

**The relationship between social support, coping strategies and psychological
functioning of rape victims in the North-West Province, South Africa**

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Declaration

I, Rothea Kruger, hereby declare that this study titled; **“The relationship between social support, coping strategies and psychological functioning of rape victims in the North-West Province, South Africa”** is my own original work and has not, previously in its entirety or in part, been submitted at any university for a degree.



11/02/2016

SIGNATURE

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The relationship between social support, coping strategies and psychological functioning of rape victims around the North-West Province

Abstract

Worldwide women are confronted with acts of violence against their gender, acts consisting of domestic violence, rape and sexual assault. In recent years in South Africa, the experiences and specialized needs of these victims have been receiving increased attention in the media. It has also been addressed in multiple research studies and on the level of policy and law-making. The aim of this quantitative study is to investigate the relationship between coping strategies, social support and psychological functioning of adult female rape victims in the North-West Province. The sample consists of 50 adult females and data was collected from the KOSH Crisis Centre, Klerksdorp. The data was collected using a Biographical Questionnaire and self-report measures known as the Brief COPE (Brief - Coping with problems experienced), the Multidimensional Scale of Perceived Social Support (MSPSS), and the General Health Questionnaire (GHQ-28). The results of this study indicated the following that may require further exploration: that there is a positive correlation between specific coping strategies and the psychological functioning of the rape victims, that there is a positive correlation between perceived social support and the psychological functioning of the rape victims, and there is a positive correlation between perceived social support and the specific coping strategies of the rape victims. The results are discussed against the background of previous studies and highlight the pressing need to effectively address the specific challenges of rape victims as well as the possibility of positively influencing the psychological functioning of these women through counselling and the use of adaptive coping strategies and social support.

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CHAPTER 1

INTRODUCTION AND BACKGROUND OF THE STUDY

In this chapter, the researcher will briefly discuss background and the context of the study. The chapter proceeds with the scope of the study and the significance of the study. In addition, a discussion of the motivation and goals for the research and the research question will be discussed. This chapter concludes with an elucidation of the structure of this study.

1.1 INTRODUCTION

Worldwide sexual violence is perpetrated against women. Women are confronted, on a daily basis, with acts of violence against their gender, acts consisting of domestic violence, rape and sexual assault (Lutwak, 2012). In recent years, the experiences and specialized needs of these victims have been receiving increased attention in the media. It has also been addressed in research studies and on the level of policy and law-making (Burrowes, 2012; Kim et al, 2007).

In South Africa and other countries obtaining accurate and reliable statistics on the prevalence of rape against women is challenging as violence against women is generally underreported (Jewkes & Abrahams, 2002; Vetten, 2014). The aforesaid occurs for many reasons that include the following: women's economic and physical dependency on the abuser, fear of further punishment by the abuser, lack of confidence in the police, lack of police stations nearby, absence of the health systems and fear of being victimised by the criminal justice system. Furthermore, the feelings of shame and self-blame prevent these abused women to report the violence. In addition, the acceptance of abuse against woman, as a normal occurrence or as a deserved or private matter, that should not be disclosed as well as a number of other rape myths that is prevalent in society (Eyssel, Bohner, & Siebler, 2006; Gregoriou & O'Hara, 2012; Jina & Thomas, 2013).

Even though there are a number of difficulties in obtaining accurate statistics; the statistics that is available is alarming. Evidence from many decades of sexual violence research has revealed that women are at risk for sexual violence and rape specifically throughout their lifetimes. Rape is present in all cultures and on every level of society (WHO, 2010). Research show that approximately 20 % of all women are sexually assaulted or raped during their lifetimes (Post, Biroscak, & Barboza, 2011). Research has also proven that women who have previously been sexually assaulted and raped are at increased risk of experiencing further sexual victimisation (Livingston, Testa, & VanZile-Tamsen, 2007; Burrowes, 2012).

According to the USA's Department of Justice 2007 National Crime Victimization (NCV) survey (2008), every two and a half minutes a woman in the United States of America (USA) is raped. The report 'Criminal Victimization in the USA' (2014), shows an overall number of 173,610 victims of rape and sexual assault, or approximately, 0.1 % of the female US population of 12 years and older thus reported being raped in 2013 (Langton & Truman, 2014).

South Africa has one of the highest rape incidences worldwide (South African Police Services, 2010) and between 28 % and 30 % of adolescents describe their first sexual experience as forced and thus defined as rape. The crime statistics released by the South African Police Service (SAPS) does not distinguish between the types of sexual crimes and the gender of the victims. However, it does reveal that most sexual crimes are committed against women. The latest available crime statistics was released the 29th of September 2015 for the period of April 2014 to March 2015. However, these statistics have not yet been analysed and released in a detailed report.

The number of sexual crimes reported to the police in the North-West province from the April 2004 to March 2014 period showed a significant increase from 4 610 to 4 850 as did the specific statistics for the area of Jouberton that rose from 242 to 327 cases reported (area in which the rape crisis centre used for data collection is situated). In addition, this does not take into account the women that did not report the violence.

The abovementioned statistics, concerning as they may be, should be seen in the context of decreasing reports of rape to the police. As a result of previously mentioned reasons as well as The South African National Victims of Crime Survey (2014) results that show that the number of victims who reported their rape to the police decreased by 21 % between 2011 and 2014 with a greater decrease expected. For the purposes of this study the researcher will concentrate only on rape. Therefore, allowing the victims to define their experience as rape with the legal definition of rape as a framework. For the purpose of this study, the legal definition of rape refers to an unlawful, intentional act of sexual penetration that occurs without the consent of the victim (The Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Act, 2012).

1.2 BACKGROUND OF THE STUDY

With so many women affected by rape, the consequences for the victims, as well as society are an important factor to consider especially for those tasked with helping these women to overcome their traumatic experiences. Experiencing rape may have short term and long term negative effects on the physical and psychological functioning of the rape victim and the victim may experience a myriad of debilitating symptoms that include but is not limited to depression, anxiety, substance abuse and other posttraumatic stress symptoms (Hyman, Gold & Cott 2003; Jewkes et al., 2010; Maniglio, 2009; Schraufnagel, Davis, George & Norris, 2010; Shin, Hong & Hazen, 2010; WHO, 2002).

However, the consequences of rape are far-reaching into all spheres of life, not simply the individual level. Rape victims may experience increased difficulty and conflicts in intimate relationships (Colman & Widom, 2004). Family relationships and friendships may also be negatively influenced, weakened or even eliminated after the rape. The previously mentioned includes shame, cultural beliefs and rape myths which subsequently may contribute to individual psychological distress (Lalumiere, Harris & Quinsey, 2005). The experience of rape may also impact the work contexts and in turn the general socio-economic circumstances of the rape victim and their families. Furthermore, rape may also have an effect on the greater economy as these victims may no longer be able to contribute to the economic growth of the country. This may also result in multiple medical and psychological services, because of the effects on their physical and mental well-being. Rape has been found to negatively impact on educational achievement, job performance, contribute to job loss and inability to work that is caused by the severe psychological and physical reactions of the victims (DeLisi, 2010; MacMillan, 2000) and to contribute to significant and possibly life-long health care costs (Dolezal, McCollum, & Callahan, 2009).

When engaging in the long term, dynamic processes of dealing with the trauma of rape and all the possible consequences both cognitive and emotional factors are involved (Banyard & Williams, 2007; Roth & Newman, 1991). As many researchers and clinicians have reported, the specific coping strategies that the victim chooses to engage in when dealing with this trauma is very significant. Thus, the specific coping strategies is influential in the recovery process and in their eventual psychological functioning, this may also include the reliance on social support (Cieslak, Benight, & Lehman, 2008; Gibson & Leitenberg, 2001; Jewkes et al., 2010; Ullman, 1996).

Psychological functioning is a multifaceted concept that refers to multiple aspects of living including psychological symptoms and other interpersonal, social and intrapersonal

aspects that is indicative of how psychologically healthy an individual function. In addition, it also suggests the absence of dysfunctional psychological symptoms and is often used as a measure to assess the mental health state of a trauma victim (Ro & Clark, 2013; Keyes, 2009).

In this study the GHQ-28 (Appendix B: Section C) will be used to measure the presence and/or absence of four categories of psychological symptomology (somatic symptoms, anxiety/insomnia, social dysfunction and depression) and thus, the psychological functioning of the victims as it is a reliable measure that have been used in many studies exploring trauma and functioning (De Kock, Görgens-Ekermans & Dhladhla, 2014).

Coping with a traumatic experience such as rape is an involved process that generally refers to any behavioural and cognitive attempts to deal with the internal and external demands of a situation that puts the individual under stress (Lazarus & Folkman, 1984). There are different distinctions between the categories of coping strategies such as problem-focused, emotion-focused or avoidant coping and each refer to the response of the individual towards the rape thus attempting to change the situation, attempting to address the emotions, or avoiding the situation. Any of the possible coping strategies may be either dysfunctional or functional and thus have a possible negative or positive effect on psychological functioning.

The reliance on social support may also be seen as a method of coping (Reynolds & Kee Hean, 2007; Zeidner and Endler, 1996). In this study the Brief COPE (Appendix B: Section B) is used to assess the different coping strategies the rape victims engage in based on 14 subscales (self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame). This Brief COPE measure looks at a variety of different coping strategies and has been successfully and reliably used in previous South African studies (Mostert & Joubert, 2005).

Social support is often categorized as a coping strategy as well, and refers to information that allows an individual to believe that she will be loved, cared for and respected as part of a social network (Fowler & Hill, 2004; Holt-Lunstad & Smith, 2012; Kaniasty, 2005). Multiple studies have established a link between social support and positive psychological functioning, decreased post-traumatic symptoms and increased feelings of self-worth (Brewin, Andrews & Valentine, 2000; Mclewin & Muller, 2006; O'Donohuea, Carlsona, Benutoa & Bennetta, 2014; Phanichrat & Townshend, 2010). Social support may also decrease negative and increase positive health outcomes in multiple areas (Littleton, 2010). The explanations for the manner in which social support affect individuals varies but it is seen as a moderator and buffer for negative outcomes. It is generally accepted that social support positively affects the cognitions and thus the evaluation and appraisal of the traumatic events by the victim. There may also be more information available on appropriate actions after the rape, assistance with the fulfilment of daily duties, encouragement to engage in positive methods of coping and general emotional buffering that may positively influence well-being (Lincoln, Chatters & Taylor, 2005; Mclewin & Muller, 2006; Tajalli, Sobhi, & Ganbaripanah 2010). In this study the Multidimensional Scale of Perceived Social Support (MSPSS) (Appendix B:Section D) will be used to measure perceived social support from significant other, friends and family.

The relationship between the specific coping strategies chosen and the perception of available social support to the psychological functioning of the rape victims will thus be the focus of this study.

1.3 PROBLEM STATEMENT

Given the abovementioned discussion and statistics, rape is a crime perpetrated against a great number of women worldwide (Lutwak, 2012; Chacko, Ford, Sbaiti, & Siddiqui, 2012) and even more so in South Africa (Anguita, 2012) and specifically in the North-West

Province of South Africa (The National Victims of Crime Survey, 2014; SAPS Crime Statistics, 2010-2015) with far reaching consequences and thus an essential topic of study given this context. Although many studies on rape have been conducted in South Africa (Anguita, 2012), limited research could be found specifically addressing the coping methods of female rape victims in the North-West Province or the unique combination of factors present in this study.

A study by Zulwayo (2013) on rape victims in the North-West Province that explored the correlation between coping strategies, post traumatic stress disorder (PTSD) and depressive symptoms, highlighted the severe consequences of rape in agreeance with other international studies. In the abovementioned research study 71.3 % of the rape victims met the criteria for PTSD and 12.2 % also met the criteria for depression. The high percentage of rape victims who met the criteria for PTSD is in congruence with other studies reporting percentages of between 65 % and 81 % (Griffin, 2008, Ullman, Filipas, Townsend & Starzynski, 2007, Gutner, Rizvi, Monson & Resick, 2006). The abovementioned study did not examine the coping strategies or PTSD related symptoms separately and thus, still leaves a gap for further study which this current study will do.

As these studies indicate, the experience of rape may leave these victims with various psychological, social and physical effects including anxiety, insomnia, substance abuse and overall difficulty adjusting to daily life afterwards. These effects may be short term or life-long and thus greatly affect the individual and all contexts of their life including intimate relationships, the family, community and work contexts (WHO, 2002; Schraufnagel, Davis, George & Norris, 2010; Jewkes, Dunkle, Nduna, Jama & Puren, 2010; Shin, Hong & Hazen, 2010; Maniglio, 2009; Hyman, Gold & Cott 2003). The human cost of rape is extensive, but also burdens the economic cost of the country. A 2014 report by KPMG (Klynveld, Peat, Marwick, Goerdeler Accounting Firm) estimates the annual costs of gender-based violence,

including rape, to the economy to be between 28.4 and 42.4 billion rand or between 0.9 % and 1.3 % of South Africa's Gross Domestic Profit (GDP).

All the above mentioned consequences of rape are severe and affect multiple contexts but may be dealt with in multiple ways. The above review of relevant research on managing the consequences of rape have thus explored the way in which the rape victims choose to cope with the experience of rape and its' symptoms and showed that this may negatively or positively affect their psychological functioning. Thus, indicating promising strategies that may be explored. Previous studies suggested that approach coping was conducive to higher psychological functioning and that avoidance coping contributed to decreased psychological well-being. However, recent findings suggest a more complex relationship and that specific coping strategies should be explored individually to determine the effect thereof (Cieslak, Benight, & Lehman, 2008; Jewkes et al., 2010).

Zulwayo (2013) found a relationship between the use of specific coping strategies and depression in the sample of rape victims in the North-West province. The utilization of maladaptive coping was associated with increased symptoms of depression and adaptive coping methods with decreased symptoms of depression. Thus, there seems to be an opportunity for an exploration of the relevant coping strategies that may positively affect psychological functioning in this specific population group and the current study attempted to explore this gap.

Another promising strategy is that of social support. A review of relevant research consistently points to a positive correlation between social support and psychological functioning (Tajalli et al, 2010; Yap & Devilly, 2007; Uchino, 2009) and indicates that social support may be one of the strongest predictors of PTSD variance (Brewin, Andrews & Valentine, 2000). The social support these victims perceive to have available may also influence both the coping strategies they choose to engage in as well as their psychological

functioning (Haden, Scarpa, Jones, & Ollendick, 2007). Scant South African research is available on the effect of perceived social support on psychological functioning after rape. However, studies conducted seem to confirm the moderating effect of social support on psychological functioning after various psychological and medical traumatic experiences (Casale et al., 2015; Maselesele & Idemudia, 2013, Naidoo & Mwaba, 2010). Consequently, social support may be another positive mediating factor to explore which the current study did.

Currently, South Africa and specifically the North-West Province lack specific intervention programs that aim to address and positively affect the psychological functioning of female rape victims as well as the research that these programs may be influenced by. Although the unmet needs of rape victims in South Africa is receiving increasing attention (Kim et al., 2007), there is still a need for increased research and the development and implementation of integrated programmes specifically addressing the needs of female rape victims (Christofides et al, 2003; Vetten, 2014; Steyn & Strydom, 2007).

This research study consists of an exploration of the manner in which female rape victims deal with the psychological aftermath of the rape experience. The researcher specifically explores the relationship between the specific coping methods they choose to engage in post rape, the social support they perceive to have available from family, friends and significant others and the positive or negative relationship of these factors to the psychological functioning of these female rape victims.

1.4 AIMS OF THE STUDY

The aim of this study is to investigate the relationship between coping strategies, social support and psychological functioning of adult female rape victims in the North-West Province.

1.5 OBJECTIVES OF THE STUDY

For the study to fulfil the abovementioned aims it will be anchored in the following objectives.

- To determine the relationship between specific coping strategies and the psychological functioning of the rape victims.
- To determine the relationship between perceived social support (from significant others, family and friends) and the psychological functioning of the rape victims.
- To determine the relationship between perceived social support (from significant other, family and friends) and the specific coping strategies of the victims.
- To establish if there are significant differences regarding coping strategies, social support and psychological functioning according to previous trauma experienced or not experienced by the rape victims.
- To establish is there are significant differences regarding coping strategies, social support and psychological functioning according to counselling received or not received by the rape victim.
- To establish if there are significant differences regarding coping strategies, social support and psychological functioning according to the incidence of rape (reported being raped once or more than once).

1.6 SCOPE OF THE STUDY

This study was conducted in the greater North-West, Klerksdorp area. The data collection was done at the KOSH Crisis Centre adjacent to the Tshepong Hospital and the Jouberton Township. Participants were identified by the researcher and appropriate allied professionals including the counsellors employed by the Thuthuzela Rape Crisis Centre and the Psychology

Department of the Tshepong Hospital. This study examined the choice of coping strategies, the perceived social support and the psychological functioning of these rape victims and the relationship between these factors.

1.7 SIGNIFICANCE OF THE STUDY

The significance of this study is discussed by briefly considering three broad areas 1) theoretical significance, 2) methodological significance and, 3) practical significance.

1.7.1 Theoretical significance

Currently, there is a lack of South African studies specifically focused on the North-West Province that explores the combination of the coping process of rape victims and its relation to social support and psychological functioning. Research on prevention, consequences and treatment of rape has not been sufficiently explored especially in an African context. Although some studies such as a multi-country study on sexual and gender based violence was conducted in Sub-Saharan Africa, that study only highlighted the need for increased research efforts to create a comprehensive research base and intervention strategy (Keesbury & Askew, 2010; WHO, 2010; Lalor, 2004). Understanding the presentation of rape in settings with lower socio-economic status is essential as most studies concentrate on high income contexts and thus lack an exploration of the cultural, societal and specifically gendered aspects that increase the vulnerability of the population group in question (WHO, 2010; Jewkes et al, 2005; Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009; Townsend & Dawes 2004; Mathews, 2009). The aforesaid includes an uncertainty of what is the most effective model of intervention to attend to the specific mental health challenges in a setting where victims experience difficulty in obtaining medical and psychological interventions (Keesbury & Askew, 2010). Therefore, there is a need for studies that focus on long-term

psychological prevention programmes to decrease the development of chronic symptoms after rape and address the challenge of providing these mental health services to the diverse South African population (Callender & Dartnall, 2010; Higson-Smith, Lamprecht & Jacklin, 2004; Resnick., Kilpatrick, Dansky, Saunders, & Best, 1993). According to the abovementioned studies it is essential to gather research related to these difficulties in a South African context regarding this vulnerable population group. The current study will attempt to contribute to the body of research in order to understand the factors influencing the post rape psychological functioning of these rape victims and indirectly thus to literature that may influence further studies and intervention programs.

1.7.2 Methodological significance

Thus, in the South African context, previous studies have been conducted assessing coping and psychological functioning of rape victims. However, no research study could be found that explore the interrelationship between coping, social support and psychological functioning of female adult women in the North-West Province. This study may be unique because of the combination of factors as well as the location of the study. Few quantitative studies have also been conducted as rape has been mainly researched as individual qualitative occurrences.

1.7.3 Practical significance

The vast incidence of the rape of women in South Africa and the long-term psychological consequences thereof reflects the need to create an integrated multi-sector intervention programme to address these consequences, thus, contribute to increased psychological well-being (Callender & Dartnall, 2010; Higson-Smith et al, 2004; Resnick, Acierno, Holmes, Kilpatrick & Jager, 1999). The development and implementation of such a programme is

outside the scope of this study but it may add to the knowledge of health care workers that attend to these rape victims and highlight the importance of both social support and specific coping strategies as it may influence the psychological functioning of these women post rape.

1.8 STRUCTURE OF THE STUDY

Chapter 1 described the rationale of this study, the background of the study, the scope of the study and significance of this research was discussed. Furthermore, the research questions and goals were deliberated.

Chapter 2 provides a literature review pertaining to the topic. This includes a discussion of the framework theory and other theories specifically addressing each variable. Operational definitions are also given.

In Chapter 3 the history of existing research on the topic is briefly explored as well as current research on coping strategies including social support used by rape victims and the influence of these strategies on psychological functioning as well as other relevant factors.

The focus in Chapter 4 is on the research approach used including the data collection methods, instruments and ethical considerations.

Chapter 5 consists of reporting the results of the statistical analysis of the data collected.

Chapter 6 provides a discussion of the results of the study; conclusions are also drawn and recommendations made.

1.9 SUMMARY

This chapter served as an introduction to the research project. The focus of this chapter was on the aim of the study. The research objectives were outlined. Furthermore, the problem statement and relevance of the current study was discussed. In the final section, the structure of the research was portrayed.

CHAPTER 2

THEORETICAL FRAMEWORK AND PERSPECTIVES

The Socio-ecological theory is used as a study framework to conceptualise the variables in this study. Furthermore, different theories to explain the psychological functioning, coping strategies and social support of the rape victims are also included.

2 THEORETICAL FRAMEWORK

2.1 BRONFENBRENNER'S ECOLOGICAL THEORY OF HUMAN DEVELOPMENT

Bronfenbrenner's (1979; 1986; 1995) ecological theory of human development aims to explain the interrelation of the various systems an individual is influenced by and influences in return. This model conceptualizes the environment as multiple interconnected systems that are always changing and adapting. Bronfenbrenner (1995) subdivided the systems based on factors such as how close the system is to the individual, and the size or the formality of the system.

The first level would be the individual level. This level includes the biological, psychological and social characteristics of the individual. Thus, this refer to the individual characteristics of the rape victims such as their coping skills, socio-economic circumstances and past personal experiences but also their age, race and gender that could all possibly play a role in this study (Bronfenbrenner, 1995).

The second level namely, the Microsystem is focused on the interactions between the individual and their immediate environment. This include family, friends and significant others. Hence, the social support systems of the rape victims will be relevant at this stage but also their church and work environments among others (Bronfenbrenner, 1995). Social

support systems by family, friends and significant others should be explored on this level.

The third level namely the Mesosystem refer to the interactions between individuals and systems and interactions between different microsystems. This may refer to the interactions between, for example, the rape victim and an informal support group (Bronfenbrenner, 1995). Informal support groups could form at the Rape Crisis Centre or in multiple other contexts of life.

The fourth level, namely the Ecosystem, includes other organizations and social systems such as the medical and legal systems. In this instance, the Rape Crisis Centres and hospitals as well as the police and legal system the rape victims may approach.

The fifth level, namely the Macro-system refers to many broader social and cultural aspects such as societal norms regarding rape, cultural beliefs about gender and rape and expectations placed on women pre and post rape (Bronfenbrenner, 1995). The rape myths that exist and affect disclosure and reporting of rape may be relevant for example.

Finally, the sixth level, namely the Chronosystem refers to the major changes and transitional events occurring between the individual and all the various environments, it may include historical and social events. This may also include the current political and social climate with increasing attention on gender issues and violence against women and the continued occurrence of rape (Campbell, Dworkin & Cabral, 2009; Duncan, Bowman, Naidoo, Pillay & Roos, 2007; McLaren & Hawe, 2005). This level may indirectly influence the rape victims in this study.

All of above-mentioned levels may have a direct or indirect effect on the rape victims studied in this research project. These interdependent contexts are constantly changing and influencing each other and the individual. Subsequently, this study mainly focusses on the micro level of the individual rape victims, the coping strategies they engage in and their psychological functioning, as well as the social support they receive. However, each of the

abovementioned systems or levels will directly or indirectly influence the rape victims and should be taken into account as far as possible.

Bronfenbrenner's (1979; 1986; 1995) theory forms the framework for many other adaptations specific to trauma victims. Discussing all such adaptations is beyond the scope of this study. Therefore, only one of these theories will be discussed as it specifically seems relevant to the aim of the current study.

2.2 AN ECOLOGICAL MODEL OF THE IMPACT OF SEXUAL ASSAULT ON WOMEN'S MENTAL HEALTH

The foundation of this model is the framework of both Bronfenbrenner's (1979, 1986, 1995) theory and Neville and Heppner's (1999) adaption of Bronfenbrenner's theory (CIEMSAR: culturally inclusive ecological model of sexual assault recovery). Neville and Heppner's (1999) model purports that rape victims' mental health is shaped by multiple factors not only by the rape and individual pre-existing factors but also by each following interaction and how the social world responds to these interactions.

Campbell, Dworkin and Cabral (2009), agree with Bronfenbrenner on many factors but the analysis of these factors may differ, others may be left out, added or combined. The first system is on the level of individual analysis and it examines individual and sociodemographic features that may have an effect on the psychological functioning of the individual after the rape. This will include characteristics of the individual as well as certain sociodemographic features such as race/ethnicity, social class, education, marital status, employment status, the role of personality characteristics, biological or genetic features and pre-existing mental health conditions. Certain factors may be seen as relevant to different contexts such as race and ethnicity should be discussed on both an individual and a macro level. On this level the coping strategies of rape victims are referred to as they may influence

the post rape psychological functioning of the individual. Consequently, when the use of social support as coping strategy is discussed, it may refer to the individual level, but be interconnected to the micro level (Campbell et al., 2009).

The second system will be the experience of the rape. The relationship between the rapist and the victim, the possible injuries sustained, threats post rape and the use of substances at the time of the rape. The aforesaid may all contribute to the psychological functioning of the rape victim (Campbell et al., 2009).

The Microsystem is the third level or system. This system explores the impact of social support on the psychological functioning of the rape victim. This includes factors such as the disclosure impact. This refers specifically to the influence of social support from close interactions from family, friends and significant others that the rape victim will experience on a regular basis and in an intimate context (Campbell et al., 2009).

In Campbell and colleagues' work (2009) the meso and exosystem are not separated as in Bronfenbrenner's (1979) original model. This combined meso and exosystem will thus refer to both the processes that link formal and informal systems and individuals. In the instance, the KOSH Crisis Centre may have been a formal exosystem that connect individuals to informal mesosystem support groups or to the formal medical or exosystem (Klerksdorp/Tshepong Hospital).

The fifth system namely the microsystem address race (as discussed on the individual level) but also refer to other broader socio-cultural contexts such as rape-culture including rape myths and gender stereotypes (Rozee & Koss, 2001).

The sixth system namely the Chronosystem refers to broad interactions between the individual and the environment. This will include expected change (normative transitional events) such as changes in schools as well as more unpredictable changes (non-normative events) such as the experience of rape that may affect the manner in which the individual

interacts with the environment. In this system various transitional events may occur over the lifetime of the victim and may have a cumulative effect. In the current study, this includes being raped more than once or previous exposure to other traumatic events may affect the psychological functioning of the rape victim over time (Campbell et al., 2009).

Campbell et al. (2009) conceptualized an added meta-construct of self-blame. These researchers argue that this is a response that victims experience on an individual and macro-level, but also from informal and formal organizations (exo/mesosystems) and on a broader chronosystem level thus a concept that cannot be limited to only one or more context.

In this study an analysis of mainly the individual and micro levels would be relevant. The researcher briefly refers to socio-demographic features and coping strategies that both fall on the individual level of this socio-ecological model as well as to social support that is on the micro level. This discussion is conducted within the framework of how these factors relate to the psychological functioning of the female rape victim. Though, each context will possibly influence all others and the eventual psychological functioning of the rape victim.

2.3 TRANSACTIONAL MODEL OF STRESS AND COPING

According to Lazarus and Folkman (1984) coping is defined as the process of appraising threat and mobilizing cognitive and behavioural resources to combat stress and the emotions evoked by the stress. Thus, the individual's assessment of the event is important as well as the thoughts and actions the individual engages in (Krohne & Hock, 2008).

The model of coping most frequently used is the coping model created by Snyder and Pulver (2001) that draws on earlier works by Folkman (1984). This coping model provides a useful conceptual framework for understanding what may cause victims to choose to engage in certain coping strategies. In addition, this model also explores the role in the manner that their chosen coping strategies may play in their recovery process. This model is based on the

assumption that there are two basic strategies an individual may use when experiencing a stressful or traumatic event namely approach and avoidance coping.

The approach coping, the individual will choose this strategy of coping when the victim feels that she has the necessary coping resources to cope with the stressor and this approach will then involve active coping strategies. These strategies are focused on the problem or on the emotional response the individual experiences (Roth & Cohen, 1986). In the instance of rape, the incident cannot be changed. Utilizing approach coping strategies involves dealing directly with the emotional responses to the incident and the recovery process. Approach coping includes help seeking strategies, cognitive reappraisal and expressing one's emotions (Roth & Cohen, 1986).

The measure used in this study to assess the use of coping strategies (The Brief COPE, Carver 1979) was derived partially from the abovementioned theory of Lazarus and Folkman (1984) and from Carver and Scheier's model of behavioural self-regulation (1981;1990). The theories on which most coping measures are based, refer to both problem (the individual attempts to change the situation) and emotion-focused (the individual attempts to manage their emotional reactions) coping or approach and avoidance coping (the individual attempts to avoid the stress causing situation) as well as maladaptive and adaptive coping strategies based on the literature on coping (Carver, 1979; Zeidner & Endler, 1996). There are incongruent results in literature and research studies. However, earlier coping research seemed to suggest that problem-focused was the most effective form of coping for rape victims while other more recent studies report that victims should use emotion-focused coping (Reynolds & Kee Hean, 2007).

In the current study the women were exposed to the traumatic experience of rape, the demands of which may have exceeded their resources. The victims of rape may engage in specific coping approaches which may have affected their psychological functioning

negatively or positively and should thus be further explored (Contrada & Baum, 2011).

2.4 THE PROCESS OF SOCIAL STRESS THEORY

The probable connection between social support and psychological functioning has been explored in numerous research studies (Cohen & Wills, 1985; Pearlin, Lieberman, Menaghan, & Mullan, 1981; Wethington & Kessler, 1986). There are two well-known social support theories namely the main effects model and the buffering effects model. Both these social support theories are supported in the literature reviewed.

The main effects model of stress purports that social support is helpful to the individual regardless of the current level of stress the victim is experiencing because basic human needs (e.g. positive interactions, affirmation, positive affect) are met and that will have an overall positive and restorative effect (Cohen & Wills, 1985).

In turn, the buffering effects model of stress or the process of social stress theory suggests that a strong basis of social support during stressful events will buffer the effects of the stress and thus the stress-related outcomes. Conversely, an individual under high stress events with little social support will not experience this protective effect (Pearlin et al, 1981; Lincoln, Chatters & Taylor, 2005). Thus, people are at risk for physical and psychological disease when exposed to stressful events such as rape.

The provision or exchanges of instrumental, emotional, informational resources in response to others' needs are thought to facilitate coping with the demands and thus be protective. These supportive influences may assist the individual in cognitive reassessment of the traumatic experience as an event that she has the ability to deal with and may encourage positive coping approaches and discourage negative approaches. Therefore, perceived availability of support is deemed as important to individuals under stress and to their psychological functioning (Cohen & Wills, 1985; Wethington & Kessler, 1986; Wheaton,

1985). In the current study, the social support (from friends, family, significant other) the rape victims perceive as available is assessed to establish the relationship thereof on the psychological functioning of the rape victim.

2.5 TRAUMA THEORY ABBREVIATED (BLOOM, 1999)

Psychological trauma is defined by an overpowering, unexpected, external force or forces that overwhelm the individual's internal and external resources. Thus, their ability to cope with the circumstances, the individual's mind and body will then react on a certain way (Terr, 1990; Van der Kolk, 1989).

As humans, we have evolved to react with either a fight or flight response to unexpected events which serves us well in emergency situations. Each of these responses will trigger a physiological effect and forming of new connections in the brain that will leave an imprint and make us more sensitive to the next threatening situation we encounter. Thus we respond in an exaggerated way and more sensitively to each new arousing situation. In the current study that may possibly be seen with participants who reported being previously exposed to different traumatic experiences including those participants who were raped before (Terr, 1990; Van der Kolk, 1989).

Additionally, another concept to consider is learned helplessness. In 1967, Martin Seligman initiated research on learned helplessness. According to Seligman and Maier (1967) individuals who identify events as uncontrollable, exhibit symptoms that threaten their mental and physical well-being. Individuals experiencing learned helplessness, will often present with emotions such as passive or aggressive behavior, and will experience difficulties in many spheres of their lives. In addition, they will show unhealthy patterns of behavior such as neglect of the self, difficulties with cognitive tasks and the inability to solve problems (Seligman, 1972; 1975). As a result, some research studies have showed a strong correlation

between depression and other psychological difficulties and learned helplessness (Maier & Watkins, 2005).

In many instances individuals feel that their resources have been overpowered and that they are helpless in stressful situations. When this occur sufficient times to demonstrate to the individual that they cannot change the outcome of the situation it will result in feelings of helplessness and therefore not reacting to the danger. This may be relevant to participants that feel disempowered. Thus, feel that they cannot cope and this results in a feeling of helplessness. Therefore, it is important to focus on empowering trauma and specifically rape survivors as they often experience powerlessness which makes them vulnerable to learned helplessness (Terr, 1990; Van der Kolk, 1989).

Loss of volume control refers to the experience of complete overwhelming fear that overcomes individuals when they are faced with traumatic and stressful experiences. This experience will affect the individual's ability to control the 'volume' and intensity of their emotions especially their fears. This feeling may then cause an inappropriate reaction to any threats that the victim may encounters. When a rape victim can no longer effectively regulate her emotions she may lose control and overreact to all threats regardless of the size thereof. The victim may exhibit arousal symptoms such as constant irritability. This is more likely to happen when she has been exposed to multiple traumas including rape (Brownmiller, 2013; Terr, 1990; Van der Kolk, 1989).

There are other ways in which people may react to severe trauma exposure such as rape. One such is dissociation when emotions and stress levels become unbearably high. This may be extreme such as splitting or only be on a level of emotional numbing. Numbing is a tendency for individuals or societies to withdraw attention from past experiences that were traumatic, or from future threats that are perceived to have massive consequences but low

probability and is thus not necessarily the most effective strategy and affect functioning (Gill, 2010).

Another relevant theory is addiction to trauma (Burke & Carruth, 2012). This refers to individuals who have been exposed to multiple recurring traumatic experiences and where the individual may become addicted to the hyperarousal and neurochemical reaction caused by high stress situations and thus feel fearful and irritable when not exposed to these circumstances (Boyle, White, Corrigan, & Loveland.,2005; Jordan, & Hartling, 2002; Ouimette, Kimerling, Shaw & Moos, 2000). This would possibly be relevant with the women in this study who reported being raped more than once.

Trauma-bonding may also occur where an individual may learn an unhealthy attachment style based on traumatic relationships and believe that is the model for relationships. Traumatic bonding follows as the result of ongoing cycles of abuse in which the recurrent reinforcement of reward and punishment forms controlling emotional bonds that are resilient to change (Allen, 2008). Traumatic re-enactment refers to the individual attempting to re-enact the traumatic event in order to integrate what was split and compartmentalised as a protective measure but is now dysfunctional. Trauma affects the body physically as well as in various short and long term ways and this needs to be considered. There is also the theory of victim and victimizer where a victim may become the victimizer possibly as a way of reducing anxiety and regaining control (Carnes, 2010).

Herman (1992) stated that the aim for a trauma survivor would be regaining their purpose and meaning of life after their traumatic experiences. The aforesaid may be a lifelong process. Lastly, creating sanctuary which is the goal of creating a safe place for the traumatized individual to heal, regain a sense of self and to grow (Bloom, 1997). Therefore, creating a physically but also psychologically and socially safe space for the victim to grow from is essential.

All of the abovementioned concepts may be relevant to the rape victims in the study to varying degrees and should thus be considered.

2.6 DIFFERENTIAL SUSCEPTIBILITY HYPOTHESIS

Belsky (1997; 2013) developed the differential susceptibility hypothesis that states that individuals will be affected to different degrees by experiences they are exposed to. Thus, of the various women in this study exposed to rape some may be more or less susceptible to negative outcomes or to lower psychological functioning because of this experience. In this study only women were included, but gender and specifically being female may make these women more susceptible to rape and to certain processes associated with it (William, Ciarocchi, & Deane, 2010). Other factors that may influence susceptibility may include age, employment status, marital status, socio-economic status, multiple incidences of rape and counselling received.

2.7 OPERATIONAL DEFINITIONS USED IN THIS STUDY

According to Folkman and Lazarus (1984) coping is defined as the cognitive and behavioral attempts individuals engage in to manage the demands placed on them both externally and internally; these efforts challenge the resources the individual has available. Thus, coping strategies or styles generally refers to the specific cognitive and behavioural measures taken by the individual to minimise, tolerate or master traumatic life experiences (Donnellan, Hevey, Hickey, & O'Neill, 2006). For the purpose of this study coping will broadly refer to all cognitive and behavioural attempts to deal with a stressful situation (Folkman & Lazarus 1984). The Brief COPE (Carver, 1979) was used to measure specific coping strategies in this study. The subscales of this measure are: self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support,

behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame.

Differing perspectives exist on how social support should be defined but it is generally regarded as resources, including material aid, socio-emotional support, and informational aid, provided by others to help an individual cope with stress. Social support may be defined differently by each author but it generally refers to the accessibility of the components of support from interpersonal relationships which may include informal and formal bases of help (Fowler & Hill, 2004; Holt-Lunstad & Smith, 2012). There may also be distinguished between different types, functions and criteria for social support. For the purpose of this study the researcher will explore the perceived social support the victim received from the most common sources of support namely significant other, family and friends. The MSPSS Questionnaire was used to measure perceived social support from these three sources.

Trauma is defined as the emotional reaction that occurs when unexpected and overwhelming threats are experienced that leaves the individual unable to manage the demands of the threat. These threats can be diverse and include physical and emotional threats to the individual or others. An example of a traumatic event is rape which may include emotional and physical threats and cause intense emotional reactions and overwhelm the capabilities of the victim to manage the threat (Bloom, 1999; Terr, 1990; Van der Kolk, 1989). In the current study the emphasis will be on rape but the consequences of previous exposure to other traumatic experiences will also be explored as well as broader research on trauma as it may be relevant to coping, social support and psychological functioning.

Rape is a criminal offence but the definition thereof is complex. According to the South African legal system rape is defined as (The Constitution, Act 108 of 1996): ‘Any

person, who unlawfully and intentionally commits an act of sexual penetration with a complainant (victim), without the consent of the complainant, is guilty of the offence of rape.’

According to the law, there is no consent if: A) you are forced by violence or the threat of violence to yourself, to a loved one, or to your property; B) you are drunk, drugged, asleep, or unconscious. C) you are younger than 12 years old or mentally challenged; D) you are forced into consent by your boss or your teacher, when you think that not having sex will affect your position at work or at your learning institute; and E) you’ve been deceived by someone or by a professional or someone in authority to the effect that you need to submit to a sexual act for your physical, emotional, or spiritual health.

The definition and classification of an offence of rape thus relies heavily on the specific legal definition and decision of the courts. The National Crime Victimization Survey of the U.S. Department of Justice (Truman & Langton, 2014) defined rape as forced sexual intercourse including both psychological coercion as well as physical force. Forced sexual intercourse means vaginal, anal or oral penetration by the offender(s). This category also includes incidents in which the penetration is from a foreign object. Other related terms used in research include sexual assault, sexual abuse and sexual trauma. In this study only the term rape will be the focus and rape will be defined as forced sexual relations between individuals and will be so defined according to the subject herself.

CHAPTER 3

LITERATURE REVIEW

Research (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) suggests that coping with the trauma of rape is a complex process involving multiple internal and external factors. In addition, research findings (O'Donohuea, Carlsona, Benutoa, & Bennetta, 2014) suggest that victims of rape engage in specific coping strategies and having access to social support are related to the psychological well-being of the trauma victims. The following literature review briefly explores the history of the existing research findings on rape in addition, the consequences, the coping strategies including social support used by rape victims and the influence of these strategies on psychological well-being will be explored. Lastly, the influence of exposure to previous trauma and on counselling received as possible contributory factors to post rape well-being will be elaborated on.

3.1 RAPE

A review of historical reports on rape indicates the consistent occurrence throughout recorded history as well as the legal and social processes surrounding it (D'Cruze, 1992; O'Donohuea et al., 2014). There are multiple examples of patriarchy, power and social relations as important factors to understanding the existence of rape. Rape is believed to bring together aspects of power regarding gender, class and age. It also illustrates an intersection of the public and private domain because of its individual consequences as well as its social impact (Brown, Testa, & Messman-Moore, 2009; Davis, 1998; Rossiaud, 1978).

Furthermore, there is evidence of the changing legal definitions of rape throughout recent recorded history although it generally referred to female victims, male perpetrators and focused on penetration and violence (Brown, Testa & Messman-Moore, 2009; Davis, 1998; Estrich, 1987; O'Donohuea et al, 2014). The impetus of proving that rape occurred remains the responsibility of the woman who reported the rape, her credibility, moral and social standing, physical injuries sustained, sufficient resistance, disclosure to others and the respectability and social standing of the rapist was all factors considered (Carter, 1985; Geis, 1978; O'Donohuea et al., 2014; Post, 1978; Toner, 1977). The accountability for the rape was often also placed on the female victim as being the cause of the crime (Lonsway & Fitzgerald, 1994). Furthermore, various barriers existed to reporting rape, securing the conviction of the rapist and coping with the experience and still exist today including prevalent rape myths (Farr, 1815; Beck, 1825; Newcombe, Eynde, Hafner & Jolly, 2008; O'Donohuea et al., 2014).

In a historical review of rape, it is evident that women, and certain other vulnerable members of society such as children and the disabled, bared an unequal burden of rape and were consistently placed in a disadvantaged position before as they are today (Gregoriou & O'Hara, 2012, Welch & Mason, 2007). However, the portrayal of female rape victims as merely victims is not the complete presentation. In addition, reports dating back to the nineteenth century reveal that there is evidence of women engaging in coping strategies and relying on social support. Often the first step was disclosing to other women and gaining their support. Furthermore, there are clear examples of the use of informal support networks to gain material and informational support. The aforesaid lead to protest actions, changes in legislation, the conviction of the perpetrator, relocation of the victim, or simply being emotionally and physically present as needed (Soothill, 1991; Ross, 1982, 1985; Phillips, 1980; Lambertz 1985).

The first known studies that focused specifically on rape appear to have been conducted by researchers with a feminist approach. This approach focused on encouraging the victims of rape to openly discuss their experiences and so gain insight into the responses and symptoms they displayed (Burgess & Holmstrom, 1974; Stefan, 1994). Feminist approaches favour unequal gender relations and divisions of power as the cause of the rape of females and other vulnerable population groups by the ruling patriarchy. Thus, it is alleged that rape is a social and cultural learning phenomenon in which males seek to dominate and control females and should be addressed as such. The movement also brought forth a more victim-centred ideology of rape (Donat & D'Emilio, 1998), challenged the traditional definitions of rape (Chasteen, 2001), highlighted the vulnerabilities of women (Hunnicut, 2009) and emphasized the social and cultural nature of rape (Brownmiller, 2007; Helliwell, 2008).

Other approaches include biological evolutionary studies (Thornhill & Palmer, 2000) that focused on the presence of rape in other species and the possible historical evolutionary adaptations of humans of which rape may have been one or a by-product of another adaptation. Rape is seen to arise from the evolved sexual psychologies of females and males. It is thus argued that rape is a consequence of Darwinian evolution and natural selection and should be researched and addressed as such. Both of these broad approaches mainly focused on male perpetrators and female victims and analyse multiple factors including childhood experiences, socio-economic circumstances and learned behaviour (Thornhill & Palmer, 2000).

Even though rape research is a fairly recent occurrence the literature available over the past few decades, show progress in this field. The major advances according to Koss (2005) include the development of an appropriate vocabulary to discuss rape, standard definitions, application of the PTSD diagnosis to rape, the physical and medical impact of

rape, explorations into the causes of rape, social responses to rape, resistance, evaluations of treatment methods, rape myths, measurement tools and others. In addition, the need for further studies or development in the following areas includes, research funding, treatment, educational and intervention programmes and a deeper exploration of the etiology of rape (Ross, 2005).

According to Coetzer (2005) and Meel, (2008) the study of rape is important in South Africa given that the country has the highest reported rate of rape worldwide and rape is the crime with the lowest conviction rate. Sexual violence and rape of women has also been revealed to be an obstacle to attain greater gender equality and development. This challenge is set out in the Bill of Rights and the Constitution (Meel, 2008; WHO, 2005a; 2005b, Department of Women, Children and People with Disabilities, 2010; The Constitution, Act 108 of 1996). Most women in South Africa live in fear of being the victim of rape and make daily choices guided by this fear (Dosekun, 2013).

The unique context of rape in South Africa should be considered in order to understand its challenges (Jewkes & Abrahams, 2002). The societal and cultural climate is seen as a contributory factor to rape incidence and violence associated with. Furthermore, a culture of violence has been identified (Cerna & Wallace, 1999), imbalances of power and cultural beliefs that oppress women (Heise, 1998; Lazard, 2009) such as virginity testing, forced marriages, widows' rituals, female genital mutilation and others (Maluleke, 2012). Multiple reasons including these beliefs and economic dependency also contribute to, many raped South African women, being unable to report their rape or have access to informal and formal support services (Jewkes & Abrahams, 2002).

South African women have reported various consequences of rape including physical injuries and social alienation; they also reported various informal and formal support measures as helpful to the process of coping with rape (Womersley & Maw, 2009). Different

approaches to managing the trauma of rape have been reported including moderate exercise, socialising and spirituality. The aforesaid, connects the individual to her experience as well as others such as substance abuse or obsessive exercising or eating that disconnects the individual from the experience. Thus, adaptive and maladaptive ways of coping that may influence the recovery of the rape victim (Bowland, Biswas, Kyriakakis & Edmond, 2011; Cargioli, 2011).

3.2 COPING

A brief history of coping research, definition of coping, the coping strategies women who experienced rape engage in and the effects these strategies have on their recovery process will be explored. There is limited literature available on these factors relating specifically to the psychological context (De Lange, 2010; Nel, Pezzolezi, & Stott, 2012; Pillay, Ahmed, & Bawa, 2013; Skinner, & Louw, 2009).

The research on coping refers to two approaches namely that of coping as a personality characteristic and the other that concentrates on the process and efforts necessary to manage stress. Research on coping began in earnest in the 1960's and 1970's when stress was widely studied. Some authors (Lazarus, 1993) postulate that the research into coping commenced with the psychoanalytic theory and its interest in ego defences that react to threats to the psychological integrity of the individual. In addition, researchers attempted to link forms of psychopathology to specific defence mechanisms to manage stress and out of this research grew a hierarchical approach to defence mechanisms as coping measures as well (Lazarus, 1993). In the 1970's these approaches were replaced by the study of stress and coping as a process with an emphasis on creating measures to assess these processes and their relationship to adaptation. However, only the process theory of coping will be discussed as it is relevant to the current study.

3.2.1 Process theory of coping

The foundation of coping research relates to positive psychology as it is postulated that the study of the strength of individuals are of great importance and that it can best be observed when they are faced with severe stressors that taxes their cognitive and emotional coping abilities (Seligman & Csikszentmihalyi, 2000). Furthermore, coping relates to well-being according to Khumalo, Temane and Wissing (2012). These researchers emphasized that well-being is not constant or stable over time. Therefore, other factors, such as meaning, resilience and positive affect, could be additional factors of coping with stressful life events. Furthermore, literature confirm that meaning, resilience and positive affect assist people in attaining well-being or positive psychological functioning as well as posttraumatic growth after traumatic events (Fredrickson, 2013; McDonald, Jackson, Wilkes, & Vickers, 2013; Seligman, 2011).

Within this framework, coping is then defined as the process of appraising threat and mobilizing cognitive and behavioural resources to combat stress and the emotions evoked by the stress and with different approaches to coping divided into problem-focused and emotion-focused coping (Lazarus & Folkman, 1984; Snyder & Pulver, 2001). Previous studies will be discussed in the following sections.

3.2.2 Problem-focused approaches

Problem-focused approaches may be used as a conceptual basis for understanding what may cause victims to choose to engage in certain coping strategies as well as the role their chosen coping strategies play in their recovery process. These strategies serve different purposes namely, problem-focused coping attempts to make changes to the environment or itself in order to manage the stressor while emotion-focused coping attempts to change the meaning of the stressor or its relationship to the stressor in order to lower the impact on the

victim (Medley, Kennedy, Lunyolo & Sweat, 2009). A third dimension is often added that is avoidance coping (Thompson et al, 2010). Avoidance coping refers to both emotion and problem-focused strategies of coping where the individual attempts to distance herself from the situation instead of managing the stress of the situation as in the two other categories of coping strategies (Roth & Cohen, 1986; Stanescu & Romer, 2013).

According to Lazarus (1993) the coping strategy used is measured separately from the outcome of the strategy. Thus, a coping strategy may be adaptive or maladaptive depending on a number of factors including the individual engaging in it, the type of stress she is exposed to and the outcome modality studied. The coping strategies the individual employ will also depend on the context in which the complex psychological stressor, rape in this instance, occurs and these strategies may change over time as the threats change. When measuring coping the researcher should concentrate on exploring the thoughts and feelings during the process of coping and not simply allow the victim to identify the strategy so that consistency may be ensured (Lazarus, 1993).

Utilizing approach coping strategies involves dealing directly with the emotional responses to the incident and to the recovery process itself. Approach coping includes help seeking strategies, cognitive reappraisal and expression of one's emotions (Burt & Katz, 1987; Meyer & Taylor, 1986). In the instance of rape, the incident itself cannot be changed although the processes surrounding it may. Therefore, a problem-focused approach contributes to the recovery process of rape victims. In addition, a problem-focused approach has a mediating effect on psychological well-being and is associated with improved mental health outcomes and increased psychological well-being (Arata, 1999; Arata & Burkhart, 1998; Phanichrat & Townshend, 2010; Valentiner, Foa, Riggs & Gershuny, 1996). As the categorization of coping strategies and its relationship to functioning is not always well

defined; noted by the differing views of previous researchers, this relationship should be critically evaluated.

3.2.3 Avoidance coping

When the individual feels that she does not have the necessary coping strategies to manage and change the stressor she will likely engage in avoidance coping. Avoidance coping strategies may include denying that the stressor exists, avoidance of thinking about the stressor and fantasising. However, there appears to be negative outcomes when an individual frequently and excessively relies on these avoidance strategies (Leiner, Kearns, Jackson, Astin & Rothbaum, 2012; Pineles et al, 2011). The majority of research studies have shown that individuals who experienced rape are more likely to use avoidance coping as one of their main coping strategies (Spaccarelli, 1994; Wolfe & Birt, 1997). Therefore, the manner in which individuals cope with stress may be used to predict the likelihood that they will become depressed or anxious (Blalock & Joiner, 2000).

In accordance to the abovementioned, Gibson and Leitenberg (2001) reported that social withdrawal and avoidance coping are more commonly used by female university students with a history of sexual abuse or rape than by those without such a history. Bal, Crombez, Van Oost, and Debourdeaudhuij (2003) found that adolescents who have experienced rape, more often use avoidance coping strategies than those who have experienced other types of stressful and traumatic events. The findings also suggested that avoidance coping in response to rape experiences mediates the relationship between rape and psychological distress. Polusny, Rosenthal, Zachary, and Aban (2004) also report that adolescent sexual victimisation and rape contributes to increased experiential avoidance, which then is associated with greater negative outcomes such as depressive symptoms and other types of distress in their sample of female university students. Thus, studies have

established that coping strategies involving avoidance or disengagement are related to poorer adjustment in adulthood (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996).

Although some studies have shown that avoidance coping strategies protect the survivor in the short-term but active coping strategies is indicated for better long-term adjustment of the individual (Herman-Stahl, Stemmler & Peterson, 1995; Man, Dougan & Rector, 2012). Thus both categories of coping may have adaptive or maladaptive effects depending on the context (Leiner, Kearns, Jackson, Astin, & Rothbaum, 2012).

3.2.4 The outcomes of the strategies utilized by the victims

Avoidance coping might manifest itself in different ways such as the use of alcohol and illegal drugs. The aforesaid appears to be a common avoidance coping strategy in victims of rape. Kendall-Tackett, Marshall, and Ness (2000) found that individuals with a history of sexual victimisation and rape are significantly more likely to use drugs. Moreover, While Briere and Runtz (1987) indicate that female survivors of childhood sexual abuse are ten times more likely to report a history of drugs addiction and two times more likely to report alcohol addiction.

Other studies also indicate the causal role of rape in the development of alcohol disorder symptoms and that alcohol-related problems are thus more common among female rape victims than those who have not experienced rape (Moncrieff & Farmer, 1998; Schuck & Widom, 2001; Jarvis, Copeland & Walton, 1998; Grayson & Nolen-Hoeksema, 2005). Furthermore, Whiffen and MacIntosh (2005) also noted studies where avoidance coping partially mediated the link between traumatic events and outcomes such as PTSD symptoms and depression.

Evidence of the use of both categories of coping strategies was found in a study by Makoae et al., (2008). In this study joining a group, receiving counselling and assisting others were identified as problem-focused while hope, rationalization, the use of humour, good

feelings towards self and turning to God were placed under emotion-focused. In another study (Chesney, Neilands, Chambers, Taylor, & Folkman, 2006), divided coping into problem-focused with an emotion-focused dimension and social support as added categories. In the South African context, the social and interpersonal context is very important and influences the outcomes and choices of coping strategies (Chesney et.al, 2006).

It is clear that coping strategies are able to change the emotional outcome of a situation. Problem solving and positive reappraisal indicates positive changes in emotions while confrontational strategies and distancing may encourage more negative emotional outcomes (Horwitz, Hill, & King, 2011). The success of a coping strategy and thus its adaptation outcome depends on the fit between the strategy and stressor, how well it is executed and the appraisal of the situation. Walker-Williams, van Eeden and van der Merwe (2012) emphasizes that a distinction should be made between coping strategies being functional or dysfunctional. It has been hypothesized that problem-focused are associated with better survivor outcomes while avoidance coping may have the opposite outcome. However, the relationship thereof is not as simplistic and should be evaluated on an individual level (Reynolds & Kee Hean, 2007).

3.3 SOCIAL SUPPORT

Social support is a widely used term with varying definitions, functions, factors and measures. The categories defined by different authors often refer either to the functions played by social support or by the ways to measure social support. Barrera (1986) suggested well-defined social support categories including enhanced support, perceived support and social embeddedness. Kaniasty (2005) defines social support as social interactions that fulfil certain functions for individuals; it may provide the loving, caring relationships they require and the knowledge that someone will be available for them when they are in need. The

functions are then actual received help, social belonging or embeddedness and perceived support or the knowledge that help will be available.

Cohen and Wills (1985) discuss two types; namely structural social support and functional social support. Furthermore, Cohen and Wills (1985) report four functions that include esteem, informational, social companionship and instrumental social support. Structural social support refers to the quantity of social support received and/or perceived. Functional social support refers to the actions or functions that are performed by providers of social support when helping the individual in question.

Correspondingly, Cohen, Underwood and Gottlieb (2000) utilized similar divisions. Informational support (provision of advice and information), tangible support (provision of material aid), emotional-affectional support (expression of affect), affirmational support (expressing appropriateness/agreement with person's feelings and beliefs), affiliation support (conveys being part of a social network of reciprocal help) as well as appraisal support (feedback to the patient that encourages them to openly express feelings).

Rowland (1989) also posited five criteria for evaluating social support. These five criteria include quality of support, type of social support, quantity and availability of support, source (provider), and perceived need for support.

Although the abovementioned authors report different specific criteria or factors of social support there seems to be an agreement, that of importance is the functions fulfilled by the support (may refer to tangible measures or emotional assistance) as well as the quantity, quality and source of support. Additionally, two other relevant categories of support are reported in literature namely perceived and received support. Perceived social support refers to the perception that support and aid provided by others such as significant other, friends and family is sufficient and adequate which may influence the psychological well-being and functioning of a trauma victim (Asberg, Bowers, Renk, & McKinney, 2008; Uchino, 2009).

As it is difficult to tangibly measure the social support an individual receives, the perception of available social support and the quality thereof is a simpler measure. The following section will explore the relationship found between social support and psychological functioning in research, structured by the abovementioned theory.

3.3.1 The relationship between social support and positive psychological functioning

Social scientists have been investigating the relationship between social support and positive psychological functioning for many years (Cohen & Wills, 1985; Pearlin, Lieberman, Menaghan & Mullan, 1981; Wethington & Kessler, 1986). Social support is generally linked to positive psychological outcomes for trauma survivors and also a moderating factor for negative consequences in rape victims. However, the process by which social support operates is still unclear (Phanichrat & Townshend, 2010; Tremblay, Hébert, & Piché, 1999).

Research has concentrated on the protective aspects of social support, especially perceived social support that buffers against negative consequences of stress and trauma (Dahlem, Zimet & Walker, 1991). In a study conducted by Spaccarelli and Kim (1995) assessing perceived social support using the Multidimensional Scale of Perceived Social Support (MSPSS) it was established that increased perceived social support resulted in decreased levels of depression and life stress. Research assessing adults who experienced childhood sexual abuse showed clear relationships between perceived social support and resilience (Runtz & Schallow, 1997). Runtz and Schallow (1997) stated that perceived social support seemed to be the reason for half of the variance in the psychological functioning of adult rape victims.

Furthermore, a meta-analysis by Brewin, Andrews and Valentine (2000) reports that low levels of social support were significantly related to increased PTSD symptoms. The

same relationship was found for depression and other forms of dysfunctionality (McLewin & Muller, 2006). The positive influence of social support on cognitions and the appraisal of rape experiences and in turn the mental well-being of the victim has also been found (Tremblay et al, 1999; Golding, Wilsnack, & Cooper, 2002; Bal et al, 2001). Social support may also present the appropriate coping behaviour and assist the victim to feel socially embedded after the traumatic experience (Vernberg, La Greca, Silverman, & Prinstein, 1996).

3.3.2 Other aspects of social support

Other relevant aspects of social support found in literature includes the social reactions of persons in a victim's life to her disclosure of the traumatic experience, the relationship between social support and the risk of revictimisation, the source of the support as well as other possible protective effects of support on symptomology. Positive reactions to disclosure did not necessarily positively contribute to the recovery process of victims but negative social reactions consistently showed a harmful effect (Borja, Callahan, & Long, 2006; Ullman, 1999).

Additionally, other studies incorporating longitudinal research results also showed that negative disclosure reactions may predict PTSD symptoms and thus show the causal link between social support and post rape recovery (Andrews, Brewin & Rose, 2003). The link between revictimisation and social support is vague although re-victimised victims reported more difficulty in keeping and building relationships in their social circle and thus may not have social support readily available when they need it (Classen, Field, Koopman, Nevill-Manning & Spiegel, 2001).

Furthermore, reporting revictimisation was also negatively correlated with satisfactory perceived social support and relationships (Collins, 1998; Mason, Ullman, Long, Long, & Starzynski, 2009). The reactions of the social support network may influence the levels of self-blame, self-esteem and coping abilities of rape victims. The aforesaid will

increase their vulnerability to future assaults and a lack of social support networks may also contribute to the victim being exposed to a higher risk environment with a higher risk of revictimisation (Mason et al., 2009). When victims are able to discuss their experiences and emotional responses without receiving negative feedback it seems to positively affect their ability to cope and lower the occurrence of psychological difficulties.

3.3.3 The correlation between perceived social support and distress

Research has suggested that there is an overall negative correlation between perceived social support and distress. Thus, if the individual believe that she has adequate support available and can effectively cope, her symptomatology post rape should decrease and her psychological functioning should increase (Yap & Devilly, 2004). The source from which the support is received also appears to affect the impact and type of the support (Lypen et al, 2015; Li, Ji & Chen, 2014). Social support is sought from various sources such as family, friends, spiritual leaders, support groups and professionals (Banyard & Williams, 2007; Phanichrat & Townshend, 2010). For trauma survivors seeking and receiving social support appears to be a significant step in their recovery process as they are likely to receive appropriate interventions that will encourage positive coping strategies such as cognitive reframing, self-reflection, and positive thinking (Phanichrat & Townshend, 2010). Therefore, understanding rape victims' perceptions of the social support available to them in all its forms following the experience of rape and its possible effect on their chosen method of coping and psychological functioning is thus of importance.

3.4 HYPOTHESES

After a review of the relevant literature the following hypotheses were formed:

1. There will be a significant relationship between specific coping strategies and the psychological functioning of the rape victims.
2. There will be a significant relationship between perceived social support and the psychological functioning of the rape victims.
3. There will be a significant relationship between perceived social support and the specific coping strategies of the rape victims.
4. There will be a significant difference between the coping strategies, social support and psychological functioning of rape victims who previously experienced trauma and those that did not.
5. There will be a significant difference between the coping strategies, social support and psychological functioning of the rape victims that reported being raped only once and those who were raped more than once (incidence of rape).
6. There will be a significant difference between the coping strategies, social support and psychological functioning of the rape victims who received counselling and those that did not.

Chapter 4

4. METHODOLOGY

This chapter will focus on the research method utilised in this study. The chapter will commence with the context of the study. The quantitative research approach and more specifically correlation research will be discussed. The demographics of the participants will be provided. Furthermore, the data collection method will be discussed. This is followed by a description of the instruments utilised in the study. Lastly, the ethical considerations will be discussed.

4.1 RESEARCH APPROACH AND DESIGN

Quantitative research is reliable and objective and is an objective method to establish the relationship between variables (Ader, Mellenberg, & Hand, 2008; Creswell, 2014; Gorard, 2008; Kotz, et al., 2006). However, the researcher is aware that the data collected to test the hypotheses, exclude contextual detail, and the research results does not take into account attitudes and behaviour (Panter & Sterba, 2011). Furthermore, the results obtained provide numerical descriptions and does not take into account the participants perceptions (Creswell, 2012). Quantitative research methods can be categorized as descriptive research, correlational research, and experimental research. For the purpose of the current study the researcher chose the correlational research method (Cresswell 2014; Goraard, 2008).

Correlational research design refers to a research study where the researcher attempts to determine if there is a relationship between two or more quantitative variables from the same group of subjects. Quantitative research focuses on gathering numerical data and generalizing it across groups of individuals or to explain a specific phenomenon. The data that was gathered in this utilized structured research instruments namely questionnaires. All

aspects of the study was carefully designed before the data was collected (Abu-Bader, 2006; Bryman, 1988; Cresswell, 2014; Gorard, 2008).

The independent variables measured in this study are perceived social support and coping strategies used, the dependent variable is psychological functioning. Scores were produced for each participant for each variable in order to establish if there is a relationship between psychological functioning and coping strategies and between social support and psychological functioning (Goertz & Mahoney, 2012; Kempf-Leonard, 2005).

4.2 TRUSTWORTHINESS, VALIDITY AND RELIABILITY

In the following section trustworthiness, validity and reliability of the current research study will be explored.

Trustworthiness of research refers to the reliability of the research and is an indication of quality research (Serba, 2011). Trustworthiness is demonstrated through credibility, transferability, dependability and confirmability (Creswell, 2014).

The credibility of qualitative research can be enhanced by paying attention to its truth value, consistency and neutrality, and the applicability thereof; aspects that the researcher attempted to ensure throughout the study by for example using critical readers and seeking the contributions of other professionals who are knowledgeable about the field and location of the study (Noble & Smith, 2015).

Transferability refers to the extent to which the results can be transferred to another similar contexts (Bryman, 2007; Cresswell, 2014; Goertz & Mahoney, 2012; Panter & Sterba, 2011). The inclusion criteria for participants in the quantitative study was that they were all rape victims, and older than 18. In addition, the participants contributed to this specific research topic, namely rape, which is another method of ensuring transferability. Furthermore, the procedure followed in the study was elucidated (Panter & Sterba, 2011).

Dependability was achieved by obtaining two experts in statistical analysis to review results. These experts acknowledged the dependability of the instruments utilized and the statistical analysis (Denzin & Lincoln, 2005). The researcher utilised the Brief COPE (Carver 1997), a self-report measure known as Multidimensional Scale of Perceived social support (Zimet, Dahlem, Zimet & Farley, 1988) and the General Health Questionnaire (GHQ-28) (Goldberg, 1972). Previous research studies also confirm the dependability of the instruments utilised in the current study. All the above-mentioned instruments indicates good internal consistency and was thus found to be dependable instruments (De Kock et al, 2014; Kotz, et al, 2006; Mostert & Joubert, 2005; Pienaar & Rothmann, 2003).

Confirmability refers to the degree to which the results can be confirmed by others. Providing sufficient descriptive data in the research document ensure that the research can be applied to other similar contexts (Panter & Sterba, 2011). Based on the factors discussed above this research is regarded as trustworthy.

4.3 PROCEDURE

This study was approved by The Postgraduate Ethics Committee at the North-West University in the Department of Psychology. The research has been conducted in accordance with the guidelines set by this committee and all ethical principles were adhered to during the research study. The ethical clearance reference number is NWU-00453-15-S9.

Approval was obtained from the Tshepong/Klerksdorp Complex Psychology Department and the KOSH Crisis Centre. In addition, the counsellors of the KOSH Crisis Centre were briefed on the study. Any possible participants were then contacted and informed about the aim and objectives of the study and of what was required of them.

The sample was collected from the KOSH Crisis Centre in Klerksdorp, North-West Province. The psychology department of Klerksdorp/Tshepong Hospital Complex was also

approached as any further therapy required by the participants would ensue in a referral to the psychology department.

4.4 SAMPLING

There are two sampling methods utilized in social science research, namely probability sampling and nonprobability sampling. For the purpose of this study non-probability sampling was applied. One of the most common types of nonprobability sampling is convenience sampling (Bryman, 1988; Creswell, 2014; Goertz & Mahoney, 2012; Kempf-Leonard, 2005). Therefore, the researcher selected the sample on the basis of their representativeness of the research study, namely adult females that were raped. Thus, convenience sampling was used to create a sample of adult female rape victims. This method was used as the population group being studied is rape victims, and the sensitivity of approaching victims should be cautiously and ethically considered prior to commencement of the research (Creswell, 2014; Health Professions Council of South Africa Form 223, 2006; Panter & Sherba, 2011).

The following requirements had to be met to be included in the study. The first inclusion criteria, was that the participants should be 18 years of age or older. Secondly, female participants who self-reported that they were raped and were voluntarily prepared to complete the measuring instruments about their experiences. Thus, the sample was relatively small because of the accessibility of the participants. Some participants were excluded from the study because they were too traumatized and thus, referred for therapy as opposed to being exposed to the measures and research procedure (HPCSA Form 223, 2006). The exact classification of too traumatized was left up to the discretion of the trained counsellors and researcher.

Many rape survivors also decline speaking about their experiences as they feel that it is a very vulnerable topic or even reported fear of retaliation by the rapist. Other studies have also encountered similar difficulties regarding the sensitive topic of rape. A study conducted by Walker-Williams, van Eeden and van der Merwe (2012), in the South African context also encountered limited participation from women with a history of childhood sexual abuse and the sample in that research study consisted of 60 participants. Additionally, a study conducted by Van Wijk (2014) examined the difficulty of recruiting participants surrounding sensitive research topics such as rape. The results indicated only 9 intimate partners of rape victims were willing to participate and successfully complete the study.

Thirdly, language was also a barrier as the participants had to be able to understand the English measures and be able to receive assistance in their first language if needed (the counsellors at the KOSH Crisis Centre assisted). Other studies have also encountered similar problems regarding this sensitive topic of research (Walker-Williams et al, 2012; Van Wijk, 2014).

The sample consisted of 50 women (N=50) who participated in the study. Their ages ranged from 19-73 with a mean age of 36.96 years of age (SD= 15.13). The race percentage of the sample was as follows: black (94% /47 participants) with 2% (1) coloured and 4% (2) white participants. Furthermore, 42% (21) of participants reported their highest education level as high school, 28% (14) as primary school level, 20% (10) as matric, 8% (4) post matric and only 2% (1) as degree studies. The greatest percentage reported their marital status as never having been married (54%/ 27 participants), 18% (9) were living together, 16% (8) were married, 6% (3) divorced and 6% (3) separated. Only 22% (11) of the participants reported being employed at the time of the data collection with 78% (39) unemployed. Of the 50 participants 42% (21) reported previous exposure to trauma before and 58% (29) did not report previous exposure to trauma. Previous exposure to trauma referred to any experiences

the participant defined as traumatic (examples were given of hijackings, housebreakings, assault and domestic violence). A full 70% of participants reported experiencing more than one incidence of rape (30%/15 did not). 68% of participants also reported receiving counselling after their experience of rape (32%/16 did not). See Table 1 below for a summary of the demographic factors of participants in the study.

Table 1
Biographical Data of Participants

	Participants (50)	M	SD		
Age	19-73	36.96	15.13		
Ethnicity	Black 47 (94%)	White 2 (4%)	Coloured 1 (2%)		
Levels of Education	Primary School 14 (28%)	High School 21 (42%)	Matric 10 (20%)	Post matric 4 (8%)	Degree 1 (2%)
Marital Status	Married 8 (16%)	Separated 3 (6%)	Divorced 3 (6%)	Living Together 9 (18%)	Never Married 27 (54%)
Employment	Employed 11 (22%)	Unemployed 39 (78%)			
Previous trauma reported	Yes 21 (42%)	No 29 (58%)			
Incidence of rape	Once 15 (30%)	More than once 35 (70%)			
Received counselling	Yes 34 (68%)	No 16 (32%)			

4.5 INSTRUMENTS

Data was collected using a biographical questionnaire, a self-report measure known as the Brief COPE (Carver 1997), a self-report measure known as Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al.; 1988) and the General Health Questionnaire (GHQ-28) (Goldberg, 1972). Descriptions of the abovementioned questionnaires are provided in the next section.

4.5.1 The Multidimensional Scale of Perceived Social Support (MSPSS)

The assessment of Perceived Social Support was conducted using the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al 1988). It is a self-report measure of subjectively assessed social support, with three subscales; family, friends and significant other. Items such as: “*There is a special person who is around when I am in need*”, “*I can talk about my problems with my friends*”. Scoring of these items is achieved by a seven-point rating scale, ranging from very strongly agree to very strongly disagree.

In this study the following Cronbach Alpha’s were found for the MSPSS subscales: Perceived Family Support .92, Perceived Support from Friends .97 and Perceived Support from Significant Other .98. All subscales and the overall total of the MSPSS was included in the study as all subscales showed good internal consistency and was thus found to be reliable. In a South African study on the effect of social support as a predictor of PTSD the Cronbach Alpha’s for the MSPSS were found to be .88 for the total scale and .91 (Significant Other), .87 (Family) and .85 (Friends) for the respective subscales (Jones & Kagee, 2005).

4.5.2 Brief COPE

The Brief COPE (Carver 1997) is a self-report questionnaire, with 28 items and 14 subscales assessing specific coping techniques. The subscales are: self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support,

behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame. Items such as “*Have you been getting scared or panicky for no good reason?*” and “*Found everything getting on top of you?*” are answered according to a four-point scale ranging from not at all to much more than usual.

In this study the following Cronbach Alpha’s were found for each subscale: Self-Blame -1.81, Religion .82, Acceptance -.99, Humour -10.07, Planning .72, Positive Reframing .35, Venting -.60, Behavioural Disengagement .47, Instrumental Support .48, Emotional Support .75, Substance Use .76, Denial .86, Active Coping .49, Self-Distraction .60. As many of the subscales did not prove internal consistency in this study based on their Cronbach Alpha scores, only the following subscales will be used for statistical analysis: Self-Distraction, Planning, Religion, Emotional Support, Substance Use and Denial. Previous South African studies indicated internal consistency and thus reliability of the measure ranging between .83 and .92 (Mostert & Joubert, 2005; Pienaar & Rothmann, 2003).

4.5.3 General Health Questionnaire-28 (GHQ-28)

The GHQ-28 was developed by David Goldberg to detect a wide range of psychological disorders mainly depression and anxiety (Goldberg, 1972). The scale is comprised of 28 items that divided into four sub-scales, which are as follows: A – Somatic symptoms [(items 1-7) reliability (0.84)], B – Anxiety/insomnia [(items 8-14) reliability (0.85)], C – Social dysfunction [(items 15-21) reliability (0.83)] and D – Severe depression [(items 22-28) reliability (0.83)].

In the GHQ-28 the participant is asked to compare her recent psychological state with her usual state. Items include “*been feeling well and in good health*” and “*feel that life is entirely hopeless*”. Scoring of these items is achieved by a four-point scale ranging from not at all to much more than usual.

In this study the following Cronbach Alpha’s were found for the GHQ subscales: GHQ

Somatic Symptoms .86, GHQ Social Dysfunction .90, GHQ Anxiety/Insomnia .92, GHQ Severe Depression .92. As can be seen by the Cronbach Alpha scores found all subscales were found to have good internal consistency and was thus used for statistical analysis as well as the overall GHQ total score. In a factor analysis study of the GHQ-28 in a black South African population Cronbach Alpha's ranging between .7 and .83 were found (De Kock et al., 2014).

4.6 STATISTICAL ANALYSIS

Statistical calculations were performed using the Statistical Package for Social Scientists Version 22. Data was inspected for consistency in answering schemas as well as for the correct coding procedures. Descriptive analysis procedures were performed to describe demographic information in terms of percentages, means and standard deviations. T-tests were done to assess for group differences in variables and effect sizes were used to assess the possible effects of variables, Spearman's Correlational analysis was done to assess for relationships between the variables (Goertz & Mahoney, 2012; Kotz, et al., 2006).

T-tests were employed to compare the groups of different variables and their means. De Winter (2013) confirms the use of T-tests to compare groups of scores and their means for smaller samples as is the case in this study (Abu-Bader, 2006; Kotz, et al., 2006).

As the sample was quite small and - some non-significant p-values were encountered, the effect size was used to measure practical significance as it is independent of sample size. The effect size indicates if the effect of a variable is large enough to have an effect in a practical situation and in the case of this study the differences in means were described (Ellis & Steyn, 2003). According to Cohen (1988) the effect sizes may be interpreted according to the following guidelines: a large effect would be 0.5 or larger, a medium effect would be 0.3 or larger and a small effect would be 0.1 or larger. The mentioned effect sizes may indicate

effects ranging from substantial and tangible effects to those that may only be seen through careful study and examination. Rosenthal, Rosnow and Rubin (2000) recommend the use of effect sizes even when non-significant p-values are found as dismissing group differences of variables on p-value alone may mean dismissing relevant statistical information. A small sample size such as the 50 participants in this study may thus be the reason that the true significance of an effect may be lost (Creswell, 2014; Kotz, et al, 2006).

The Spearman's Rho correlation or Spearman Rank-Order Correlation Coefficient is a nonparametric measure of the direction and the strength of relationship existing between two different variables. The choice was made to use this method as the sample was relatively small, not normally distributed and made use of ranked data and thus may not produce valid results when using another method such as Pearson's product-moment correlation coefficient (Abu-Bader, 2006; Bishara & Hittner, 2012).

The requirements to use the Spearman's Rank-Order method of correlation is that the data is ordinal (for example measured on a Likert scale such as the GHQ 28-item, MSPSS and Brief COPE that was used in this study) and that they be monotonically related which refers to variables that either increase in value together, or as one variable value increases the other variable value will decrease. The monotonic nature of the relationship between the variables was tested using a scatter plot before the correlations were conducted (Creswell, 2014; Bishara & Hittner, 2012).

The Spearman's correlation coefficient is a value that shows the strength of the correlation between the two variables. This value will be between -1 and +1 and will either show a positive relationship between the two variables (when one increases the other increases as well) or a negative relationship between the variables (as one variable increase the other decreases). When this value is 0 it indicates no linear relationship or correlation between the analysed variables (Kotz, et al, 2006; Puth, Neuhäuser & Ruxton, 2015).

4.7 ETHICAL CONSIDERATION

4.7.1 Voluntary participation

Participation was voluntary. Potential participants were provided with information relating to the research study. This allowed the participants with an option to decide if they wanted to partake in the study. The researcher also informed the participants that they had the option to withdraw from the study at any time (HPCSA Form 223, 2006; Bishara & Hittner, 2012).

4.7.2 Informed Consent

All the participants received the information pertaining to the study. All the participants signed a consent form (HPCSA Form 223, 2006; Bishara & Hittner, 2012). This form included the following: There are no foreseen risks to participation in this project, participants' identities and all material obtained will be kept confidential, that no compensation will be given and that participants are free to withdraw from the project at any time. Voluntary participation was also discussed with all participants (HPCSA Form 223, 2006; Panter & Sherba, 2011).

4.7.3 Privacy, confidentiality and anonymity

The participant's right to privacy was respected. Confidentiality implies that only the researcher is aware of the identity of the participants. The researcher upheld confidentiality by not assigning names to the data collected. The participants were therefore not identifiable in the research report (HPCSA Form 223, 2006; Bishara & Hittner, 2012).

4.7.4 Avoidance of harm

Therapy was made available for any participants who felt that it was needed and many referrals were made to relevant professionals as requested by the participants or as identified by the researcher and counsellors involved in the study. Some participants were excluded from the study because they were too traumatized, and thus referred for therapy as opposed to

being exposed to the measures and research procedure (HPCSA Form 223, 2006; Bishara & Hittner, 2012).

4.7.5 Release or publication of the findings

The researcher has an ethical obligation to report only the truth in the presentation of the findings of the research. The research study or any publications derived from this study will contain all information for researchers to understand the research context, the procedures that were followed as well as the research findings. The participant will be anonymous in any report or article (HPCSA Form 223, 2006; Bishara & Hittner, 2012).

4.8 SUMMARY

This chapter focuses reference to specific aspects such as the research method, demographics of the participants of and the sampling procedure that was followed. Furthermore, the chapter provided detail regarding the data collection method as well as the instruments utilised in the study. Lastly, ethical considerations involved in this study were provided.

Chapter 5

5 RESULTS

In this section the results of the statistical analysis of the data will be reported. This includes the T-tests comparing differences in groups (Exposure to previous trauma, incidence of rape and counselling received) for all variables. Thereafter, the correlational results for all variables will be reported. All results in the study are presented using tables. Although all the results obtained are reported, not all of these results are statistically significant or directly related to the hypotheses and will thus not all be discussed.

5.1 RELATIONSHIP BETWEEN COPING, SOCIAL SUPPORT AND PSYCHOLOGICAL FUNCTIONING

Spearman's rank order correlations were ran to determine the correlations between the variables social support, coping and psychological functioning. See table 2.

Table 2

Spearman's rho Correlations for independent and dependent variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. GHQ Somatic Symptoms	1														
2. GHQ Anxiety/ Insomnia	.745	1													
3. GHQ Social Dysfunction	.672	.648	1												
4. GHQ Severe Depression	.333	.505	.369	1											
5. GHQ Total	.858	.861	.834	.607	1										
6. Self-distraction	.077	.172	.201	.260	.190	1									
7. Substance Use	.150	.091	.111	.194	.126	-.259	1								
8. Emotional Support	.175	.176	.131	-.078	.120	-.205	-.050	1							
9. Denial	.253	.159	.103	.201	.219	-.277	.260	.140	1						
10. Planning	-.117	-.208	-.346*	-.352*	-.289*	-.526	-.018	.334	.157	1					
11. Religion	-.041	-.066	-.173	.025	-.117	-.164	-.101	.180	-.053	.465	1				
12. Family	-.145	-.085	-.121	.007	-.135	.292*	-.158	.184	-.070	.091	.059	1			
13. Friends	-.218	-.182	-.093	-.102	-.232	.234	.083	-.085	-.178	-.082	.141	.576	1		
14. Significant Other	-.273	-.168	-.218	-.096	-.239	.285*	-.253	.128	-.222	.126	.158	.445	.310	1	
15. Social Support Total	-.308*	-.230	-.224	-.089	-.293*	.240	-.107	.039	-.145	.067	.138	.740	.736	.747	1

* Correlation is significant at the 0.05 level

** Correlation is significant at the 0.01 level

5.1.1 Hypothesis one stated: There will be a significant relationship between specific coping strategies and the psychological functioning of the rape victims.

There is a negative correlation between Planning and GHQ Social Dysfunction which was statistically significant on the 0.05 level ($r(50) = -0.346, p = 0.14$). Thus as Planning increases GHQ Social Dysfunction will decrease or vice versa.

Between Planning and GHQ Severe Depression which was statistically significant on the 0.05 level ($r(50) = -0.352, p = 0.12$) shows a negative correlation. Thus as Planning increases GHQ Severe Depression will decrease or vice versa.

As Planning increases GHQ Total will decrease or vice versa, because there is a negative correlation between Planning and GHQ Total, which was statistically significant on the 0.05 level ($r(50) = -.289, p = 0.042$).

There is a positive correlation between GHQ Severe Depression and Self-distraction but which was not statistically significant ($r(50) = 0.260, p = 0.068$). Thus as GHQ Severe Depression increases or decreases so will Self-Distraction.

There is a positive correlation between GHQ Somatic Symptoms and denial but which was not statistically significant ($r(50) = 0.253, p = 0.073$). Thus as GHQ Somatic Symptoms increases or decreases so will Denial.

5.1.2 Hypothesis two stated: There will be a significant relationship between perceived social support and the psychological functioning of the rape victims.

There is a negative correlation between Social Support Total and GHQ Somatic Symptoms which was statistically significant on the 0.05 level ($r(50) = -0.308, p = 0.03$). Thus as Social Support Total increases GHQ Somatic Symptoms will decrease or vice versa.

As Social Support Total increases the GHQ Total will decrease or vice versa because there is a negative correlation between Social Support Total and GHQ Total which was statistically significant on the 0.05 level ($r(50) = -0.293, p = 0.039$).

There is a negative correlation between Social Support Total and GHQ Anxiety/Insomnia which was not statistically significant ($r(50) = -0.23, p = 0.109$). Thus as Social Support Total increases GHQ Anxiety/Insomnia will decrease or vice versa.

Between Social Support Total And GHQ Social Dysfunction there is a negative correlation which was not statistically significant ($r(50) = -0.224, p = 0.118$). Thus as Social Support Total increases GHQ Social Dysfunction will decrease or vice versa.

5.1.3 Hypothesis three stated: There will be a significant relationship between perceived social support and the specific coping strategies of the rape victims.

There is a positive correlation between Family Support and Self-Distraction which was statistically significant on the 0.05 level ($r(50) = 0.292, p = 0.039$). Thus as family support increases or decreases so will Self-Distraction.

A positive correlation was found between perceived Social Support from Significant Other and Self-Distraction which was statistically significant on the 0.05 level ($r(50) = 0.285, p = 0.045$). Thus as perceived Social Support from Significant Other increases or decreases so will Self-Distraction.

Between perceived Social Support from Significant Other and Substance Use there is a negative correlation which was not statistically significant ($r(50) = -0.253, p = 0.076$). Thus as perceived Social Support from Significant Other increases Substance Use will decrease or vice versa.

There is a negative correlation between perceived Social Support from Significant

Other and Denial but which was not statistically significant ($r(50) = -0.222$, $p = 0.121$). Thus as perceived Social Support from Significant Other increases Denial will decrease or vice versa.

A positive correlation was found between Social Support Total and Self-Distraction which was not statistically significant ($r(50) = 0.24$, $p = 0.093$). Thus as Social Support Total increases or decreases so will Self-Distraction.

5.2 Hypothesis Four stated: There will be a significant difference between the coping strategies, social support and psychological functioning of rape victims who previously experienced trauma and those that did not.

This hypothesis stated that there will be a significant difference between participants who were previously exposed to trauma and those who were not on measures of coping, perceived social support and psychological functioning. Thus comparisons will be made of the analysed data. The hypothesis was tested with independent t-tests. Hypothesis four was broken up into different parts in order to simplify reporting of the results thereof.

5.2.1 Hypothesis Four- Part one state: There will be a significant difference on psychological functioning (GHQ) between participants previously exposed to trauma and those that weren't (See Table 3).

Table 3

Means, standard deviations and summary of the independent sample T-test for the GHQ

Subscales and Total and previous exposure to trauma.

	Reported previous trauma exposure(21)		Did not report previous trauma exposure (29)		T	P	Cohen <i>d</i>
	M	SD	M	SD			
GHQ Somatic Symptoms	2.19	2.09	2.10	2.37	0.14	0.89	0.04
GHQ Anxiety/Insomnia	2.24	2.74	2.07	2.60	0.22	0.83	0.06
GHQ social dysfunction	2.33	2.63	2.17	2.42	0.22	0.83	0.06
GHQ severe depression	1.29	2.35	.48	1.33	1.41	0.17	0.34
GHQ Total	8.05	8.14	6.83	7.07	0.55	0.58	0.15

The study did not show a statistical difference on GHQ Somatic Symptoms $t(48) = .14$, $p = ns$. The mean scores revealed that participants who reported previous trauma scored slightly higher on GHQ Somatic Symptoms ($\bar{x} = 2.19$; $SD = 2.09$) than those who did not ($\bar{x} = 2.1$, $SD = 2.37$). This showed no effect (Cohen $d = 0.04$).

The mean scores revealed that participants who reported previous trauma scored slightly higher on GHQ Anxiety/Insomnia ($\bar{x} = 2.24$, $SD = 2.74$) than those who did not ($\bar{x} =$

2.07, SD= 2.60) but the study did not show a statistical difference on GHQ Anxiety/Insomnia $t(48)= 0.22$, $p = ns$. This displayed no effect (Cohen $d = 0.06$).

The study did not show a statistical difference on GHQ Social Dysfunction $t(48) = 0.22$, $p = ns$. The mean scores revealed that participants who reported previous trauma scored slightly higher on GHQ Social Dysfunction ($\bar{x} = 2.33$, $SD = 2.63$) than those who did not ($\bar{x} = 2.17$, $SD = 2.42$). This showed no effect (Cohen $d = 0.06$).

The mean scores revealed that participants who reported previous trauma scored slightly higher on GHQ Severe Depression ($\bar{x} = 1.29$, $SD = 2.35$) than those who did not ($\bar{x} = 0.48$, $SD = 1.33$), a small effect was revealed (Cohen $d = 0.34$). No statistical difference on GHQ Severe Depression $t(48) = 1.41$, $p = ns$ could be found.

The study did not show a statistical difference on GHQ Total $t(48) = 0.55$, $p = ns$. The mean scores revealed that participants who reported previous trauma scored higher on GHQ Total ($\bar{x}= 8.05$, $SD= 8.14$) than those who did not ($\bar{x}= 6.83$, $SD = 7.07$). This showed no effect (Cohen $d = 0.15$).

Based on the mean scores participants who reported previous trauma scored higher on all GHQ Subscales and the GHQ Total Scale than participants who did not report trauma, with the GHQ Severe Depression subscale showing a small effect (effect size Cohen $d =0.34$).

5.2.2 Hypothesis four- part two state: There will be a significant difference on coping between participants previously exposed to trauma and those who weren't (See Table 4).

Table 4

Means, standard deviations and summary of the independent sample T-test for the Brief COPE Subscales and exposure to previous trauma.

	M	SD	M	SD	T	P	Cohen <i>d</i>
Self-distraction	4.14	2.01	5.59	1.72	-2.66	0.01	0.72
Substance use	5.67	2.01	6.62	1.97	-1.67	0.10	0.48
Emotional Support	5.62	1.53	5.72	1.81	-.22	0.83	0.06
Denial	4.57	2.00	4.76	2.23	-.31	0.76	0.08
Planning	5.10	1.81	4.93	1.60	.33	0.74	0.09
Religion	6.24	1.73	6.04	1.92	.39	0.70	0.11

The study showed a statistical difference on Self-Distraction $t(48) = -2.66, p = <0 .05$. The mean scores revealed that participants who reported previous trauma scored lower on Self-Distraction ($\bar{x} = 4.14, SD = 2.01$) than those who did not ($\bar{x} = 5.59, SD = 1.72$). This showed a medium effect (Cohen $d = 0.72$).

The mean scores revealed that participants who reported previous trauma scored lower on Substance Use ($\bar{x} = 5.67, SD = 2.01$) than those who did not ($\bar{x} = 6.62, SD = 1.97$). This showed a small effect (Cohen $d = 0.48$). No statistical difference on Substance Use $t(48) = -1.67, p = ns$ could be found.

The study did not show a statistical difference on Emotional Support $t(48) = -.22$, $p = ns$. The mean scores revealed that participants who reported previous trauma scored slightly lower on Emotional Support ($\bar{x} = 5.62$, $SD = 1.53$) than those who did not ($\bar{x} = 5.72$, $SD = 1.81$). This showed no effect (Cohen $d = 0.06$).

The mean scores revealed that participants who reported previous trauma scored slightly lower on Denial ($\bar{x} = 4.57$, $SD = 2$) than those who did not ($\bar{x} = 4.76$, $SD = 2.23$). This showed no effect (Cohen $d = 0.08$). The study did not show a statistical difference on Denial $t(48) = -.31$, $p = ns$.

The study did not show a statistical difference on Planning $t(48) = 0.33$, $p = ns$. The mean scores revealed that participants who reported previous trauma scored slightly higher on Planning ($\bar{x} = 5.1$, $SD = 1.81$) than those who did not ($\bar{x} = 4.93$, $SD = 1.60$). This showed no effect (Cohen $d = 0.09$).

No statistical difference on Religion $t(48) = 0.39$, $p = ns$ was revealed but the mean scores revealed that participants who reported previous trauma scored slightly higher on Religion ($\bar{x} = 6.24$, $SD = 1.73$) than those who did not ($\bar{x} = 6.04$, $SD = 1.92$). This showed no effect (Cohen $d = 0.11$).

Based on the mean scores participants who reported previous trauma scored lower on Self-distraction (This showed a medium effect (Cohen $d = 0.72$), Substance Use (This showed a small effect (Cohen $d = 0.48$), Emotional Support and Denial than participants who did not report previous trauma. Participants that reported previous trauma scored higher on Planning and Religion.

5.2.3 Hypothesis Four- part three state: There will be a significant difference on perceived social support between participants previously exposed to trauma and those who weren't (See Table 5).

Table 5

Means, standard deviations and summary of the independent sample T-test for the MSPSS (Social Support) Subscales and Total and exposure to previous trauma.

	Reported previous trauma exposure (21)		Did not report previous trauma exposure (29)		T	P	Cohen <i>d</i>
	M	SD	M	SD			
Significant other	16.52	7.20	21.72	5.37	-2.80	0.01	0.72
Family	21.48	3.88	23.83	3.24	-2.26	0.03	0.61
Friends	20.00	5.04	18.86	7.21	.66	0.51	0.16
Social Support Total	58.00	12.22	64.41	12.21	-1.83	0.07	0.52

The study showed a statistical difference on Significant Other $t(48)=12.8$, $p<0.05$. The mean scores revealed that participants who reported previous trauma scored lower on Significant Other ($\bar{x}= 16.52$, $SD = 7.2$) than those who did not ($\bar{x}= 21.72$, $SD = 5.37$). This showed a medium effect (Cohen $d = 0.72$).

The mean scores revealed that participants who reported previous trauma scored lower on Family ($\bar{x} = 21.48$, $SD = 3.88$) than those who did not ($\bar{x} = 23.83$, $SD = 3.24$). The study showed a statistical difference on Family $t(48)=-2.26$, $p<0.05$. This showed a medium effect (Cohen $d = 0.61$).

The study did not show a statistical difference on the Friends $t(48) = 0.66$, $p = ns$. The mean scores revealed that participants who reported previous trauma scored higher on Friends ($\bar{x} = 20$, $SD = 5.04$) than those who did not ($\bar{x} = 18.86$, $SD = 7.21$). This showed no effect (Cohen $d = 0.16$).

No statistical difference on the Social Support Total ($t(48) = -1.83$, $p = ns$) could be shown. The mean scores revealed that participants who reported previous trauma scored lower on Social Support Total ($\bar{x} = 58$, $SD = 12.22$) than those who did not ($\bar{x} = 64.41$, $SD = 12.21$). This showed a medium effect (Cohen $d = 0.52$).

This study showed a statistically significant difference on Significant Other (Cohen $d = .72$) and Family (Cohen $d = .61$) with both subscales showing a medium effect. Participants who reported previous trauma scored lower on Family and Significant than those who did not report previous trauma. Participants who reported previous trauma scored higher on Friends than those who did not based on mean scores. Overall participants who reported previous trauma scored lower on Social Support Total than those who did not.

5.3 Hypothesis five stated: There will be a significant difference between the coping strategies, social support and psychological functioning of the rape victims that reported being raped only once and those who were raped more than once (incidence of rape).

Hypothesis five stated that participants who were raped more than once will differ significantly from participants who were only raped once on measures of coping, social support and psychological well-being. The testing of this hypothesis entailed the use of independent T-tests. Thus comparisons will be made of the analysed data. Hypothesis five was broken up into different parts in order to simplify reporting of the results thereof.

5.3.1 Hypothesis five- part one state: Participants who were raped more than once will differ significantly from participants who were only raped once on Psychological well-being (GHQ) (See Table 6).

Table 6

Means, standard deviations and summary of the independent sample T-test for the GHQ subscales and total and being a victim of rape once or more than once under investigation

	Victim of rape once (35)		Victim of rape more than once (15)		T	P	Cohen <i>d</i>
	M	SD	M	SD			
GHQ Somatic Symptoms	2.31	2.30	1.73	2.086	0.88	0.39	0.25
GHQ Anxiety/Insomnia	2.26	2.68	1.87	2.62	0.48	0.64	0.15
GHQ social dysfunction	2.34	2.41	2.00	2.726	0.42	0.68	0.13
GHQ severe depression	0.83	1.81	0.80	2.007	0.05	0.96	0.01
GHQ Total	7.74	7.51	6.40	7.58	0.58	0.57	0.18

The study did not show a statistical difference on GHQ Somatic Symptoms $t(48) = .88$, $p = ns$. The mean scores revealed that participants who were a victim of rape once scored higher on GHQ Somatic Symptoms ($\bar{x} = 2.31$; $SD = 2.29$) than those who reported being raped more than once ($\bar{x} = 1.73$, $SD = 2.1$). This showed a small effect (Cohen $d = 0.25$).

The mean scores revealed that participants who were a victim of rape once scored higher on GHQ Anxiety/Insomnia ($\bar{x} = 2.26$, $SD = 2.62$) than those who reported being raped

more than once ($\bar{x} = 1.87$, $SD = 2.62$). This showed no effect (Cohen $d = 0.15$). The study did not show a statistical difference on GHQ Anxiety/Insomnia $t(48) = .48$, $p = ns$.

No statistical difference was found on GHQ Social Dysfunction; $t(48) = 0.42$, $p = ns$. The mean scores revealed that participants who were a victim of rape once scored higher on GHQ Social Dysfunction ($\bar{x} = 2.34$, $SD = 2.41$) than those who reported being raped more than once ($\bar{x} = 2$, $SD = 2.73$). This showed no effect (Cohen $d = 0.13$).

The study did not show a statistical difference on GHQ Severe Depression $t(48) = 0.05$, $p = ns$. The mean scores revealed that participants who were a victim of rape once scored slightly higher on GHQ Severe Depression ($\bar{x} = .83$, $SD = 1.81$) than those who reported being raped more than once ($\bar{x} = 0.8$, $SD = 2.01$). This showed no effect (Cohen $d = 0.1$).

The mean scores revealed that participants who were a victim of rape once scored slightly higher on GHQ Total ($\bar{x} = 7.74$, $SD = 7.51$) than those who reported being raped more than once ($\bar{x} = 6.4$, $SD = 7.58$). This showed no effect (Cohen $d = 0.18$). The study did not show a statistical difference on GHQ Total $t(48) = .58$, $p = ns$.

Based on the mean scores all participants who reported being raped once scored higher than participants who reported being raped more than once on all GHQ subscales and GHQ Total with GHQ Somatic Symptoms showing a small effect (Cohen $d = 0.25$).

5.3.2 Hypothesis five- part two state: Participants who were raped more than once will differ significantly from participants who were only raped once on coping (self-distraction, Substance Use, Emotional Support, Denial, Planning and religion (see Table 7).

Table 7

Means, standard deviations and summary of the independent sample T-test for the relevant Brief COPE Subscales and being a victim of rape once or more than once under investigation

	Victim of rape		Victim of rape more		T	P	Cohen <i>d</i>
	once (35)		than once (15)				
	M	SD	M	SD			
Self-distraction	5.11	1.80	4.67	2.35	0.66	0.52	0.19
Substance use	6.26	2.06	6.13	2.00	0.20	0.84	0.06
Emotional Support	5.80	1.55	5.40	1.99	0.69	0.50	0.20
Denial	4.63	2.16	4.80	2.08	-0.26	0.80	0.08
Planning	5.06	1.59	4.87	1.92	0.34	0.74	0.10
Religion	6.37	1.73	5.53	1.96	1.43	0.17	0.43

The study did not show a statistical difference on Self-Distraction $t(48) = .66$, $p = ns$. The mean scores revealed that participants who were a victim of rape once scored higher on Self-Distraction ($\bar{x} = 5.11$, $SD = 1.8$) than those who reported being raped more than once ($\bar{x} = 4.67$, $SD = 2.35$). This showed no effect (Cohen $d = 0.19$).

The mean scores revealed that participants who were a victim of rape once scored higher on Substance Use ($\bar{x} = 6.26$, $SD = 2.06$) than those who reported being raped more

than once ($\bar{x} = 6.13$, $SD = 2$). This showed no effect (Cohen $d = 0.06$). The study did not show a statistical difference on Substance Use $t(48) = .20$, $p = ns$.

No statistical difference on Emotional Support could be found; $t(48) = 0.69$, $p = ns$. The mean scores revealed that participants who were a victim of rape once scored higher on Emotional Support ($\bar{x} = 5.8$, $SD = 1.55$) than those who reported being raped more than once ($\bar{x} = 5.4$, $SD = 1.99$). This showed a small effect (Cohen $d = 0.2$).

The study did not show a statistical difference on Denial $t(48) = -0.26$, $p = ns$. The mean scores revealed that participants who were a victim of rape once scored lower on Denial ($\bar{x} = 4.63$, $SD = 2.16$) than those who reported being raped more than once ($\bar{x} = 4.8$, $SD = 2.08$). This showed no effect (Cohen $d = 0.1$).

The mean scores revealed that participants who were a victim of rape once scored higher on Planning ($\bar{x} = 5.06$, $SD = 1.59$) than those who reported being raped more than once ($\bar{x} = 4.87$, $SD = 1.92$). This showed no effect (Cohen $d = 0.1$). The study did not show a statistical difference on Planning $t(48) = 0.34$, $p = ns$.

The study did not show a statistical difference on Religion $t(48) = 1.43$, $p = ns$. The mean scores revealed that participants who were a victim of rape once scored higher on Religion ($\bar{x} = 6.37$, $SD = 1.73$) than those who reported being raped more than once ($\bar{x} = 5.53$, $SD = 1.96$). This showed a small effect (Cohen $d = 0.43$).

Based on the mean scores participants who reported being a victim of rape once scored higher on all the Brief COPE subscales with the exception of the denial score where participants who reported being raped more than once scored higher than those who reported being raped once. Subscale Religion showed a small effect (Cohen $d = 0.43$).

5.3.3 Hypothesis five- part three state: Participants who were raped more than once will differ significantly from participants who were only raped once on perceived Social Support (MSPSS) (see Table 8).

Table 8

Means, standard deviations and summary of the independent sample T-test for the MSPSS (Social Support) Subscales and Total and being a victim of rape once or more than once under investigation.

	Victim of rape		Victim of rape more		T	P	Cohen <i>d</i>
	once (35)		than once (15)				
	M	SD	M	SD			
Significant other	19.80	6.00	18.93	8.20	.37	.72	0.11
Family	22.91	3.82	22.67	3.44	.23	.82	0.06
Friends	18.94	6.86	20.27	5.06	-.76	.45	0.19
Social Support Total	61.66	12.01	61.87	14.04	-.05	.96	0.01

The study did not show a statistical difference on Significant Other $t(48)=.37$, $p=ns$. The mean scores revealed that participants who were a victim of rape once scored higher on Significant Other ($\bar{x}= 19.8$, $SD=6$) than those who reported being raped more than once ($\bar{x}= 18.93$, $SD=8.2$). This showed no effect (Cohen $d =0.11$).

The mean scores revealed that participants who were a victim of rape once scored higher on Family ($\bar{x}= 22.91$, $SD=3.82$) than those who reported being raped more than once ($\bar{x}= 22.67$, $SD=3.44$). This showed no effect (Cohen $d =0.06$).The study did not show a statistical difference on the Family $t(48)=.23$, $p=ns$.

No statistical difference on the subscale Friends could be found; $t(48)=-.76$, $p=ns$. The mean scores revealed that participants who were a victim of rape once scored lower on Friends ($\bar{x}= 18.94$, $SD = 6.86$) than those who reported being raped more than once ($\bar{x}= 20.27$, $SD = 5.06$). This showed a small effect (Cohen $d = 0.19$).

The study did not show a statistical difference on the Social Support Total $t(48) =-.05$, $p = ns$. The mean scores revealed that participants who were a victim of rape once scored higher on Social Support Total ($\bar{x}= 61.66$, $SD = 12.01$) than those who reported being raped more than once ($\bar{x}= 61.87$, $SD = 14.04$). This showed no effect (Cohen $d = 0.01$).

Based on the mean scores, participants who reported being a victim of rape once scored higher on Significant Other and Family. Participants who were a victim of rape more than once scored higher than participants who reported being raped once on Social Support Total and on the subscale Friends which showed a small effect (Cohen $d = 0.19$).

5.4 Hypothesis six stated: There will be a significant difference between the coping strategies, social support and psychological functioning of the rape victims who received counselling and those that did not.

Sub-hypothesis three state; there will be a significant difference on measures of coping, social support and psychological well-being between participants who received counselling and those who did not. The testing involved the use of independent T-tests. Thus results are comparisons of analysed data not effects as in an experimental research design. Hypothesis six was broken up into different parts in order to simplify reporting of the results thereof.

5.4.1 Hypothesis six- part one: There will be a significant difference on psychological functioning between participants who received counselling and those who did not (See Table 9).

Table 9

Means, standard deviations and summary of the independent sample T-test for the GHQ (psychological functioning) Subscales and Total and counselling received under investigation.

	Counselling		No counselling		T	P	Cohen <i>d</i>
	Received(21)		received (29)				
	M	SD	M	SD			
GHQ Somatic Symptoms	1.79	1.87	2.88	2.78	-1.41	0.17	0.39
GHQ Anxiety/Insomnia	1.88	2.23	2.69	3.36	-.87	0.39	0.24
GHQ social dysfunction	1.97	2.22	2.81	2.97	-1.01	0.32	0.28
GHQ severe depression	.65	1.67	1.19	2.20	-.87	0.39	0.25
GHQ Total	6.29	6.11	9.56	9.64	-1.24	0.23	0.34

The study did not show a statistical difference on GHQ Somatic Symptoms $t(48) = -1.41, p = ns$. The mean scores revealed that participants who received counselling scored lower on GHQ Somatic Symptoms ($\bar{x} = 1.79; SD = 1.87$) than those who did not ($\bar{x} = 2.88, SD = 2.78$). This showed a small effect (Cohen $d = 0.39$).

The mean scores revealed that participants who received counselling scored slightly lower on GHQ Anxiety/Insomnia ($\bar{x} = 1.88, SD = 2.23$) than those who did not ($\bar{x} = 2.69, SD$

= 3.36). This showed a small effect (Cohen $d = 0.24$). The study did not show a statistical difference on GHQ Anxiety/Insomnia $t(48) = -0.87$, $p = ns$.

No statistical difference on GHQ Social Dysfunction could be found; $t(48) = -1.01$, $p = ns$. The mean scores revealed that participants who received counselling scored slightly lower on GHQ Social Dysfunction ($\bar{x} = 1.97$, $SD = 2.22$) than those who did not ($\bar{x} = 2.81$, $SD = 2.97$). This showed a small effect (Cohen $d = 0.28$).

The study did not show a statistical difference on GHQ Severe Depression $t(48) = -0.87$, $p = ns$. The mean scores revealed that participants who received counselling scored slightly lower on GHQ Severe Depression ($\bar{x} = 0.65$, $SD = 1.67$) than those who did not ($\bar{x} = 1.19$, $SD = 2.2$). This showed a small effect (Cohen $d = 0.25$).

The mean scores revealed that participants who received counselling scored lower on GHQ Total ($\bar{x} = 6.29$, $SD = 6.11$) than those who did not ($\bar{x} = 9.56$, $SD = 9.64$). This showed a small effect (Cohen $d = 0.34$). The study did not show a statistical difference on GHQ Total $t(48) = -1.24$, $p = ns$.

Based on the mean scores participants who received counselling scored lower on all GHQ Subscales and GHQ Total than those who did not receive counselling. All Subscales and the GHQ Total Score showed a small effect.

5.4.2 Hypothesis six- part two: There will be a significant difference on coping between participants who received counselling and those that did not (See Table 10).

Table 10

Means, standard deviations and summary of the independent sample T-test for the Brief COPE (coping strategies) Subscales and counselling received under investigation.

	Counselling		No counselling		T	P	Cohen <i>d</i>
	Received (21)		received (29)				
	M	SD	M	SD			
Self-distraction	5.09	2.08	4.75	1.73	0.60	.55	0.16
Substance use	6.68	1.82	5.25	2.15	2.30	0.03	0.67
Emotional Support	5.97	1.77	5.06	1.34	2.01	0.05	0.51
Denial	4.79	2.21	4.44	1.93	0.58	0.57	0.16
Planning	5.00	1.78	5.00	1.51	0.00	1.00	0.00
Religion	6.18	1.88	6.00	1.75	0.32	0.75	0.09

The study did not show a statistical difference on Self-Distraction $t(48)=.60$, $p=ns$. The mean scores revealed that participants who received counselling scored slightly higher on Self-Distraction ($\bar{x} = 5.09$, $SD = 2.08$) than those who did not ($\bar{x} = 4.75$, $SD = 1.73$). This showed no effect (Cohen $d = 0.16$).

The mean scores revealed that participants who received counselling scored higher on Substance Use ($\bar{x} = 6.68$, $SD = 1.82$) than those who did not ($\bar{x} = 5.25$, $SD = 2.15$). This

showed a medium effect (Cohen $d = 0.67$). The study showed a statistical difference on Substance Use $t(48) = 2.30$, $p < 0.05$.

A statistical difference on the Brief COPE subscale Emotional Support was revealed; $t(48) = 2.01$, $p = 0.05$. The mean scores showed that participants who received counselling scored higher on Emotional Support ($\bar{x} = 5.97$, $SD = 1.77$) than those who did not ($\bar{x} = 5.06$, $SD = 1.34$). This showed a medium effect (Cohen $d = 0.51$).

The study did not show a statistical difference on Denial $t(48) = 0.58$, $p = ns$. The mean scores revealed that participants who received counselling scored slightly higher on Denial ($\bar{x} = 4.79$, $SD = 2.21$) than those who did not ($\bar{x} = 4.44$, $SD = 1.93$). This showed no effect (Cohen $d = 0.16$).

The mean scores revealed that participants who received counselling scored the same on Planning ($\bar{x} = 5$, $SD = 1.78$) than those who did not ($\bar{x} = 5$, $SD = 1.51$). This showed no effect (Cohen $d = 0.00$). The study did not show a statistical difference on Planning $t(48) = 0$, $p = ns$.

The study did not show a statistical difference on Religion $t(48) = 0.32$, $p = ns$. The mean scores revealed that participants who received counselling scored slightly higher on Religion ($\bar{x} = 6.18$, $SD = 1.88$) than those who did not ($\bar{x} = 6$, $SD = 1.75$). This showed no effect (Cohen $d = 0.09$).

Based on the mean scores participants who received counselling scored lower on the Brief COPE subscales Self-Distraction, Substance Use (This showed a medium effect (Cohen $d = 0.67$)), Emotional Support (This showed a medium effect (Cohen $d = 0.51$)), Denial and Religion than those who did not receive counselling. Both participants who received counselling and those who did not scored similar on the subscale Planning.

5.4.3 Hypothesis six- part three: There will be a significant difference on social support between participants who received counselling and those who did not (See Table 11).

Table 11

Means, standard deviations and summary of the independent sample T-test for the MSPSS (Social Support) Subscales and Total and counselling received under investigation.

	Counselling		No counselling		T	P	Cohen <i>d</i>
	Received (21)		received (29)				
	M	SD	M	SD			
Significant other	20.65	6.80	17.19	5.88	1.84	0.07	0.51
Family	23.21	3.44	22.06	4.16	0.96	0.35	0.28
Friends	19.12	7.01	19.81	4.83	-0.41	0.69	0.10
Social Support Total	62.97	12.59	59.06	12.28	1.04	0.31	0.31

The study did not show a statistical difference on the Significant Other $t(48) = 1.84$, $p = ns$. The mean scores revealed that participants who received counselling scored higher on Significant Other ($\bar{x} = 20.65$, $SD = 6.80$) than those who did not ($\bar{x} = 17.19$, $SD = 5.88$). This showed a medium effect (Cohen $d = 0.51$).

The mean scores revealed that participants who received counselling scored higher on Family ($\bar{x} = 23.21$, $SD = 3.44$) than those who did not ($\bar{x} = 22.06$, $SD = 4.16$). This showed a small effect (Cohen $d = 0.28$). The study did not show a statistical difference on the Family $t(48) = 0.96$, $p = ns$.

No statistical difference on the subscale Friends was found; $t(48) = -0.41$, $p = ns$. The

mean scores revealed that participants who received counselling scored slightly lower on Friends ($\bar{x} = 19.12$, $SD = 7.01$) than those who did not ($\bar{x} = 19.81$, $SD = 4.83$). This showed no effect (Cohen $d = 0.1$).

The study did not show a statistical difference on the Social Support Total $t(48) = 1.04$, $p = ns$. The mean scores revealed that participants who received counselling scored higher on Social Support Total ($\bar{x} = 62.97$, $SD = 12.59$) than those who did not ($\bar{x} = 59.06$, $SD = 12.28$). This showed a small effect (Cohen $d = 0.31$).

Based on the mean scores participants who received counselling scored higher on Family (showed a small effect (Cohen $d = 0.28$)), Significant Other (showed a medium effect (Cohen $d = 0.51$)) and Social Support Total (showed a small effect (Cohen $d = 0.31$)). Participants who received counselling scored slightly lower on Friends than those who did not.

CHAPTER 6

6 DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

6.1 DISCUSSIONS

The purpose of this study was to explore the relationship between the coping strategies the rape victims in this study utilized, the social support they perceived to have available from their family, friends and significant others and their psychological functioning. As well as to determine if there were significant differences with regards to coping strategies, perceived social support and psychological functioning according to incidences of rape, previous exposure to trauma and counselling received.

6.2 COPING STRATEGIES AND PSYCHOLOGICAL FUNCTIONING

6.2.1 *Hypothesis one*

The researcher postulated that there will be a significant relationship between specific coping strategies and the psychological functioning of the rape victims.

Previous research studies indicate that there is a positive correlation between planning and psychological functioning (Prenda & Lachman, 2001). Thus, planning for a specific personal goal increases the likelihood of reaching that goal, and consequently, improved psychological functioning. Therefore, encouraging planning may be a useful intervention (Macleod, Coates & Hetherton, 2008).

In a study conducted by Del-Ben (2012), the research results showed that planful-problem solving decreased the PTSD symptoms amongst firefighters. The current study is congruent with the research results establish in the aforesaid study. In the current research study, a statistically significant relationship between the coping strategy of planning and two different categories of psychological functioning namely Severe Depression and Social

Dysfunction as well as the Total Psychological Functioning score was found. Therefore, an increase in planning resulted in decreased symptomology of Severe Depression and Social Dysfunction, and subsequently improved psychological functioning.

The current study found a relationship between the category of psychological functioning subscale namely Severe Depression and the coping strategy subscale Self-distraction. Consequently, when self-distraction increased the symptomology of severe depression increased as well. There are scant research studies available on the effect of self-distraction on depression. However, self-distraction may be regarded as an emotion-focused strategy. Furthermore, Horwitz, Hill and King (2011) found that specific emotion-focused coping strategies, such as self-blame, are related to high levels of depression and suicidal ideation. Similarly, a study conducted by Bedard-Gilligan, Cronce, Lehavot, Blayne and Kaysen (2014) established that participants who do not utilize self-distraction as a coping strategy, are better equipped to cope with PTSD related symptoms including depression.

The current research study also found a positive correlation between the manifestation of somatic symptoms and the use of denial as a coping strategy. Therefore, as the practice of denial increased, the rape victims experienced an increase in somatic symptoms. Hence, the use of denial resulted in decreased psychological functioning. Previous studies also established that avoidant coping strategies, such as denial, may result in an increase in physical symptoms and a decrease in feelings of well-being (Bedard-Gilligan et al, 2014). The quantity and intensity of symptomology and thus the long-term positive adjustment and psychological functioning of rape victims have been found to be related to the use of active coping strategies with the opposite effect being shown for avoidant coping strategies such as denial in this study (Man et al, 2012). This is in congruence with the theory of avoidant and approach coping (Snyder & Pulver, 2001) that suggests that engaging in avoidant coping strategies such as denial and self-distraction may lead to negative psychological functioning

related outcomes. Thus discouraging the use of denial and self-distraction as coping strategies could possibly lead to a decrease in the presence of somatic and depressive symptoms in rape victims and an increase in positive psychological functioning and is worth exploring.

6.3 SOCIAL SUPPORT AND PSYCHOLOGICAL FUNCTIONING

6.3.1 *Hypothesis two*

The researcher postulated that there will be a correlation between perceived social support (from significant others, family and friends) and the psychological functioning of the rape victims.

Previous research indicated a relationship between psychological well-being and social support. A meta-analysis conducted by Brewin, Andrews and Valentine (2000) reported that low levels of social support resulted in an increase of PTSD related symptoms in the participants (Husky, Lepine, Gasquet, & Kovess-Masfety; 2015). Numerous other research results also established that perceived social support may positively influence the psychological functioning of a trauma victim (Asberg et al, 2008, Uchino, 2009; Yap & Devilly, 2004; Mclewin & Muller, 2006). Social support may also contribute to feelings of belonging and the encouragement of positive appraisals of the rape experience that may in turn positively affect psychological functioning (Tremblay et al, 1999; Golding, Wilsnack, & Cooper, 2002; Bal et al, 2001; Vernberg, La Greca, Silverman, & Prinstein, 1996). A lack of social support may in turn contribute to exposure to risky environments and so an increased risk of revictimisation (Classen, Field, Koopman, Nevill-Manning & Spiegel, 2001).

The current study found a correlation between total perceived social support and psychological functioning. Therefore, when the total perceived social support of the rape victim was high, the victim experienced a decrease in somatic symptoms. Conversely, when the total perceived social support was low, it resulted in an increase in somatic symptoms.

Thus, the rape victim will experience positive psychological functioning when social support from significant others, family and friends are perceived to be available. This study cannot prove or disprove the main effects or stress buffering models of social support specifically but confirms the protective relationship of perceived social support. In the current study individuals who believed that they had access to social support seemed to experience decreased symptomology and thus increased psychological functioning (Cohen & Wills, 1985; Lincoln, Chatters & Taylor, 2005; Pearlin et al, 1981). Therefore, the current research findings, concerning support for the rape victim, are in accordance with previous research results and stress related theories.

6.4 SOCIAL SUPPORT AND COPING

6.4.1 Hypothesis three

The researcher postulated that there will be a positive correlation between perceived social support and the specific coping strategies of the rape victims.

The current study established a positive correlation between the total perceived social support of the rape victim, from significant others, and the use of self-distraction as a coping strategy. The results indicated that when the total levels of perceived social support available were high, the rape victim utilized self-distraction. Self-distraction is seen as an emotion-focused coping strategy (Tuncay, Musabak, Gok & Kutlu, 2008). The rape victim's need for social support is a coping strategy that is linked to emotion-focused coping. Thus, the researcher anticipates a relationship between self-distraction and social support.

Furthermore, the current study found a relationship between perceived social support from significant others and the utilization of specific coping strategies namely, denial and substance use. When the rape victim perceived that she had high levels of social support from her significant others, the victim was unlikely to engage in substance use or the coping

strategy, denial. Previous studies support the aforesaid, that rape victims who received positive social support were less likely to use avoidant coping methods such as denial (Ullman, 1996; Ullman, Townsend, Filipas & Starzynski, 2007).

This above-mentioned relationship may also partially be elucidated by the protective nature of social support. Therefore, rape victims who believe that they have sufficient social support will have less exposure to high risk environments, where the victim will be vulnerable to the availability of substances (Mason, Ullman, Long, Long & Starzynski, 2009). In addition, an association between higher levels of perceived social support and lower substance use have been established in incarcerated individuals and community populations (Johnson & Zlotnick, 2012; Borelli, Goshin, Joestl, Clark & Byrne, 2010; Vranceanu et al. 2007; Kendler, Kuhn & Prescott, 2004; Peirce, Frone, Russell, Stice, Ragan & Randall, 2004; Simpson and Miller 2002). Thus the perceived availability of social support may positively or negatively affect the choice of coping strategy.

6.5 COPING STRATEGIES, SOCIAL SUPPORT AND PSYCHOLOGICAL FUNCTIONING ACCORDING TO PREVIOUS EXPOSURE TO TRAUMA

6.5.1 Hypothesis Four

The researcher hypothesized that there will be a significant difference between the coping strategies and psychological functioning of rape victims who previously experienced trauma and those victims that has not been exposed to previously experienced trauma.

The current study, based on mean scores, presented the tendency that the rape victims who reported previous exposure to trauma reported slightly higher somatic, anxiety/insomnia, social dysfunction and symptoms of severe depression. Therefore, those victims not exposed to previous trauma presented with lower psychological dysfunction than those victims that did report previous exposure. According, to Mueser and colleagues (1998), the presence of

severe symptomology and the diagnosis of PTSD is as a result of the number of traumas that participants' experience which would in turn affect the psychological functioning of the rape victim. This finding is in agreement with a number of trauma related theories (Bloom, 1999); as these participants may have been experiencing a number of factors that could affect their emotional responses and thus symptomology such as fight or flight, learned helplessness and loss of volume control. These factors may have influenced the choice of coping strategy and the intensity of the response to the rape experience which would in turn influence the psychological functioning of the woman (Seligman, 1972; 1975; Terr, 1990; Van der Kolk, 1989; Maier & Watkins, 2005). The use of a coping strategy and its relationship to psychological functioning will also depend on how well the coping strategy addressed the situation and the individual circumstances of the rape victim (Horwitz, Hill & King; 2011). In the case of previous traumatisation the presence of more severe symptomology will be expected and may in turn influence the choice of coping strategy or vice versa (Whiffen & MacIntosh, 2005; Bal et al, 2003; Polusny et al, 2004). Questions remain about the exact way in which these relationships influence the variables involved and should be further investigated.

6.5.2 Coping and previous trauma

The current study revealed a difference between rape victims who reported previous trauma and those that did not, on the utilization of the following coping strategies namely, self-distraction (showed a medium effect and statistically significant difference), substance use (small effect), emotional support and denial. Thus, the previously exposed victims, reported lower use of the aforesaid coping strategies. Hence, victims who were exposed to previous trauma scored higher on the use of planning and religion than those who did not. These differences may be related to counselling received after previous trauma experienced or other individual characteristics and suggests the need for further investigation. In this study

rape victims who reported receiving counselling also scored lower on some of the same abovementioned coping strategies of Self-Distraction, Substance Use (a medium effect), and Emotional Support (medium effect) and Denial than those who did not receive counselling and that may be related to the focus of counseling on the adoption of adaptive coping strategies (Sanderson, 2007).

6.5.3 Social support and previous trauma

The current study found a statistically significant difference between victims exposed to previous trauma and those who were not exposed to previous traumas. Rape victims exposed to previous trauma reported a lower overall level of perceived social support.

According to Kao et al (2014), that reported on incarcerated populations, any previous traumas including physical, sexual and crime-related traumas were associated with decreased levels of current perceived social support (Kao et al, 2014). In addition, a relationship between lower levels of perceived social support and higher levels of reported trauma exposure have also been found in the general population. Victims who reported previous interpersonal and other traumas were more likely to report lower levels of perceived social support than individuals who were not exposed to previous traumas (Golding et al. 2002; Muller, Gragtmans & Baker, 2008; Pepin and Banyard 2006). Thus there may be a reciprocal relationship between perceived social support availability and previous trauma exposure that should be further explored but is worth noting.

6.6 COPING STRATEGIES, SOCIAL SUPPORT AND PSYCHOLOGICAL FUNCTIONING ACCORDING TO INCIDENCE OF RAPE

6.6.1 Hypothesis Five

The researcher hypothesized that there will be a significant difference between the coping strategies, social support and psychological functioning of the rape victims that

reported being raped only once, and those who experienced previous rape incidences.

6.6.2 Psychological well-being and the incidence of rape

Sexual revictimisation or being raped more than once has been linked to the presence of more PTSD related symptoms than those victims who were raped only once (Classen, Palesh & Aggarwal, 2005). In addition, victims exposed to more than one rape experience reported an increase in depressive symptoms (Messman-Moore, Long, & Siegfried, 2000). Those victims exposed to more incidences of rape also experienced elevated anxiety levels (Walsh, DiLillo & Scalora, 2011; Cloitre, Scarvalone and Difede, 1997, Cloitre, Miranda, Stovall-McClough & Han, 2005).

The abovementioned, will in all likelihood lead to a decrease in psychological functioning. The current study showed a similar tendency; that rape victims who reported being raped more than once scored higher than those who reported being raped once. Those exposed to more incidences of rape scored higher on all GHQ subscales and GHQ Total, with GHQ Somatic Symptoms showing a small effect (Cohen $d = 0.25$). Thus, victims who were raped more than once reported increased symptomology and consequently, decreased psychological functioning. According to these findings multiple exposures to rape may complicate the healing process post rape and the factors that increase the risk of revictimisation should thus be explored and the influence thereof minimized if possible.

6.6.3 Coping and incidence of rape

Revictimisation has been linked to increased alcohol and substance abuse (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997) and increased dissociation (Walsh et al, 2011; Cloitre et al, 1997) as coping methods. Correspondingly, the current study revealed that rape victims who were raped more than once reported higher utilization of self-distraction, substance use, emotional support, planning and religion (small effect). These victims also reported lower utilization of denial than those who were only raped only.

A number of factors could affect the current functioning of the rape victim that may have been caused by the previous rape experience. She may exhibit exaggerated symptoms or inappropriate intensity of reaction and unhealthy patterns of behavior and coping caused by her inability to regulate her emotions and responses after the previous traumatic rape experience and this finding is thus in agreement with what is postulated by a number of trauma related theories (Bloom, 1999; Maier & Watkins, 2005; Terr, 1990; Van der Kolk, 1989; Seligman, 1975) but leaves some unanswered questions for further examination.

6.6.4 Perceived social support and incidence of rape

The current study also indicated that those rape victims who were raped only once reported higher levels of perceived social support from significant other and family. Conversely, those who were raped more than once reported higher levels of total perceived social support from significant others.

The research results pertaining to social support and revictimisation are unclear. However, the following has been established namely that revictimized rape victims were not as satisfied with their social relationships as non-revictimized victims. In addition, revictimized individuals may have more difficulty in relating to their social networks and thus be less capable to gain social support (Classen, Field, Koopman, Nevill-Manning & Spiegel, 2001). Previous research results also established that satisfaction with social relationships or perceived social support were a predictor of sexual revictimisation and rape (Collins, 1998). According to Ullman (1999) and Golding et al (2002) there is evidence that social support may have protective properties against the symptomology that rape victims may experience. In addition, revictimized rape victims tend to have less social support than non-revictimized individuals (Golding et al, 2002). These findings are in line with Campbell and colleagues' (2009) theoretical framework; the revictimization of these women may then influence the

way they interact with their environment on multiple levels and thus their access to social support.

6.7 COPING STRATEGIES, SOCIAL SUPPORT AND PSYCHOLOGICAL FUNCTIONING ACCORDING TO COUNSELLING RECEIVED

6.7.1 Hypothesis six

The researcher hypothesized that there will be a significant difference between the coping strategies, social support and psychological functioning of the rape victims who received counselling and those that did not receive counselling.

6.7.2 Counselling received and psychological well-being

Previous studies have demonstrated that receiving psychotherapy after experiencing trauma decreased PTSD symptoms (Bradley, Greene, Russ, Dutra & Weston 2005) and consequently, resulted in an increase in positive psychological functioning. The current study revealed a difference and small effect between rape victims who reported receiving counselling on all categories of psychological functioning (severe depression, anxiety/insomnia, social dysfunction). Thus victims who reported receiving counselling reported higher levels of psychological functioning than those who did not receive counselling. This may be seen as in congruence with Campbell and colleagues '(2009) theoretical framework that postulates that the different levels of functioning will influence each other; the individual or micro level that includes the current psychological functioning may be influenced by changes in the combined meso and ecosystems such as counselling intervention from the Rape Crisis Centre counsellors.

6.7.3 Counselling received and coping

The current study showed a difference between rape victims who reported receiving

counselling and those that did not. Rape victims who reported receiving counselling scored lower on the coping strategies of Self-Distraction, Substance Use (a medium effect), and Emotional Support (medium effect), Denial and Religion than those who did not receive counselling. According to Sanderson (2007), counselling and psychotherapy often focus on cognitive approaches for the treatment of rape victims. During psychotherapy the focus is on encouraging the adoption of adaptive problem-solving skills, positive appraisals of events, acquisition of knowledge and enhanced evaluation skills (Sanderson, 2007). These findings may be seen as in congruence with the theoretical framework of coping of Snyder and Pulver (2001) where rape victims will be less likely to engage in avoidant coping; including the use of strategies such as self-distraction, denial and substance use, when they feel that they have the necessary resources, in this case counselling support, to deal directly with the trauma of the rape. As for the decreased use of emotional support and religion as coping strategies, the relationship requires further investigation as well.

6.7.4 Social support and counselling received

The current study showed a difference between rape victims who reported receiving counselling. Those that received counselling scored higher on Social Support Total (small effect), Family (small effect), and Significant Others (medium effect). Counselling often encourages the establishment of and reliance on a good support network as an adaptive form of coping. The aforesaid, reduces feelings of isolation and increases the belief that one is capable of coping with the stressors they have experienced (Masi, Chen, Hawkley & Cacioppo, 2011). The differential susceptibility of these women and the social circumstances where counselling is available may have also contributed to making these women more or less susceptible to experiencing severe negative outcomes following the rape experience and

thus more likely to maintain strong social bonds (William, Ciarocchi & Deane, 2010; Belsky, 2013; Classen, Field, Koopman, Nevill-Manning & Spiegel, 2001).

6.8 CONCLUSIONS

This study offers the following conclusions:

Firstly, from the results obtained in this study, it is evident that specific coping strategies are related to psychological functioning and social support. However, the complex interactional relationships require further exploration.

Secondly, specific coping strategies may have both a positive and negative effect on psychological functioning.

Thirdly, social support may encourage the victim's choice to employ positive adaptive coping strategies and thus, increase psychological functioning.

Fourthly, previous trauma exposure may in diverse ways negatively influence the choice of coping strategy, the social support received and thus psychological functioning.

Fifthly, the presence of multiple incidences of rape may negatively influence the choice of coping strategy, the perceived social support and thus psychological functioning.

Lastly, counselling may encourage the use of more adaptive coping strategies and reliance on social support which will positively influence psychological functioning.

6.9 RECOMMENDATIONS FOR FUTURE RESEARCH

Further research is required on the choice of specific coping strategies and its relationship to psychological functioning. In addition, further exploration of the specific cultural and social factors that affect the psychological well-being of the specific population group is required.

The development of Setswana versions of the measures to apply in the population groups that is not fluent in English.

In addition, it is recommended that a more in depth study with a bigger sample be embarked on in order to gain generalizable results, and create possible intervention programs. This was not an intervention study but from the information obtained from this quantitative study, intervention programs should be explored, as counselling appeared to have contributed to the functioning of the rape victims and social support to the choice of more adaptive coping strategies.

Qualitative research may also add in-depth information on the experiences, coping mechanisms, support and overall psychological functioning of the rape victims. It may contribute by providing information on the experiences of these women and how to assist them in coping with the rape. Qualitative measures have much to offer researchers dealing with rape victims, and minority or marginalized groups. It is also important to note that a combination of methods to describe the experiences of the rape victims may also be beneficial for these victims. Therefore, researchers should not refrain from using all the tools available to elicit the essence of rape participants' experiences.

Based on existing research studies with rape victims, it may also now be the time to shift the focus of research to the dissemination of the research findings so that appropriate intervention programs may be instituted for rape victims.

6.10 LIMITATIONS OF THE STUDY

This study explored a population group that has not been well-researched but have experienced rape and the consequences of rape. Firstly, research into implications for rape victims is problematic, due to the highly sensitive nature of the topic and subsequent requirements for anonymity and confidentiality. It may be easy to envision superior research

designs, but as a result of the aforesaid constraints, it may be difficult to obtain participants that are willing to partake in such a study. Thus, whilst quantitative methods may offer important information, the study of rape victims will remain a difficult task.

Secondly, language and the availability of measures in Setswana (main language spoken by participants) and other languages may have influenced the statistical results. This quantitative study consisted of 50 participants ($n = 50$). This sample size is due to the sensitive nature of the topic and the possible vulnerability of the population as previously mentioned. However, given the sample size the results caution must be used in generalising the results of the present study, to the general population of rape victims.

Thirdly, the research participants were collected from the KOSH Crisis Centre in Klerksdorp, North-West Province. Data from other Crisis Centres may result in different research results.

There were also other possible areas of interest that became clear during the analysis of data and exploration of the results; thus another limitation of this study is its limited scope and the fact that only a number of hypotheses could be explored.

6.11 CONCLUSION

The findings of this study in context with past research have significant implications with regards to the psychological functioning of rape victims. One of the greatest challenges for South Africa is to develop a safe environment for rape victims, to access effective assistance in order to obtain positive psychological functioning. Therefore, it is important to keep in mind that within the category rape victims, there exist a vast group of people with varying socio-economic circumstances, possible mental health difficulties and other challenges that each has their own expectations and responses to trauma (Arndt, 2006). This study not only highlights the pressing need to continue, and increase efforts to address these

specific challenges but also the possibility of positively influencing the psychological functioning of rape victims through the use of adaptive coping strategies and social support.

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Appendix A

Informed Consent Form

Research project Title: The relationship between social support and coping skills of rape victims

Location of data collection: Tshepong Hospital, KOSH Crisis Centre

This research project is undertaken as part of a master's degree in Clinical Psychology at the North-West University, Mafikeng Campus.

Please consider this information carefully before deciding whether to participate in this research.

Purpose of the research: Investigation of the influence of social support and coping on the psychological functioning of rape victims.

What you will do in this research: You will be asked to fill in four separate questionnaires. These questionnaires will refer to basic biographical information, social support, coping and general health.

Time required: Participation will take approximately 60 minutes to two hours to complete depending on individual speed.

Risks: Risks are not anticipated with participation in this study. If you experience any emotional distress please make the researcher aware of that, the process will be ended and the necessary counseling provided.

Benefits: This research project may contribute to the literature available on social support and coping of rape victims specifically in a South African context.

Confidentiality: Your participation in this study will remain confidential and there will be no link between your responses and your identity except if you so wish, you will be assigned a code number in order to store the data.

Participation and withdrawal: Your participation in this study is completely voluntary, and you may withdraw at any time without penalty. You may withdraw by informing the researcher that you no longer wish to participate (no questions will be asked).

Publication of data: The data collected will be used as part of research thesis and may be published; confidentiality will be maintained and no identifying information will be given.

How to contact the researchers: If you have questions or concerns about your participation, or want to request a summary of research findings, please contact the researcher: Rothea Kruger, rothea_k@yahoo.com, 0723488462. For any problems related to this study, you may also contact the faculty member who is supervising it: Dr. Petro Erasmus, Petro.Erasmus@nwu.ac.za, 018 3892386.

Agreement:

I declare that the nature and purpose of this research have been sufficiently explained and I voluntarily agree to participate in this study. I understand that I am free to withdraw at any time without incurring any negative consequences.

Signature: _____

Date: _____

Name (print): _____

Section A

Biographical questionnaire:

Please answer all questions accurately and honestly by circling a number in a shaded box or by writing your answer in the shaded space provided.

For office use

Respondent's Number

A0

Question 1

Have you been a victim of rape?

Yes – only once	1		A1	
Yes – more than once	2			
No	3			

Question 2

How old are you at present?

			A2	
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Question 3

What is your current marital status?

Married	1		A3	
Separated	2			
Divorced	3			
Living together	4			
Never been married	5			

Question 4

What is your current work status?

Employed	1		A4	
Unemployed	2			

Question 5

What ethnic group do you belong to?

Black	1		A5	
Asian	2			
Coloured	3			
White	4			
Other	5			

Question 6

What is your highest level of education?

Primary school	1		A6	
High School (didn't complete matric)	2			
Matric	3			
Post matric qualification	4			
Degree	5			
Postgraduate qualification	6			

Question 7

Have you previously been exposed to other traumatic experiences?
(e.g. Hijackings, housebreakings, assault, domestic violence etc.)

Yes	1	A7	
No	2		

Please specify the traumatic experiences and state how old you were when these incidents happened:

Question 8

Did you go for any counselling after the rape?

Yes	1	A8	
No	2		

Question 9

If you answered yes to question 9, please specify when, where and how many times you went for counselling.

	A9	

Is there any other information you would like to share with the researcher?

Section B

Brief COPE

Instructions:

- These items deal with ways you've been coping with the stress in your life since you have been through the traumatic experience of rape.
- There are many ways to try to deal with problems but these items ask what you've been doing to cope with this one.
- Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it.
- Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently have been doing what the item says.
- Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it.
- Try to rate each item separately in your mind from the others.
- Make your answers as true FOR YOU as you can.

Please answer all questions accurately and honestly by drawing a cross in the appropriate box.

	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1. I've been turning to work or other activities to take my mind off things.				
2. I've been concentrating my efforts on doing something about the situation I'm in.				
3. I've been saying to myself "this isn't real".				

4. I've been using alcohol or other drugs to make myself feel better.				
5. I've been getting emotional support from others.				
6. I've been giving up trying to deal with it.				
7. I've been taking action to try to make the situation better.				
8. I've been refusing to believe that it has happened.				
9. I've been saying things to let my unpleasant feelings escape.				
10. I've been getting help and advice from other people.				
11. I've been using alcohol or other drugs to help me get through it.				
12. I've been trying to see it in a different light, to make it seem more positive.				
13. I've been criticizing myself.				
14. I've been trying to come up with a strategy about what to do.				
15. I've been getting comfort and understanding from someone.				
16. I've been giving up the attempt to cope.				

17. I've been looking for something good in what is happening.				
18. I've been making jokes about it.				
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.				
20. I've been accepting the reality of the fact that it has happened.				
21. I've been expressing my negative feelings.				
22. I've been trying to find comfort in my religion or spiritual beliefs.				
23. I've been trying to get advice or help from other people about what to do.				
24. I've been learning to live with it.				
25. I've been thinking hard about what steps to take.				
26. I've been blaming myself for things that happened.				
27. I've been praying or meditating.				
28. I've been making fun of the situation.				

Section C

The General Health Questionnaire (28-items scaled version)

Mark the appropriate block with a cross to indicate how frequently you have been feeling a certain way.

HAVE YOU RECENTLY:	Not at all	No more than usual	Rather more than usual	Much more than usual
1. Been feeling perfectly well and in good health?				
2. Been feeling in need of a good tonic?				
3. Been feeling run down and out of sorts?				
4. Felt that you are ill?				
5. Been getting any pains in your head?				
6. Been getting a feeling of tightness or pressure in your head?				
7. Been having hot or cold spells?				
8. Lost much sleep over worry?				
9. Had difficulty in staying asleep once you are off?				
10. Felt constantly under strain?				
11. Been getting edgy and bad-tempered?				
12. Been getting scared or panicky for no good reason?				
13. Found everything getting on top of you?				
14. Been feeling nervous and strung-up all the time?				

HAVE YOU RECENTLY:	Not at all	No more than usual	Rather more than usual	Much more than usual
15. Been managing to keep yourself busy and occupied?				
16. Been taking longer over the things you do?				
17. Felt on the whole you were doing things well?				
18. Been satisfied with the way you've carried out your task?				
19. Felt that you are playing a useful part in things?				
20. Felt capable of making decisions about things?				
21. Been able to enjoy your normal day-to-day activities?				
22. Been thinking of yourself as a worthless person?				
23. Felt that life is entirely hopeless?				
24. Felt that life isn't worth living?				
25. Thought of the possibility that you might make away with yourself?				
26. Found at times you couldn't do anything because your nerves were too bad?				

HAVE YOU RECENTLY:	Not at all	No more than usual	Rather more than usual	Much more than usual
27. Found yourself wishing you were dead and away from it all?				
28. Found that the idea of taking your own life kept coming into your mind?				

Section D

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the “1” if you **Very Strongly Disagree**

Circle the “2” if you **Strongly Disagree**

Circle the “3” if you **Mildly Disagree**

Circle the “4” if you are **Neutral**

Circle the “5” if you **Mildly Agree**

Circle the “6” if you **Strongly Agree**

Circle the “7” if you **Very Strongly Agree**

	1	2	3	4	5	6	7	
1. There is a special person who is around when I am in need.								So
2. There is a special person with whom I can share my joys and sorrows.								So
3. My family really tries to help me.								Fam
4. I get the emotional help and support I need from my family.								Fam
5. I have a special person who is a real source of comfort to me.								So
6. My friends really try to help me.								Fri
7. I can count on my friends when things go wrong.								Fri
8. I can talk about my problems with my family.								Fam
9. I have friends with whom I can share my joys and sorrows.								Fri
10. There is a special person in my life who cares about my feelings.								So
11. My family is willing to help me make decisions.								Fam
12. I can talk about my problems with my friends								Fri

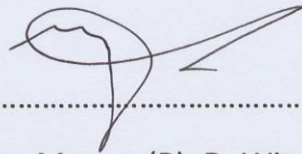
Thank you for your participation in this study!

Appendix C

Letter from the Editor

TO WHOM IT MAY CONCERN

I, Dr. Magdalena Josina van der Merwe (4303140036082) confirm that I have edited Rothea Kruger's dissertation/mini-thesis for the fulfilment of her Master's degree in psychology at UNW.



.....
MJ van der Merwe (Ph.D. Wits University); M.Sc. (UP)

10 February 2016



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11 February 2016

To Whom It May Concern

Re: Rothea Kruger

Dear: Sir/Madam

This is to confirm that I and Dr Magdalena Josina van der Merwe have proofread Miss. Krugers presentation.

I have suggested some corrections she complied and resubmitted to me.

I am satisfied with the dissertation.

Thank you

Dr. DM van der Merwe.