivor for a follow up. They would then implement and collaborate with effective psychotherapies such as debriefing, counselling, supportive counselling and trauma-focused CBT, provision of SSRIs and BWRT with other post-rape management activities that are currently being practised. Barriers to the provision of mental healthcare services such as the lack of human resources at the level of mental health practitioners should also be dealt with as a matter of urgency.

However, in order to increase access to mental healthcare and the provision of optimum mental healthcare services, the use of cross-referral systems should be adopted within the public mental healthcare institutions and TCCs. Staff working in TCCs might also adopt the management style of MDTs working in mental healthcare institutions, for example, have weekly meetings to discuss the progress of their clients diagnosed with PTSD. The adoption of MDTs could be done through benchmarking in mental healthcare institutions and through training provided by mental healthcare practitioners in TCCs to strengthen TCCs in MDTs. Various stakeholders such as close families, communities and police officers should also be recognised when managing PTSD among rape survivors to reduce stigma and game-blaming.

Limitations of the Study

Public mental healthcare institutions are relatively few in the NWP and other public provincial hospitals that have psychiatric units were considered to increase the sites of data collection. Again, the results of this study cannot be generalised to other provinces of South Africa because the study was done in the NWP.

Recommendations

The study recommends further research on the development guidelines for the psychological management of PTSD for rape survivors in order to increase available services of mental healthcare for rape survivors. It is also recommended that training be conducted by mental healthcare practitioners to equip staff working in TCCs with knowledge on the management of PTSD. Training could also be provided by rape survivor advocates to police officers on how to handle rape-related cases when they are reported. Critical factors raised were that personnel need to offer privacy and respect for rape survivors, and to avoid game-blaming the rape survivors. In addition, policymakers ought to include the psychological management of PTSD in the protocols for rape management in TCCs to foster collaboration of mental care services with those that are already practised, for example, counselling of HIV- and AIDS-related cases that include rape care services for rape survivors.

Acknowledgements

The authors would like to acknowledge the mental healthcare practitioners who participated in the study, and also the NWU, the Department of Health and the NRF (TTK160601167061) for funding the study. We also thank the UCLA/South African Trauma Training Research (Phodiso) programme and the Tirisano Training Project for their support and guidance.

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