

**PSYCHOLOGICAL EFFECTS OF RAPE AND COPING  
STRATEGIES OF RAPE VICTIMS IN THE GAUTENG PROVINCE**

By  
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Dissertation submitted in partial fulfilment of the requirements for the  
degree

Master of Social Science (Clinical Psychology)

In the

Department of Psychology

(Faculty of Human and Social Sciences)

at the

North West University (Mafikeng Campus)



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Mafikeng

November 2012



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## ACKNOWLEDGEMENTS

I wish to express my sincere gratitude and appreciation to the following people:

The Lord Almighty for His guidance and unconditional love throughout my studies. To my first supervisor, Prof. Tholene Sodi for his guidance and my current supervisor, Dr. Choja Oduaran for her assistance. To my husband Simon, for his love and support and to my son Sizwe for his understanding and support. To my mother, Rosy Lebitso for being a shoulder to cry on when times were really tough and to my father, Tsietsi Lebitso for always believing in me, and to my siblings Dineo, Rebone and Thabang for their love and support.

## DECLARATION

I declare that:

**“PSYCHOLOGICAL EFFECTS OF RAPE AND COPING STRATEGIES  
OF RAPE VICTIMS IN THE GAUTENG PROVINCE”,**

is my own work and that all the resources used or quoted have been duly acknowledged by means of complete references, and that I have not previously submitted the thesis for a degree at another university.

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## ABSTRACT

This study investigated the psychological effects and coping strategies of women who were raped in the Gauteng province. The study aimed to determine the effects that rape has on the victims and to determine the coping strategies that the victims employ to deal with their ordeal.

Using a quantitative methodology the study was conducted among 100 female rape victims that were sampled from selected rape crisis centres in the Gauteng province. The researcher used the Trauma Symptom Checklist (TSC-40), as well as the Coping Strategies Inventory Short Form (CSI-SF) which are both standardised and validated instruments. The responses of the participants were analysed to determine which of them were more traumatised than others. To come to the conclusion of who was more traumatised than the other, a comparison of the rating of the Trauma Symptom Checklist (TSC) was done and consideration of all questions was taken. It was then determined how the more traumatised and the less traumatised used the coping strategies to deal with the negative emotions due to rape. This was done by analysing the coping strategies of each participant according to how they responded on each question on the Coping Strategies Inventory (SF).

Using means, standard deviations and regression analysis, the results revealed that a high number of rape victims had higher levels of trauma. This was indicated by their high scores on the dissociation, anxiety, depression, sexual abuse trauma index, sleep disturbance and sexual problems subscales of the TSC. Higher percentages of those, rarely engaged in problem focused coping and resorted to emotion focused coping instead. Those who had less trauma were found to be engaging more in problem focused coping.

The victims that had less trauma were found to be communicating effectively with other people and were engaging in positive thinking. Those who had high levels of trauma were found to be not interacting effectively with people in their immediate environment which may have influenced their emotion focused coping strategies. The results also revealed that emotional reactions and coping strategies are not affected by age and marital status of rape victims.

## **CHAPTER 1**

### **ORIENTATION AND BACKGROUND**

#### **1. INTRODUCTION**

The World Health Organisation (WHO) estimates that at least one in five women suffer rape or attempted rape during their lifetimes (WHO's study as cited by Pickup, Williams & Sweetman, 2001). The statistics on rape reported by the Crime Information Management Centre of the South African Police Service, indicate a gradual increase in reported rape cases for 1994 (42 429), 1995 (47 506) and 1996 (50 481). According to the SAPS's Crime Information Management (2009) in 2007 there were 8,073 reported incidences of rape in the Gauteng province alone. Although there is a decrease of reported rape cases in this province from 2001 to 2007 the number of rape cases is still too high considering what each woman has to go through when or after the act has been perpetrated on her.

In the SAPS's crime statistics currently available there is a slight decrease in the reported rape cases in the Gauteng province for 2009/2010 (SAPS, 2010). The Annual Report of the SAPS for 2009/2010 indicates a ratio decrease of -4,4%, from 144.8 sexual offences per 100 000 of the RSA population in 2008/2009 to 138.5 sexual offences per 100 000 in 2009/2010. This represents a decrease of 2 182 cases, from 70 514 to 68 332 (Rape Statistics, 2011).

According to a study done by the Medical Research Council in 2009, one in four men in South Africa have admitted to rape and many confess to attacking more than one victim, and three out of four rapists first attacked while still in their teens. The same study reported that only 7% of reported cases lead to a conviction.

The Medical Research Council's study which was conducted only in the Eastern Cape and Kwa-Zulu Natal provinces on a sample of 1738 men also found out that of those surveyed, 28% said they had raped a woman or girl, 3% said they had raped a man or boy, almost half of those who admitted to have raped said they had done so more than once, and 73% said they have carried out the assault before age 20 (Medical Research Council, 2009).

According to the South African Police Service (SAPS) statistics available for 2007, 5499 rape cases were reported in the Eastern Cape region alone while 6502 cases were reported in Kwa-Zulu Natal (Mhlongo, 2009).

It has long been suspected that women's sexual fantasies include rape fantasies, but after scientific investigation the interpretation has changed (Sichtermann, 1994).<sup>1</sup>

Every woman is vulnerable to rape, and according to the statistics the incidents of rape remain very high. It is these reports about the high levels of rape that motivated the researcher to embark on the present study which will focus on female victims only.

## **1.1 STATEMENT OF THE PROBLEM**

A woman who survives a rape ordeal can experience consequences of trauma such as irritation, flash-backs, and loneliness and may also have a changed relationship with her body and with men (Medica Zenica Women's Therapy Centre's study cited in Pickup, Williams & Sweetman, 2001). This can have long-term effects not only on the woman's physical and psychological health, but also on their fertility and sexuality (Pickup et al., 2001).

According to the Medica Zenica's psychologists, women survivors of rape arrived at the therapy centre 'feeling shame, guilt, and frequently with a mental block against speaking about rape or an unreadiness to receive help. In these instances, most of the women experience stomach pains, loss of appetite, difficulty concentrating, and feelings of indifference. Some women also reported being aggressive to their children, feeling separated from their bodies or constantly feeling an urge to bath themselves.' (Medica Zenica's study cited in Pickup et al., 2001, p.100).

The Medical Foundation for the Care of Victims of Torture conducted a study on the effects of rape on women of the Luwero Triangle in the sub-countries of Masulita and Wakiso in Uganda and found that five years after their ordeal, rape victims were still suffering considerably. The study found that a quarter of the women who were interviewed had no relationship at all with a man, due to the negative feelings following the rape. For those who were in relationships, half of them had not told their husbands or boyfriends about the rape, and two-thirds no longer enjoyed sexual relationships (Giller & Kabaganda, cited in Pickup et al., 2001).

In a study published by Burgess and Holmstrom (cited in Hazelwood & Burgess, 2001) 146 rape victims were interviewed at the emergency room in Boston Hospital. And when

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<sup>1</sup> The idea of rape was previously considered to sexually arouse women as well as men, however, rape fantasies are no longer considered to be evidence of women's elementary masochism but merely to be figurative transports which are part of normal sexuality.

contacted 4 to 6 years later they were found to be experiencing what is known as the rape trauma syndrome. This term is used to describe an acute phase and long-term reorganisation process that occurs as a result of forcible rape.

In the acute phase the victim experiences the physical injuries of the sexual assault, emotional problems and stress and in the reorganisation phase the victim tries to resolve feelings of guilt and fears that were generated by the trauma of the assault, and to rebuild a safe physical, emotional and social environment to function in (Bezuidenhout, 1998).

Rape Trauma Syndrome is considered to be a form of Post-Traumatic Stress Disorder. However, Rape Trauma Syndrome does not affect all rape survivors but the probability of symptoms associated with it occurring is high (Pickup et al., 2001).

Some victims of sexual assault experience a level of psychological distress that affects their daily lives and women are more likely to experience distress than men and to experience higher levels of distress. Whether sexually motivated or not, assaults are clearly associated with a significantly greater likelihood of distress if they are not witnessed, are located in the home, or are perpetrated by a relative or partner (Feehan, Nada-Raja, Martin & Langley, 2001).

According to Novello & O'Sullivan's study (2008) conducted at the University of Johannesburg on the victim's reactions to rape, it was found that rape can have an impact on the psychological and social functioning of the victim. These reactions include fear, anxiety, anger, aggression, hostility, guilt, shame, doubt, self-blame, depression, disruptions in self-esteem and grief. The rape victim also has to face the social implications of her trauma. The victim may experience social withdrawal and sexual dysfunction.

The crime of rape is still prevalently viewed in our society in terms of a collection of myths about rapists and rape victims. These include the notions that women enjoy "being taken" by force; that women provoke men by teasing them and therefore these women get what they deserve; that most rapes are committed by strangers who attack lone women on isolated streets or in dark alleys; and that women falsely accuse men of rape out of shame or revenge. These myths have led to strict rules of evidence in rape cases that essentially placed the burden of proof on the victim (Renzetti & Curran, 1995).

According to Renzetti & Curran (1995) there are societies that are considered "rape free", and the striking feature of these societies is their relatively egalitarian gender relations.

Women in these societies are not socially and economically dependent on men; they control resources and act as autonomous decision makers. In these societies nurturance and non-aggression are valued traits in individuals, and women are highly regarded for their wisdom and not their sexuality.

The researchers above focused on the physiological impact, the psychological impact and the social impact but none of them have focused entirely on the emotional reactions and coping strategies associated with rape which is what this study seeks to do.

## **1.2 AIMS AND OBJECTIVES OF THE STUDY**

### **1.2.1 Aim of the study**

The study investigated the psychological effects and coping strategies of women who are victims of rape in the Gauteng Province.

### **1.2.2 Objectives of the study**

Specifically, the objectives of this study were:

- a). To determine the emotional reactions associated with rape;
- b). To determine the impact of marital status on the emotional reactions and coping strategies of rape victims; and
- c). To determine the impact of age on the emotional reactions and coping strategies of rape victims.

## **1.3 HYPOTHESES**

This study was guided by the following hypotheses:

- a). Rape victims who are less traumatised will cope better than those who are highly traumatised.
- b). Single women who are victims of rape will report less negative emotional reactions and will consequently cope better than those who are married.
- c). Rape victims who are younger will report less negative emotional reactions and will therefore cope better than those who are older.

#### **1.4 SIGNIFICANCE OF THE STUDY**

It is hoped that this study would:-

- a). Contribute towards a better understanding of rape by family members of sexual assault victims. It would enable family members to better understand the victim's reactions to rape with the hope that this would enable them to provide the necessary support;
- b). Assist victims of rape to better understand their behavioural reactions following incidents of rape. This could help victims to understand their reactions as experiences that normally follow traumatic events such as rape;
- c). Contribute towards efforts aimed at identifying and developing coping strategies that could be used by the victims of rape; and
- d). Deepen the understanding of rape by psychologists and other mental health professionals, including institutions like rape crisis centres.

#### **1.5 SCOPE OF THE STUDY**

The researcher conducted the study in the Sedibeng District Municipality and included the City of Johannesburg Metropolitan Municipality. The researcher has selected only a few areas in the province for this study and this was due to the limited resources and time available to complete the study. The crisis centres visited in these areas were those deemed accessible to the researcher.

#### **1.6 LIMITATIONS**

The limitations of this study is that its findings are based only on a small range of women and some of the sample sizes were too small which can hamper the validity of the study. The study also focused only on adult women and failed to focus on whether rape has the same effects on minors. Many victims were reluctant to participate in the study even though their identity was to remain anonymous and most of them did not make any follow-ups on their counselling sessions which made it difficult for them to receive the necessary therapy which is meant to assist them to deal effectively with the negative emotional reactions due to rape.

## **CHAPTER 2**

### **2. THEORETICAL FORMULATIONS**

This chapter features the theoretical formulations that guided this study. It begins with the discussion of relevant and related theories and concludes with the definition of concepts.

#### **2.1 THE THEORIES OF COPING**

Through the process of daily living, people learn to use many methods to cope with anxiety and reduce tension. Lifestyles are developed around patterns of response, which in turn are established to cope with stressful situations. These lifestyles are highly individual and quite necessary to protect and maintain equilibrium (Aquilera, 1998).

It has not been unusual over the years to find the term coping used interchangeably with such similar concepts as adaptation, defence, mastery and adjustive reactions. Coping activities take a wide variety of forms, including all the diverse behaviours that people engage in to meet actual or anticipated challenges. In psychological stress theory, coping emphasises various strategies used, consciously or unconsciously, to deal with stress and tensions arising from perceived threats to psychological integrity. It is not synonymous with mastery over problematical life situations, rather, it is the process of attempting to solve them (Lazarus's study cited in Aquilera, 1998).

Coping is an adjustive reaction made in response to actual or imagined stress in order to maintain psychological integrity. Human beings are perceived as responding to stress by either attack, flight or compromise reactions. These reactions become complicated by various ego-defence mechanisms whenever the stress becomes ego involved (Coleman's study cited in Aquilera, 1998). Attack reactions usually attempt to remove or overcome the obstacles seen as causing tension in life situations. Flight, withdrawal or fear reactions may be as simple as removing the threat from the environment or removing oneself from the threatening situation. They might also involve much more complex psychological manoeuvring, depending on the perceived extent of the threat and the possibilities to escape. When either attack or flight from the threatening situation is thought to be impossible compromise or substitution reactions occur (Aquilera, 1998).

In situations of extended frustrations individuals find it increasingly possible to compromise for substitute goals. This often involves the use of defence mechanisms such as rationalisation (Masserman's study cited in Aquilera, 1998).

Tension-reducing mechanisms can be overt or covert and can be consciously or unconsciously activated. They have been generally classified into such behavioural responses as aggression, regression, withdrawal and repression. The selection of a response is based on tension reducing actions that successfully relieved anxiety and reduced tension in similar situations in the past. The response may through repetition pass from conscious awareness during its learning phase to a habitual level of reaction as a learned behaviour. In many instances the individual may not be aware of how let alone why he reacts to stress in given situations. Except for having vague feelings of discomfort, the individual may not notice the rise and consequent reduction in tension. Defence mechanisms are normally used constructively in the process of coping. This is particularly evident whenever there is danger of becoming psychologically overwhelmed. Almost all defence mechanisms are seen as important for survival. None is equated with a pathological condition unless it interferes with the process of coping, such as being used to deny, to falsify or to distort perceptions of reality (Aquilera, 1998).

The strength of the individual's conviction in his own effectiveness in overcoming or mastering a problematic situation determines whether coping behaviour is even attempted. People fear and avoid stressful, threatening situations that they believe exceed their ability to cope. They behave with assurance in those situations where they judge themselves able to manage and they expect eventual success. It is the perceived ability to master that can influence the choice of coping behaviours as well as the persistence used once one is chosen (Bandura's study cited in Aquilera, 1998).

Self-statements affect a person's behaviour in much the same way as statements made by another person. The adaptive and the maladaptive behaviours are linked to the person's inner dialogue. People need to modify the instructions they give to themselves so that they can cope more effectively with the problems they encounter (Meichenbaum's study cited in Corey, 2005). Although the psychosocial literature on coping with stress does not deal with self-statements, it does however, suggest that how one responds to stress in large part is influenced by how one appraises the stressor, or to what he attributes the arousal she feels, and how she assesses the ability to cope. A person's self-statements about the stress situation

and ability to handle it influence that person's behaviour in the situation. Anxiety level is related to such self-appraisals in relation to the situation. High anxiety is associated with a person's focusing on the self and her inadequacy and self-deprecating thoughts. Low anxiety is associated with a person's focusing on the external situation, with a resulting higher level of coping. One function of internal dialogue in changing affect, thought and behaviour is to influence the client's attentional and appraisal processes (Patterson, 1986).

## **2.2 THE THEORIES OF RAPE**

### **2.2.1 Feminist theory**

According to the feminist theories rape is considered to be the result of long and deep-rooted social traditions in which males have dominated nearly all important political and economic activities (Ellis, 1989).

Many feminist theories consider the exclusion of women from political decision-making processes to be one of the factors perpetuating rape and other forms of oppression against women. Such exclusion of women from the positions of political and economic power is premised on the false notion that women are unequal participants in interpersonal interactions (Ellis, 1989). Consequently, many feminists view the act of rape as a direct function of the degree to which women are politically and economically powerless relative to men (Davis; Herschberger & Metzger's study cited in Ellis, 1989). Rape is also considered a perpetuation of a view by men or even some women themselves that women are a property over which men compete (Clark & Lewis; and Dworkin's study cited in Ellis, 1989). The implication of the feminist theory is that reduction in sex disparities when it comes to political and economic power will either reduce rape or will increase it by frustrating males into using rape to re-establish their supremacy (Baron & Straus; and Gibbon cited in Ellis, 1989).

Feminists argue that rape cannot be understood in isolation from an analysis of the position of women and the notions of sexuality operating within a given culture. In western societies acts of rape and other forms of aggression against women are used as an implicit form of social control on women (Garrett, 1992).

### **2.2.2 The social learning theory of rape**

The social learning theory suggests that repeated exposure to almost any type of stimulus tends to promote positive feelings towards it (Ellis, 1989). According to Bandura (cited in Ellis, 1989) aggression is learned through imitation (modelling), and thereafter sustained largely through various forms of intermittent reinforcement. He also argued that models for aggression mainly come from three sources:

1. Primary associations with family members and peers;
2. One's culture and subculture; and
3. The mass media.

Social learning theory basically portrays rape as manifestations of aggressive behaviour toward women learned through four interrelated processes:

- By imitating rape scenes and other acts of violence toward women, as one may see in real life or as depicted in the mass media;
- By associating sexuality and violence, like in many pornographic and horror films where sex and violence are repeatedly depicted in the same context;
- By perpetuating rape myths; and
- By desensitising viewers to the pain, fear and humiliation of sexual aggression (Ellis, 1989).

### **2.2.3 The evolutionary theory of rape**

The evolutionary theory of rape considers sexual assault as resulting from natural selection for males who are eager to copulate with numerous sex partners and females who are strongly committed to retaining major control over who will mate with them. The pressure on males and females to select partners is considered to be largely emanating from the fact that males can produce offspring in potentially large number without gestating them, whereas females cannot produce large numbers of offspring and are expected to care for their offspring (Ellis, 1989).

Males will try to copulate with whoever they see as being a suitable partner and may even resort to aggressive methods of copulating if the female resists their attempts.

Copulatory tactics used by males are considered by evolutionary theorists to be more assertive than those used by females. Forced copulations therefore, reduce the ability for

females to confine coitus primarily to males who will help care for the offspring that they produce (Ellis, 1989).

### **2.3 SECONDARY VICTIMISATION**

According to Campbell & Raja (1999) victims of rape experience what is known as secondary victimisation or second rape. This is when the victims do not receive the assistance from legal, medical or mental health systems. It is also believed by some therapists that some community professionals engage in behaviours that are detrimental to rape survivors' psychological well being.

In one incident in Limpopo the police were exposed for not pursuing rape cases because they were considered to make their statistics look bad.

Another is that of a victim who was called a liar after reporting a rape incident and she was put into the same van as the alleged offender and later charged for rape herself (Times live, 2009).

According to Vetten (1997) rape survivors may be compressed into the crude category of either 'good' or 'bad' victim. This can have serious implications for the treatment women receive from the police, courts and medical professionals. For the rapist this may result in his conviction when the woman is a 'good' victim and an acquittal when she is 'bad'.

According to the above factors, it is obvious why many women do not report their ordeal to the police or to even speak openly about their experiences.

## **2.4 Theoretical perspectives on Post Traumatic Stress Disorder (PTSD)**

### **2.4.1 Cognitive appraisal models**

According to Janoff-Bulman cited in Peterson, Prout & Schwarz (1992) PTSD following victimization is largely a function of the shattering of basic assumptions that the victims held about themselves and the world. She identified three assumptions that the victims had held about themselves and the world, which are: 1. The belief in personal invulnerability; 2. The perception of the world as meaningful and comprehensible; and 3. The view of ourselves in a positive light.

### **The assumption of invulnerability**

People assume that they cannot be victimized and people who have been victimized can no longer think, "It can't happen to me." There is a marked sense of vulnerability and the fear that the same victimization can happen again.

The effect of altering the assumption of invulnerability becomes acutely clear in the finding that rape victims who experienced serious physical injury or the cognitive appraisal of life threat were almost three times likely to have developed PTSD than those who did not (Kilpatrick et al cited in Peterson et al., 1992).

### **The world as meaningful**

People generally regard the world as controllable, predictable and just. The victimization invalidates this assumption and forces individuals to search for new meanings and assumptions about the world and themselves to fit in with the new personal experience (Janoff-Bulman et al cited in Peterson et al., 1992). The result is that until equilibrium is re-established the world for the victim is not meaningful nor is it controllable or predictable. The need for meaning may force the victim into regressive irrational modes of thinking in order to find an answer (Peterson et al., 1992).

### **The self as worthy**

People operate under the assumption that they are decent people who do not deserve to be victimized. Once they have been victimized there are numerous sources that undermine their sense of self worth, these include:

- A sense of helplessness about the victimization;
- Further helplessness and confusion about the uncontrollable thoughts and feelings in reactions to the event, and
- Reasonable or unreasonable demands on the self to have been able to do more to prevent the event or to help (Peterson et al., 1992).

In the case of severe trauma the victim may be unable to assimilate the experience into the old personal theory of reality. Some degree of intrusive thoughts and anxiety are seen as natural and healthy responses and occur until the maximum amount of information has been assimilated and appropriate accommodation has occurred (Peterson et al., 1992).

## **2.4.1 A behavioural learning theory**

Classical conditioning and instrumental learning are used to explain the development of the basic pattern of PTSD. Concepts such as conditioning of cues, negative reinforcement and the incomplete exposure to memories help explain the complexity of the symptomatology.

### **Conditioning of cues**

A cue is a signal and determines when and where a person responds. Cues can be external events and can also be thoughts, particular people, specific times and so on. Cues can become organized into clusters, so that the specific combination of cues will determine the response. For example, darkness alone may not cause a rape victim to become afraid. It may take a combination of being alone and hearing footsteps to trigger the fear response (Peterson et al., 1992).

### **Negative reinforcement**

The experiences of trauma and its sequelae are generally aversive. According to the principle of negative reinforcement (NR), behavior that leads to a reduction in an aversive is reinforced and is likely to be repeated. NR can account for many of the associated features of PTSD. All of the avoidance behaviours and psychic numbing are mediated by NR. Behavioural disturbances such as anger and aggression, drug and alcohol abuse "are conceptualised as behavioural patterns that are functionally reinforced by their capacity to reduce aversive feelings" (Peterson et al., 1992).

### **Incomplete exposure to memories**

According to Keane et al cited in Peterson et al., 1992 constant exposure to conditioned stimuli does not lead to the extinction of conditioned responses. The conditioned stimuli match only part of the traumatic memory constellation; only repeated exposure to stimuli matching the original stimuli in its entirety could lead to extinction of resulting symptoms. Patients with PTSD actively avoid any possible complete exposure to stimuli resembling the original trauma, including the avoidance of thoughts associated with the trauma. This avoidance may also be reinforced by familial and cultural expectations for victim not to discuss the trauma (Peterson et al., 1992).

### 2.4.3 An information-processing model

Horowitz's model of PTSD builds upon classical and contemporary theories of trauma, but places a major emphasis on information processing and cognitive theories of emotion. Basic elements of the information-processing model includes:

- "information" (ideas, images, affect, etc.);
- A "completion tendency", in which important information is processed until reality and cognitive models match (i.e., the information must terminate or the cognitive model must be altered to incorporate the new information);
- "information overload": a situation in which new information cannot be processed; and
- "incomplete information processing": a state in which new information has only been partially processed and where the information remains in an "active form of memory" out of conscious awareness with concomitant influences on ego functioning (Horowitz's study cited in Peterson et al., 1992).

Catastrophic events involve massive amounts of internal and external information, most of which cannot be matched with a person's cognitive schemata because it lies outside the realm of normal experience. This results in information overload; the person experiences ideas, affects and images which cannot be integrated with the self (Horowitz's study cited in Peterson et al., 1992).

Since the person experiencing extreme traumatization cannot process the information, it is shunted out of awareness. It therefore remains in an unprocessed, active or raw form. Denial and numbing are employed as defensive mechanisms to keep the traumatic information unconscious. However, due to completion tendency the traumatic information does become conscious at times as part of the process of information processing. A person may therefore experience flashbacks, repetitive nightmares, unwanted thoughts and the like. Theoretically such intrusive psychic material continues to enter consciousness until the traumatic information is fully processed. When the ego experiences information overload during intrusive episodes, denial and numbing again come into play. Hence, there is an oscillation between intrusion and denial-numbing prior to full integration of traumatic material (Peterson et al., 1992).

## **2.5 FACTORS THAT MAY LEAD TO RAPE**

### **Date and Acquaintance rape**

According to Norris & Cubbins' study as cited in James and Gilliland (2005) alcohol consumption has been linked to acquaintance rapes and date rapes as a risk factor; and that if both members of a dating couple had been consuming alcohol, the rape was not judged as severely as when only the woman had been drinking where the man was likely to be viewed as taking advantage of a vulnerable woman.

### **Gang rape**

Gang rapists see rape as recreation, adventure and proving that they are "macho" and gang rape is seen as male bonding at its height (Sussman & Bordwell and Scully & Marolla's study cited in James and Gilliland (2005)).

## **2.6 DEFINITION OF CONCEPTS**

### **2.6.1 Rape**

Any person who unlawfully and intentionally commits an act of sexual penetration with another person without the latter's consent is guilty of the offence of rape (Snyman, 2008). Rape from a woman's perspective is the sexual invasion of the body by force, an incursion into the private, personal inner space without consent. It is an internal assault from one of several avenues and by one of several methods that constitute a deliberate violation of emotional, physical and rational integrity and is a hostile, degrading act of violence (Brownmiller's study cited by James & Gilliland, 2005).

### **2.6.2 Sexual Assault**

Sexual assault refers to a wider range of forced or pressured sexual contact, specifically, child sexual assault, incest, acquaintance rape or marital rape (Hazelwood & Burgess, 2001).

### **2.6.3 Date Rape**

Date rape is the rape of a female by a male during a date (Bezuidenhout, 1998). Date rape occurs when the victim and the perpetrator are known to each other and are either dating or out on a date.

#### **2.6.4 Gang Rape**

Gang rape occurs when a woman is raped by two or more men (Bezuidenhout, 1998). During the rape the men take turns in raping the woman and the woman can only be released when the perpetrators have satisfied themselves with her.

#### **2.6.5 Marital Rape**

It occurs when a wife refuses to have sex with her husband and he forces himself on her (Bezuidenhout, 1998). Marital rape may not be considered as an offence especially in patriarchal societies where a wife is expected to submit to her husband all times. A woman is expected to do whatever her husband asks her to do and many women may not report the sexual assault to the police in fear of being ostracised even by their own families.

#### **2.6.6 Statutory Rape**

It is regarded as sexual intercourse with a child under the legal age of consenting (Bezuidenhout, 1998). Sexual intercourse with a minor is a criminal offence even if the minor has consented to it.

#### **2.6.7 Stranger rape**

Stranger rape is the rape of a victim by a person not known to the victim (Bezuidenhout, 1998). This type of rape occurs when the perpetrator is someone that the victim sees for the first time during the sexual assault.

#### **2.6.8 Acquaintance rape**

Acquaintance rape is the rape of a victim by a person who is known to the victim (Bezuidenhout, 1998). This type of rape can be perpetrated by anyone whom the victim knows. It can be a neighbour, friend or colleague.

#### **2.6.9 Coping strategies**

The set of behaviours and attitudes that a person may use to mediate difficult internal and external demands (Siquera, Diab, Bodian & Rolnitzky's study cited in Theron, 2002).

### **2.6.10 Emotional reactions**

A reaction to a particular intra-psychic feeling or feelings, accompanied by physiological changes that may or may not be outwardly manifested but that motivate or precipitate some action or behavioural response (Farlex, 2010).

### **2.6.11 Defence mechanisms**

The psychological defences used to prevent socially unacceptable impulses from rising into consciousness (Nevid, Rathus & Green, 2006). A defence mechanism is a strategy used to cover up or change unconscious desires and wishes that may be inappropriate or difficult to express (Tull, 2012). Socially acceptable learned behaviours enable a person to interact with others in ways that elicit positive responses and assist the person in avoiding negative responses (Elliot, Racine & Busse's study as cited in Bellini, 2007).

## CHAPTER 3

### 3. LITERATURE REVIEW

In this section the researcher will discuss the prevalence of rape in South Africa; the effects of rape; the coping strategies and the defence mechanisms used by victims; the factors that make other victims vulnerable to PTSD as well as the hypotheses that are guiding this study.

#### 3.1 PREVALENCE STUDIES

According to Statistics South Africa (2008) the statistics of rape have gone up over the past five years (from 2002 to 2006); (see the Table 1 below), and this is on trend with the rest of the world. About 450 000 rape cases go unreported in the country every year. A study conducted by the National Institute of Crime Rehabilitation reported that only one in twenty rapes are reported, resulting in over 494 000 rape incidences a year (Statistics South Africa, 2008). This suggests that approximately one thousand and three hundred women can be expected to be raped a day in South Africa. Equally worrying are the findings of a study by which it was found that South Africa leads the world in rape cases. And a woman is raped every 17 seconds in South Africa (Statistics South Africa, 2008).

**Table 1**

*Rape Cases Reported in South Africa- from South African Police Services*

<b>Year</b>	<b>Reported cases</b>
2002	54 293
2003	52 425
2004	52 733
2005	55 114
2006	54 926

(Source: Statistics South Africa, 2008)

The statistics above are an indication that rape in the country is extremely high. This suggests that many women or girls in this country can expect to be raped at some point in their lives, either by a stranger or by someone they know very well. The legal system in South Africa seems to be inefficient in dealing with issues regarding violence against women and children because more and more rape incidences are still taking place. This could be the major reason why thousands of victims do not even report the sexual assault to the police in the first place, they know that they may not be assisted in any way and may only be victimised again by the system itself.

It was stated in the Annual Report of the SAPS for 2008/2009 that fully valid comparisons pertaining to the sexual offences will only become possible after the period 1 October 2009 to 31 March 2010. In the 2008/2009 Annual Report, a 10,1% increase was indicated. This report for 2009/2010 indicates a ratio decrease of -4,4%, from 144.8 sexual offences per 100 000 of the RSA population in 2008/2009 to 138.5 sexual offences per 100 000 in 2009/2010. This represents a decrease of 2 182 cases, from 70 514 to 68 332 (Rape Statistics, 2011).

Comparisons between these figures of 70 514 and 68 332 cases and the figures of previous years are extremely difficult and even impossible because sexual offences as presently defined differ substantially from those recorded in the past, prior to December 2007. These now include a widened definition of rape (encompassing the formerly exclusive concept of vaginal rape, as well as adding oral and anal rape and thus also male rape; which previously fell under the category of indecent assault) (Rape Statistics, 2011).

If all sexual offences cases registered in 2009/2010 which would have qualified as rape and indecent assault cases before 16 December 2007 are identified and counted, the results adds up to 55 097 cases. If this figure is compared to the last combined rape and indecent assault figures recorded for 2006/2007, which stood at 61 984 cases, a decrease of -11,1 % is actually noted. This implies an average annual decrease of -3,7% from 2006/2007 to 2009/2010 (Rape Statistics, 2011).

Table 2 below depicts the reported rape cases in the Gauteng province from 2003/2004 to 2009/2010.

<u>Years</u>	<u>Reported cases</u>
2003/2004	16,137
2004/2005	16,054
2005/2006	15,362
2006/2007	14,820
2007/2008	15,074
2008/2009	18,176
2009/2010	15,645

(SAPS, 2010)

From the above statistics currently available from the SAPS crime statistics, it is clear that the incidents of rape are very high in the Gauteng province although there seems to be a slight decrease on the reported cases. It is obvious that a lot still needs to be done to put an end to this epidemic that women in this country are faced with on a daily basis.

### **3.2 THE EFFECTS OF RAPE**

The victim experiences many negative psychological reactions due to rape and amongst them is self-blame. There are two main types of self-blame: behavioural self blame and characterological self-blame. The victims who experience behavioural self-blame feel that they should have done something different and as a result feel at fault. Victims who experience characterological self-blame feel that there is something inherently wrong with them, which had caused them to deserve to be assaulted (Wikipedia, 2011).

They also experience shame, which is connected to psychological problems such as eating disorders, substance abuse, anxiety, depression and other mental disorders. The counselling responses that were found to be helpful in reducing self-blame were supportive responses, psycho-educational responses such as learning about Rape Trauma Syndrome and those responses addressing the issue of blame. Cognitive therapy has also been found to be a helpful type of therapy for self-blame (Wikipedia, 2011).

Victims of rape are more likely to attempt or commit suicide. The experience of being raped can lead to suicidal behaviour as early as adolescence. In Ethiopia 6% of raped schoolgirls

reported to have attempted suicide and also felt embarrassed to talk about their ordeal (Wikipedia, 2011).

The victims of rape usually suffer intense emotional reactions after the rape. These can be described as the personal crises wherein the victim relives the fear, agony or anxiety mixed with emotional numbness. These reactions occur days or weeks after the rape and decrease after two to six months for most rape victims. However, the disturbing emotions combined with low self-respect and sexual dysfunction may last for a year or more for some (Rautio, 2008).

According to a study conducted by Burgess and Holmstrom cited in Slaikau (1990) a significant percentage of the victims of rape attempt suicide or abuse drugs and/or alcohol. The women also experienced sex related anxieties, difficulties experiencing any sexual feelings or being orgasmic during sex and had flashbacks during intercourse. The victims also had a preoccupation with negative opinions of significant others and experienced increased sadness.

A high percentage of victims of rape have a fear of men and display hostility towards men (Media & Thompson's study cited in Slaikau, 1990). Women who have been raped have trouble sleeping and cry frequently, they report eating problems, cystitis, headaches, irritability, mood changes, anxiety and depression. They may become withdrawn, sullen, and mistrustful and may at least partly blame themselves which can lead to feelings of guilt and shame ( Koss et al. as cited in Nevid et al., 1990).

The experience of rape challenges and may even transform the victim's identity and the assumptions she makes about the world. The emotional impact is manifested largely as fear, anxiety, depression, sexual dysfunction and feelings of isolation (Karmen, 1990).

The experience of being treated as an object instead of a person can plunge the woman into a "rape crisis syndrome." The acute initial stage of this syndrome lasts for about two to three weeks immediately following the ordeal and is marked by sleeplessness, nausea, tension headaches, fear, fury, embarrassment and self-recrimination. The second stage in which the victim's personality integrates, can last much longer and is characterised by recurring nightmares, defensive reactions, phobias, and strains in the victim's sex life and in relationships with men in general (Burgess & Holmstrom's study cited in Karmen, 1990).

The women who are raped can suffer from PTSD because they can re-experience their crises over and over again in day dreams, flashbacks or nightmares. Other symptoms of PTSD may include a desire to avoid things that remind one of the trauma, feeling different, a general lack of interest or enthusiasm, an inability to concentrate and increased irritability (Williams' study cited in Karmen, 1990).

The woman who is raped may respond to the assault by exhibiting no emotions or appearing unaffected. She may suffer immediate psychological injury as well as long-term trauma. Victims may experience fantasies, day dreams or nightmares of having additional encounters with the assailant or may have mental images of scenes of revenge. The victim may be reluctant to discuss the assault with family members, friends and others because of the risk of rejection and embarrassment. The woman who is raped will never be the same even though over time, they develop ways to recover, cope and go on with their lives (James & Gilliland, 2005).

### **3.3 COPING STRATEGIES USED BY VICTIMS**

Women who are victims of rape employ certain coping strategies which can be both positive and negative to assist them to cope with their experience and to continue with their lives. Burgess & Holmstrom cited in Kleinke (1998) listed the following coping strategies that rape victims reported to employ:

- Seek reasons for why the rape occurred;
- Minimise the impact of the rape by telling themselves that it was not really so terrifying;
- Suppress their reactions to the rape by refusing to think about it;
- Keep busy and engage in activities;
- Use self-relaxation and meditation to reduce stress;
- Withdraw from other people; and
- Use drugs and alcohol.

In a study conducted by Meyer & Taylor cited in Kleinke (1998) among the least effective coping strategies used by victims were withdrawing from others and staying isolated; suppressing one's feelings and minimizing the impact of the rape did not seem to hurt, but it also did not help. Among the most effective coping strategies were techniques that involved

some form of stress reduction, such as self-relaxation, physical activity and rational thinking; and also using support systems that suit one's needs.

The victims that suffered most from depression, anxiety and sexual dysfunction were those who had negative thinking and blamed themselves for their ordeal. At least half of the women rape victims blame themselves for their ordeal and take personal responsibility for the fact that they had been raped. Much of this self-blame is said to result from the fact that people like to believe that they live in a fair and just world and to believe in this kind of world, it is necessary to convince yourself that you must somehow deserve your plight (Kleinke, 1998). The victims who feel responsible for rapes may dwell on the circumstances of the rape and what they might have done differently. By focusing on these issues, it may be difficult for victims to resolve their feelings about what they have experienced and move on to other concerns (Abbey's study cited in Frieze & Bookwala, 1996).

According to Janoff-Bulman's study cited in Frieze & Bookwala (1996) behavioural self-blame, especially in the absence of characterological self-blame, may be adaptive for the victim's coping and recovery. She found that victims who made characterological attributions saw their victimisation as more deserved, whereas those who attributed their rapes to behavioural factors were more confident about avoiding future rapes.

However, more recent research has failed to replicate the association between behavioural self-blame by victims and adaptive outcomes. In one study both behavioural and characterological self-blame has been associated with more depression after victimization (Frazier's study cited in Frieze & Bookwala, 1996).

**Self-help:** Victims may respond to the challenges of regaining control by immersing themselves vigorously into life's activities. The victim may relocate to a new place, change a career or install a new home security system in order to implement changes in her life. These activities may convey to victims quite concretely that once again they have control over the activities and events of their lives (Janoff-Bulman's study cited in Frieze & Bookwala, 1996).

Avoidance of social contact and staying home rather than going out whenever possible have also been reported strategies used by rape victims (Scheppelle & Bart cited in Frieze & Bookwala, 1996).

**Family and friends:** Positive social support after victimisation is very important to the traumatised victim (Cobb; Silver & Wortman's study cited in Frieze & Bookwala, 1996).

Family members and friends assist the victim first by being available to talk with the person after the event, they allow the victim to express emotions. Having companions and being able to disclose one's feelings about the event have been found to be highly important for successful coping (Greenberg & Stone; Pennebaker & Bealle's study cited in Frieze & Bookwala, 1996).

Formal help givers: Victims of crime can get help from formal helpers who provide psychotherapy and the criminal justice system. If the offender is caught and punished for the crime, this can reduce the victim's sense of injustice and can re-establish the victim's sense of control and feelings of safety (Frieze & Bookwala, 1996).

### **3.4 DEFENCE MECHANISMS USED BY VICTIMS**

Defence mechanisms such as denial, dissociation and suppression are common among rape victims. Suppression is used to block out the strong emotions and therefore escaping the painful feelings for a short time, which can be psychologically exhausting. Denying or putting the worst parts of the assault out of the memory allow the victim to avoid the immediate distress (Rautio, 2008). Even though traditionally denial has been considered to be a maladaptive coping strategy because it interferes with the accurate interpretation of reality, some researchers propose that denial can be adaptive in protecting the victim from being too overwhelmed by the event (Horowitz; Janoff-Bulman & Timko's study cited in Frieze & Bookwala, 1996).

Dissociation is a defence mechanism which may be employed during painful psychological or physical abuse impossible to escape, and as a survival strategy it provides a feeling of leaving one's body making the trauma harder to remember especially the details. Defence mechanisms such as these may affect the victim's ability and motivation to talk about the abuse suffered (Rautio, 2008).

### **3.5 WHAT MAKES SOME VICTIMS MORE VULNERABLE TO PTSD?**

Personality has been considered to be a factor that contributes to the development of PTSD following a violent attack. One personality that might be related to the risk of violent attack and/or increasing the development of PTSD once the woman has been sexually assaulted is the trait of sensation seeking. It should however be clear that the perpetrators always bear the moral responsibility for violent attacks to avoid blaming the victims for the attacks (Kilpatrick, Resnick, Saunders & Best, 1998).

According to Zuckerman's study (as cited in Kilpatrick et al., 1998) sensation seeking is a personality trait defined by the need for varied, novel and complex sensations and experiences and the willingness to take risks for such experiences. High sensation seekers are more vulnerable to assault because they are more likely than low sensation seekers to engage in high risk behaviours; they appraise most situations as less risky than low sensation seekers; and they are more adventuresome in phobic situations that make low sensation seekers anxious, fearful and avoidant. These behaviours might result in potential attackers having greater access to high sensation seeking women than low sensation seeking women.

In a study that was conducted by Kilpatrick et al., (1998), the victims that had no prior history of assault had a significantly lower rate of PTSD than those who had a history of one or more prior assaults. And regardless of the prior history of assault, the PTSD rate within the group that had experienced a new assault was higher than the group that had not experienced a new assault. Age was also significantly associated with current PTSD as those with current PTSD were significantly younger than those without current PTSD. Those victims who were students or unemployed also had a higher rate of PTSD.

## **CHAPTER 4**

### **4. RESEARCH METHODOLOGY**

#### **4.1 RESEARCH DESIGN**

This was a quantitative study that sought to collect and analyse data from many respondents who have been victims of rape. A quantitative research is a means for testing objective theories by examining the relationship among variables. These variables, in turn, can be measured, typically on instruments, so that the numbered data can be analyzed using statistical procedures (Creswell, 2009). A survey research was used for this study whereby respondents in the rape crisis centres were given questionnaires to fill in. A survey research is the administration of questionnaires in a face-to-face interview, over the phone, through the mail or other self-administered formats, to a sample of respondents selected from some population (Babbie & Mouton, 2001). The advantage of questionnaire survey is that it is considered to be a useful way to obtain information about sensitive topics (Chadwick, Bahr & Albrecht, 1984).

##### **4.1.1 The Dependent and Independent variables**

The dependent variables in this study are the measured behaviour of the subjects assumed to be caused by an independent variable. The variable that is considered to be the “cause” is the independent variable and the variable considered to be the “effect” is the dependent variable (Cozby, 1993). In this study the independent variable is the rape experience, and the coping strategies and the emotional reactions of rape victims are the dependent variables.

#### **4.2 SAMPLING TECHNIQUE**

The crisis centres which were covered included the organisations such as the Alpha Trauma Centre and Life line centres in Gauteng province because these are the well known and more accessible to the general public. Respondents for this study were obtained through non-probability sampling and convenience sampling techniques. Convenience sampling involves selecting respondents primarily on the basis of their availability and willingness to respond (Shaughnessy, Zechmeister & Zechmeister, 2009). Convenience sampling technique was used because the population of this study was difficult to obtain; the issue that was dealt with was highly sensitive. The advantage of the non-probability sampling is that it is less

complicated to set up and is generally acceptable since there is no intention or need to make a statistical generalisation to any population beyond the sample to be surveyed (Robson, 1993).

The respondents in this study comprised 100 women as the study was focusing on female rape victims only. The victims had experienced their ordeal at least three months prior to participating in the study. To get this sample from the population the researcher asked only women who were willing to participate in the study to fill in the questionnaires until the required number of participants was reached. The data collected revealed the women who were more traumatised and badly affected emotionally than others and then the coping strategies of both groups were determined. The respondents were made up of women found at rape crisis centres covered. The women were in the age range of 18 and above because the researcher avoided using minors as they would have required permission to participate in the study from their parents, which would have been time consuming.

#### **4.3 INSTRUMENTATION**

The research instruments that were used to conduct this study are the adapted version of the Briere & Runtz's (1996) Trauma Symptom Checklist (TSC-40) and the Coping Strategies Inventory Short Form (CSI-SF) (see **Appendix D**). The TSC-40 is a 40-item self-report instrument consisting of six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index (SATI), Sexual Problems, and Sleep Disturbance, as well as a total score.

The CSI-SF is a 16 item questionnaire and was structured to reflect the original scale, with four 4-item subscales: (a) Problem-Focused Engagement, (b) Problem-Focused Disengagement, (c) Emotion-Focused Engagement, and (d) Emotion-Focused Disengagement. Emotion-focused coping emphasizes the regulation of one's affective response, whereas Problem-focused coping emphasizes management of the stress-producing situation. The engagement refers to approach-related actions that result in confronting the stressors and the disengagement refers to avoiding to confront the stressors. Emotion-focused coping emphasises the regulation of one's affective response, whereas Problem-focused coping emphasises management of the stress producing situation (Addison, Campbell-Jenkins, Sarpong, Kibler, Singh, Dubbert, Wilson, Payne, & Taylor, 2007).

### **4.3.1 Reliability of a measuring instrument**

A reliable measuring instrument is one which consistently produce the same reading for the same amount (Coolican, 1999). The subjects were given the same questionnaires to ensure the reliability of the study. The researcher checked the questionnaires before collecting the data to ensure that they indeed measured what they were intended to.

### **4.3.2 Validity of a measuring instrument**

A measuring instrument is considered to be lacking in validity if it does not measure what it is originally intended (Coolican, 1999). The studies that have used the TSC-40 (Whiffen, Benazon & Bradshaw; Zlotnick, Shea, Begin, Pearlstein, Simpson & Costello cited in Briere & Runtz, 1996), indicate that it is a relatively reliable measure and has predictive validity with reference to a wide variety of traumatic experiences. The studies that have used the CSI-SF (Addison et al., 2007) indicate that it is an adequate measure of coping.

### **4.3.3 Pilot study**

According to Coolican (1999) piloting refers to trying out a prototype of a study or questionnaire on a small sample in order to discover snags or errors in design or to develop a workable measuring instrument.

The researcher did not conduct the pilot trials because the measuring instruments used have been used by other researchers previously and were found to be both reliable and valid.

## **4.4 DATA COLLECTION**

To collect the data, the victims were visited at the selected rape crisis centres in Gauteng province. They were each given a questionnaire to fill in and their responses were recorded (see **Appendix D** for the Questionnaire).

## **4.5 DATA ANALYSIS AND PROCEDURE**

Analysis refers to establishing what the findings are and how they answer the research questions (Barker, Pistrang & Elliot, 1998). In the proposed study the data was analysed by using the Statistical Program for Social Sciences (SPSS) version 18.0. The analysis was done using t-test, multiple regression and ANOVA; and the results were presented using frequency tables, histograms and graphs. These statistical measures were used to determine whether the categorical variables obtained from the collected data differ from each other (Cozby, 1993).

## Regression analysis

### Assumptions of regression analysis

#### i. Variables are normally distributed

Non-normally distributed variables (highly skewed or kurtotic variables, or variables with substantial outliers) can distort relationships and significance tests.

#### ii. Linear relationship between the independent variable and dependent variable

Linear Regression can only accurately estimate the relationship between dependent and independent variables if the relationship is linear in nature. As there are many instances in the social sciences where non-linear relationships occur, it is essential to examine analyses for non-linearity. If the relationship between independent variables and the dependent variable is not linear, the results of the regression analysis will *under-estimate* the true relationship.

#### i. Variables are measured without error

Many variables we are interested in are difficult to measure, making measurement error. This unreliable measurement can cause the relationship to be *under-estimated* increasing the risk of Type II errors.

#### ii. Homoscedasticity

Homoscedasticity means that the variance of errors is the same across all levels of the independent variable. When the variance of errors differs at different values of the independent variable, heteroscedasticity is indicated, and this can lead to serious distortion of findings and seriously weaken the analysis – thus increasing the possibility of a Type I error.

One major assumption underlying a t-test is that Z follows a standard normal distribution under the null hypothesis and in the t-test comparing the means of two independent samples, each of the two populations being compared should follow a normal distribution.

Preferably, the two sample sizes should be equal; otherwise, the t statistic to test whether the means are different can be calculated as follows:

$$t = \frac{\bar{X}_1 - \bar{X}_2}{S_{12} \cdot \sqrt{\frac{1}{n_1} + \frac{1}{n_2}}}$$

where

$\bar{X}_i$  is the sample mean for sample  $i$ .

$S$  is the pooled standard deviation, and

$N$  is sample size

### **The regression equation**

Consider the model

$$Y = \alpha + \beta x + e$$

where  $x$  is a non-random variable and  $e$  is a random error distributed with mean zero and variance  $\sigma^2$ .

Fitting a straight line to the scatter diagram leads to a regression line  $\hat{y} = a + bx$ , where  $a$  is an estimate of  $\alpha$  in the model and  $b$  is an estimate of  $\beta$ , and  $\hat{y}$  is the estimate of  $y$ .

### **iii. Analysis of variance (ANOVA)**

#### **Assumptions**

- i. Independence of cases – this is an assumption of the model that simplifies the statistical analysis.
- ii. Normality – the distributions of the residuals are normal.
- iii. Equality (or "homogeneity") of variances, called homoscedasticity – the variance of data in groups should be the same. Model-based approaches usually assume that the variance is constant.

The null hypothesis  $\mu_1 = \mu_2$  is tested using the two-sample t-test. If we have more than 2 groups or population means to compare, we use the analysis of variance technique. The data used in the analysis of variance are usually sample data from different populations. The observations are  $y_{ij}$ ,  $i = 1, 2, 3, \dots, k$  and  $j = 1, 2, \dots$ , where  $k$  represents the number of groups and  $n_i$  the observations in each group.

ANOVA separates the variation in the sample data into two independent components; one of them reflecting variation between groups and the other variation within groups.

The within groups component is

$$\sum_i \sum_j (y_{ij} - \bar{y}_i)^2$$

And the between groups component is

$$n_i \sum_i (\bar{y}_i - \bar{y}_{..})^2$$

where  $\bar{y}_{..}$  is the grand mean.

The total variation is

$$\sum_i \sum_j (y_{ij} - \bar{y}_{..})^2$$

and we have the identity

$$\sum_i \sum_j (y_{ij} - \bar{y}_{..})^2 = \sum_i \sum_j (y_{ij} - \bar{y}_i)^2 + n_i \sum_i (\bar{y}_i - \bar{y}_{..})^2$$

which can be read as:

Total variation (total sum of squares) = Within sum of squares (SS) + Between groups SS  
abbreviated as

$$TSS = SSE + SST.$$

The technique partitions the total sum of squares (abbreviated SS) into components related to the effects used in the statistical model. For a simplified ANOVA with one type of treatment at different levels,

$$SS_{\text{Total}} = SS_{\text{Error}} + SS_{\text{Treatments}}$$

*ANOVA Table*

Source	SS	DF	MS	F
Treatments	SST	k-1	SST / (k-1)	MST/MSE
Error	SSE	N-k	SSE / (N-k)	
Total (corrected)	SS	N-1		

Where

SS = Sum of squares

DF= Degrees of freedom

MS=Mean square

F=F ratio

The ANOVA table is used to test hypotheses about means. For this study, the null hypothesis was:

$$\mu_1 = \mu_2 = \dots \mu_k$$

The alternative hypothesis was

$$\mu_1 \neq \mu_2 \neq \dots \mu_k$$

where

$\mu_i$  = the population mean of group i

K = Number of groups to be compared

The calculated F-ratio in the ANOVA table is compared with the critical F-ratio obtained from the F table. If the calculated F-ratio is greater, the hypothesis is rejected, otherwise it is not rejected. Alternatively, the probability value associated with the calculated F-ratio is compared with the level of significance. If it is lower, then the hypothesis is rejected, otherwise it is not.

#### **4.6 ETHICAL CONSIDERATIONS**

In conducting this study, the ethical principles of informed consent (see **Appendix B**), confidentiality and privacy were observed. The participant's identity remained anonymous to guarantee the wellbeing of the participants and only numbers were used to identify the participants. To obtain the data from the victims, the researcher asked for permission to conduct the study from the managers of the crisis centres. See **Appendix A, Appendix B and Appendix C**. The researcher provided the participants with full information about the research project and also emphasised the voluntary nature of the engagement. In line with the ethical research guidelines provided by Coolican (2005), the participants were assured of their right to withdraw from the research project at any time they wished to do so. Furthermore, the researcher provided debriefing services to the participants who needed such support after revealing painful emotions during the interviews. The research has also been approved by the North West University Ethics Committee.

## **CHAPTER 5**

# **RESULTS, DISCUSSION, CONCLUSION AND SUGGESTION FOR FURTHER RESEARCH**

## **5.1 RESULTS**

### **Introduction**

The results presented in this chapter are structured according to the objectives and the hypotheses of the study. The objectives include, to determine the emotional reactions associated with rape, to determine the impact of marital status on the emotional reactions and coping strategies of rape victims; and to determine the impact of age on the emotional reactions and coping strategies of rape victims. The results incorporated the demographic data of the participants, emotional reactions associated with rape and the coping strategies reported by the participants.

### **5.1.1 Demographic data of the participants**

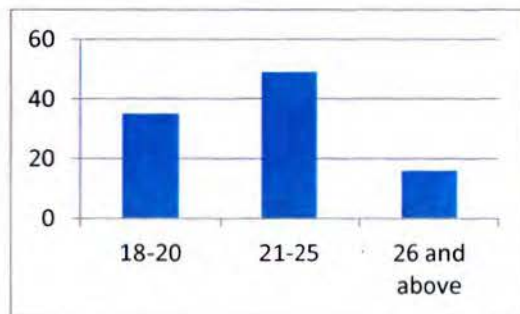
A total of 100 psychometric instruments inclusive of demographic data, TSC-40 and CSI-SF scales were distributed to and returned by participants. The demographic data incorporated age, race group, occupation, home language and marital status of participants as indicated in the tables below. Participants were all women.

Participants' age ranged from 18 to 30 years, with the mean age being 22.27 (Standard Deviation (SD)=3.01). Most of the participants' race group were African (98%) and only 2% were coloured. Majority of participants (57%) were unemployed followed by students (33%), sales persons (4%), clerks (3%), self-employed (1%), domestic worker (1%) and a waitress (1%). Different language groups were evident among participants and composed mostly of IsiZulu (22%) and Sesotho sa borwa (Southern Sotho) (29%). The results revealed that more participants were single (91%) and only 9% were married.

Table 5.1

**Demographic data: Age**

	Frequency	Percent
		35.0
8-20	35	
21-25	49	49.0
26 and above	16	16.0
Total	100	100



**Figure 5.1. Age**

Table 5.2

**Race group**

	Freq	Percent
African	98	98
Coloured	2	2
Total	100	100

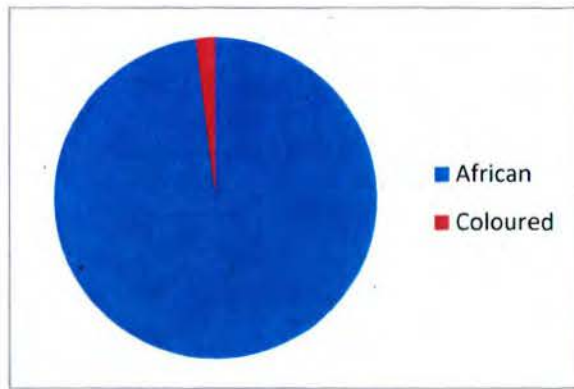


Figure 5.2. Race

Table 5.3

**Occupation**

	<b>Freq</b>	<b>Percent</b>
Clerk	3	3.0
domestic worker	1	1.0
sales person	4	4.0
self employed	1	1.0
Student	33	33.0
Unemployed	57	57.0
Waitress	1	1.0
<b>Total</b>	<b>100</b>	<b>100</b>

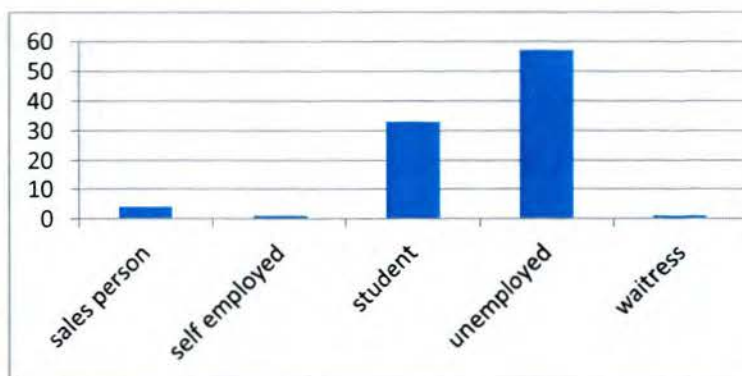


Figure 5.3. Occupation

Table 5.4

*Marital status*

	<b>Freq</b>	<b>Percent</b>
married	9	9.0
single	91	91.0
<b>Total</b>	<b>100</b>	<b>100</b>

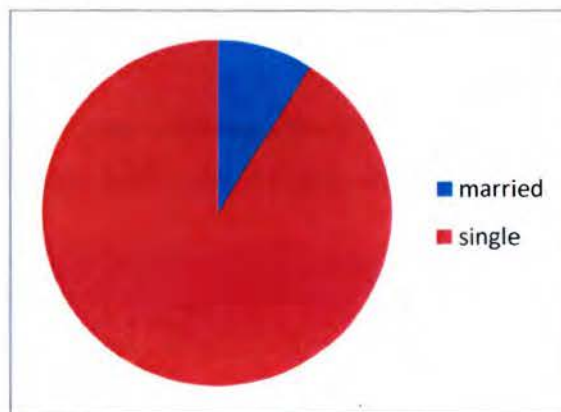
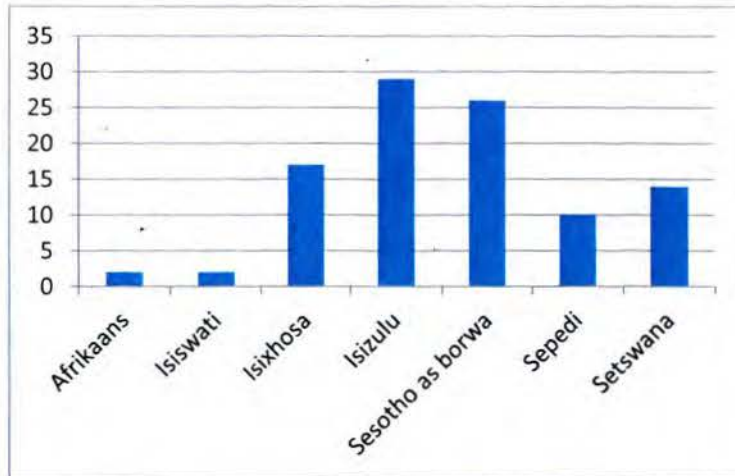


Figure 5.4. Marital status

Table 5.5

*Language*

	<b>Freq</b>	<b>Percent</b>
Afrikaans	2	2.0
Isiswati	2	2.0
Isixhosa	17	17.0
Isizulu	29	29.0
Sesotho as borwa	26	26.0
Sepedi	10	10.0
Setswana	14	14.0
<b>Total</b>	<b>100</b>	<b>100</b>



**Figure 5.5. Language**

### 5.1.2 The emotional reactions associated with rape

Table 5.6 shows some descriptive statistics of all the variables that were used in this study.

Table 5.6

*Mean values*

	Mean	Std. Dev	Min	Max
How old are you?	22.3	3.0	18	30
Race group	1.0	.3	1.0	3.0
What is your nationality?	1.0	.0	1.0	1.0
What is your home language?	6.5	1.5	1.0	9.0
What is your occupation?				
Marital status	1.9	.3	1.0	2.0
Headache	2.2	.6	1.0	3.0
insomnia	2.7	.5	1.0	3.0
Weight loss (without dieting)	1.75	1.0	.0	3.0
Stomach problems	1.4	.8	.0	3.0
Sexual problems	2.6	.6	.0	3.0
Feeling isolated from others	2.4	.7	.0	3.0
Flashbacks (sudden, vivid, distracting memories)	2.7	.5	1.0	3.0
Restless sleep	2.6	.6	.0	3.0
Low sex drive	2.7	.6	.0	3.0
Anxiety attacks	2.3	.85	.0	3.0
Sexual over-activity	.6	.9	.0	3.0
Loneliness	2.7	.5	.0	3.0



Nightmares	2.4	.6	.0	3.0
"spacing out" (going away in your mind)	1.4	1.0	.0	3.0
Sadness	2.6	.6	.0	3.0
Dizziness	1.1	.9	.0	3.0
Not feeling satisfied with your sex life	2.6	.6	.0	3.0
Trouble controlling your temper	2.65	.6	.0	3.0
Waking up early in the morning and can't get back to sleep	2.4	.6	.0	3.0
Uncontrollable crying	2.4	.6	1.0	3.0
Fear of men	2.7	.5	2.0	3.0
Not feeling rested in the morning	2.5	.6	.0	3.0
Having sex that you didn't enjoy	2.8	.5	.0	3.0
Trouble getting along with others	2.0	.8	.0	3.0
Memory problems	2.2	.8	.0	3.0
Desire to physically hurt yourself	1.8	1.2	.0	3.0
Fear of women	.2	.4	.0	2.0
Waking up in the middle of the night	2.4	.7	.0	3.0
Bad thoughts or feeling during sex	2.8	.6	.0	3.0
Passing out	.5	.7	.0	2.0
Feeling that things are unreal	.7	.9	.0	3.0
Unnecessary or over-frequent washing	1.4	1.35	.0	3.0
Feeling of inferiority	2.25	.8	.0	3.0
Feeling tense all the time	2.0	.8	.0	3.0
Being confused about your sexual feelings	2.5	.7	.0	3.0
Desire to physically hurt others	1.3	1.2	.0	3.0
Feelings of guilt	2.3	.8	.0	3.0
Feelings that you are not always in your body	1.0	1.0	.0	3.0
Having trouble breathing	1.2	1.0	.0	3.0
Sexual feeling when you shouldn't have them	1.3	1.2	.0	3.0
I make a plan of action and follow it	2.25	.9	1.0	5.0
I look for the silver lining or try to look on the bright side of things	2.3	.85	1.0	5.0
I try to spend time alone	3.8	.9	2.0	5.0
I hope the problem will take care of itself	3.6	.8	1.0	5.0
I try to let my emotions out	2.3	1.0	1.0	5.0
I try to talk about it with a friend or family	2.2	.8	1.0	4.0
I try to put problem out of my mind	3.4	.7	2.0	5.0
I tackle the problem head on	2.5	.8	1.0	5.0
I step back from the situation and try to put things into perspective	2.7	.7	2.0	4.0

I tend to blame myself	3.4	.8	1.0	5.0
I let my feelings out to reduce the stress	2.2	.9	1.0	5.0
I hope for a miracle	3.3	.5	2.0	5.0
I ask a close friend or relative that I respect for help and advice	2.4	.8	1.0	5.0
I try not to think about the problem	3.5	.7	2.0	5.0
I tend to criticize myself	3.5	.8	2.0	5.0
I keep my thoughts and feelings to myself	3.9	.9	1.0	5.0

Table 5.7 shows the descriptive statistics of the key variables and constructs of the study. The values of their skewness and kurtosis were acceptable for the statistical explanatory analyses because they were less than 2 and 6 respectively. For this kind of values, their distribution approximates the normal distribution.

Table 5.7

*Descriptive Statistics for the key variables and constructs*

Variable/construct	N	Minimum	Maximum	Mean	Std. dev.	Skewness	Kurtosis
Dissociation	96	2.00	17.00	9.2604	2.83677	.439	.320
Anxiety	100	7.00	22.00	14.5500	3.40046	-.125	-.596
Depression	100	8.00	27.00	20.9100	4.08519	-1.064	.649
Sexual abuse trauma index	100	7.00	21.00	16.1800	2.45928	-.944	1.442
Sleep disturbance	100	8.00	18.00	15.0600	2.42803	-1.005	.433
sexual problems	99	2.00	24.00	18.0505	3.42671	-1.898	6.002

About 44% of participants scored above the total dissociation mean of 9.26 (SD=2.83) with the majority of participants (56%) having low symptoms of dissociation with the maximum score of 17. The majority of participants (53%) reported symptoms of anxiety as they had scored higher than the mean score of 14.55 (SD=3.40) on the total anxiety with the maximum score of 22. Most participants (65%) scored higher than the mean of 20.91 (SD=4.08) on total depression score with the maximum score of 27.

Approximately 51% of participants scored higher than the mean score of 16.18 (SD=2.45) on total SATI score with the maximum score of 21. On the total sleep disturbance score the majority of the participants (56%) scored above the mean 15.06 (SD=2.42) with the

maximum score of 18. About 51% of participants scored higher than the mean score of 18.05 (SD=3.42) on total sexual problems with the maximum score of 24.

### **5.1.3 Coping Strategies among Raped Women**

The coping strategies inventory-short form is inclusive of four subscales, namely: problem-focused engagement, problem-focused disengagement, emotion-focused engagement and emotion-focused disengagement. The results below for each subscale indicate the coping strategies among this sample of rape victims.

#### **(i) Problem-Focused Engagement**

Participants reported to rarely engage themselves to items “I try to let my emotions out” (62%), “I try to talk about it with a friend or family” (72%), “I let my feelings out to reduce the stress” (69%) and “I ask a close friend or relative that I respect for and advice” (76%).

#### **(ii) Problem-Focused Disengagement**

Most of the participants reported rarely in high percentage on items “I make a plan of action and follow it” (49%), “I look for the silver lining or try to look on the brighter side of things” (54%) and “I tackle the problem head on” (66%). Hence the item “I step back from the situation and try to put things into perspective” was reported rarely (43%) and sometimes (45%).

#### **(iii) Emotion-Focused Engagement**

About 57% of participants reported that they often hope the problem will take care of itself, with only 6% reporting very often. Majority of participants reported to sometimes try to put problems out of their mind (50%) and hope for miracle (70%). Hence 47% of participants often try not to think of the problem.

#### **(iv) Emotion-Focused Disengagement**

The results revealed that participants often try to spend time alone (57%) and keep their thoughts to themselves (62%) hence 18% and 21% very often resorted to these items respectively.

### 5.1.4 The impact of age on the emotional reactions and coping strategies of rape victims.

Emotional reaction was regressed against age. Table 5.8 shows the results. The results indicate that age does not affect emotional reactions of rape victims. The total score of TSC was used as the dependent variable. Adjusted R-square was -.01.

Table 5.8

	Parameter			
	Estimate	T	S.e	P-value
Constant	89.1	8.5	10.5	.000
Age	-.3	-.7	.5	.461

Table 5.9

#### ANOVA

Model	Sum of Squares	Df	Mean Square	F	P-value
Regression	94.8	1	94.8	.548	.461
Residual	15405.6	89	173.1		
Total	15500.58	90			

The one-way analysis of variance (ANOVA) also showed that the regression model was not significant. This implies that the null hypothesis that age does not affect emotional reactions of rape victims is not rejected at the 0.05 level of significance.

In the following ONE-WAY ANOVA, age was used as a factor of Dissociation, Anxiety, Depression, Sexual abuse trauma index, Sleep disturbance, Sexual problems and TSC total score (TSCTOTALSCORE), to test its effect on these variables

Table 5.10

*ANOVA*

		Sum of Squares	df	Mean Square	F	P-value.
Dissociation	Between Groups	36.197	2	18.098	2.311	.105
	Within Groups	728.293	93	7.831		
	Total	764.490	95			
Anxiety	Between Groups	31.278	2	15.639	1.362	.261
	Within Groups	1113.472	97	11.479		
	Total	1144.750	99			
Depression	Between Groups	40.774	2	20.387	1.227	.298
	Within Groups	1611.416	97	16.613		
	Total	1652.190	99			
Sexual abuse trauma index	Between Groups	11.095	2	5.547	.916	.404
	Within Groups	587.665	97	6.058		
	Total	598.760	99			
Sleep disturbance	Between Groups	3.138	2	1.569	.262	.770
	Within Groups	580.502	97	5.985		
	Total	583.640	99			
sexual problems	Between Groups	16.493	2	8.246	.698	.500
	Within Groups	1134.255	96	11.815		
	Total	1150.747	98			
TSCTOTALSCORE	Between Groups	240.571	2	120.286	.694	.502
	Within Groups	15259.846	88	173.407		
	Total	15500.418	90			

According to the results, the null hypothesis that age does not affect emotional reactions (that is, Dissociation, Anxiety, Depression, Sexual abuse trauma index, Sleep disturbance, Sexual problems) is not rejected at the 0.05 level of significance. Therefore, emotional reactions are not affected by age.

In the following analysis, the hypothesis that rape victims who are younger will report less negative emotional reactions and will therefore cope better than those who are older was tested.

In the following ONE-WAY ANOVA, age was used as a factor of coping to test its effect on coping with rape.

Table 5.11

*ANOVA*

		Sum of Squares	df	Mean Square	F	Sig.
I make a plan of action and follow it	Between Groups	1.370	2	.685	.859	.427
	Within Groups	77.380	97	.798		
	Total	78.750	99			
I look for the silver lining or try to look on the bright side of things	Between Groups	1.876	2	.938	1.305	.276
	Within Groups	69.684	97	.718		
	Total	71.560	99			

I try to spend time alone	Between Groups	.317	2	.158	.204	.815
	Within Groups	75.073	97	.774		
	Total	75.390	99			
I hope the problem will take care of itself	Between Groups	.157	2	.079	.132	.877
	Within Groups	58.033	97	.598		
	Total	58.190	99			
I try to let my emotions out	Between Groups	.727	2	.364	.371	.691
	Within Groups	94.983	97	.979		
	Total	95.710	99			
I try to talk about it with a friend or family	Between Groups	.580	2	.290	.480	.620
	Within Groups	58.580	97	.604		
	Total	59.160	99			
I try to put problem out of my mind	Between Groups	6.917	2	3.458	7.096	.001
	Within Groups	47.273	97	.487		
	Total	54.190	99			
I tackle the problem head on	Between Groups	.472	2	.236	.345	.709
	Within Groups	66.368	97	.684		
	Total	66.840	99			
I step back from the situation and try to put things into perspective	Between Groups	.359	2	.179	.386	.681
	Within Groups	45.031	97	.464		
	Total	45.390	99			
I tend to blame myself	Between Groups	.606	2	.303	.480	.620
	Within Groups	61.184	97	.631		
	Total	61.790	99			
I let my feelings out to reduce the stress	Between Groups	.240	2	.120	.158	.854
	Within Groups	73.470	97	.757		
	Total	73.710	99			
I hope for a miracle	Between Groups	.499	2	.249	.960	.387
	Within Groups	25.211	97	.260		
	Total	25.710	99			
I ask a close friend or relative that I respect for help and advice	Between Groups	.310	2	.155	.240	.787
	Within Groups	62.730	97	.647		
	Total	63.040	99			
I try not to think about the problem	Between Groups	.564	2	.282	.565	.570
	Within Groups	48.436	97	.499		
	Total	49.000	99			
I tend to criticize myself	Between Groups	.777	2	.388	.606	.548
	Within Groups	62.213	97	.641		
	Total	62.990	99			
I keep my thoughts and feelings to myself	Between Groups	.474	2	.237	.319	.727
	Within Groups	72.036	97	.743		
	Total	72.510	99			

According to the results, the null hypothesis that age does not affect the coping of rape victims is not rejected at the 0.05 level of significance, except for “I try to put problem out of my mind” variable (P value=.001). Therefore, in general, coping strategies of rape victims are not affected by age.

### 5.1.5 The impact of marital status on the emotional reactions and coping strategies of rape victims

In the following analysis, the hypothesis that single women who are victims of rape will report less negative emotional reactions and will consequently cope better than those who are married was tested.

ONE-WAY ANOVA was used and marital status was used as a factor of coping to test its effect on coping with rape.

Table 5.12

		Sum of Squares	df	Mean Square	F	Sig.
I make a plan of action and follow it	Between Groups	.923	1	.923	1.163	.284
	Within Groups	77.827	98	.794		
	Total	78.750	99			
I look for the silver lining or try to look on the bright side of things	Between Groups	.041	1	.041	.056	.813
	Within Groups	71.519	98	.730		
	Total	71.560	99			
I try to spend time alone	Between Groups	.010	1	.010	.013	.908
	Within Groups	75.380	98	.769		
	Total	75.390	99			
I hope the problem will take care of itself	Between Groups	.210	1	.210	.354	.553
	Within Groups	57.980	98	.592		
	Total	58.190	99			
I try to let my emotions out	Between Groups	.023	1	.023	.023	.879
	Within Groups	95.687	98	.976		
	Total	95.710	99			
I try to talk about it with a friend or family	Between Groups	.000	1	.000	.000	.993
	Within Groups	59.160	98	.604		
	Total	59.160	99			
I try to put problem out of my mind	Between Groups	3.443	1	3.443	6.648	.011
	Within Groups	50.747	98	.518		
	Total	54.190	99			
I tackle the problem head on	Between Groups	2.093	1	2.093	3.168	.078
	Within Groups	64.747	98	.661		
	Total	66.840	99			
I step back from the situation and try to put things into perspective	Between Groups	.179	1	.179	.387	.535
	Within Groups	45.211	98	.461		
	Total	45.390	99			
I tend to blame myself	Between Groups	.757	1	.757	1.216	.273
	Within Groups	61.033	98	.623		
	Total	61.790	99			
I let my feelings out to reduce the stress	Between Groups	.001	1	.001	.001	.978
	Within Groups	73.709	98	.752		
	Total	73.710	99			
I hope for a miracle	Between Groups	.040	1	.040	.151	.698
	Within Groups	25.670	98	.262		
	Total	25.710	99			
I ask a close friend or relative that I respect for help and advice	Between Groups	.188	1	.188	.293	.590
	Within Groups	62.852	98	.641		
	Total	63.040	99			

I try not to think about the problem	Between Groups	.031	1	.031	.061	.805
	Within Groups	48.969	98	.500		
	Total	49.000	99			
I tend to criticize myself	Between Groups	1.574	1	1.574	2.511	.116
	Within Groups	61.416	98	.627		
	Total	62.990	99			
I keep my thoughts and feelings to myself	Between Groups	.048	1	.048	.066	.798
	Within Groups	72.462	98	.739		
	Total	72.510	99			
TSCTOTALSCORE	Between Groups	283.930	1	283.930	1.661	.201
	Within Groups	15216.488	89	170.972		
	Total	15500.418	90			
Dissociation	Between Groups	16.751	1	16.751	2.106	.150
	Within Groups	747.739	94	7.955		
	Total	764.490	95			
Anxiety	Between Groups	27.290	1	27.290	2.393	.125
	Within Groups	1117.460	98	11.403		
	Total	1144.750	99			
Depression	Between Groups	1.243	1	1.243	.074	.787
	Within Groups	1650.947	98	16.846		
	Total	1652.190	99			
Sexual abuse trauma index	Between Groups	5.351	1	5.351	.884	.350
	Within Groups	593.409	98	6.055		
	Total	598.760	99			
Sleep disturbance	Between Groups	2.517	1	2.517	.424	.516
	Within Groups	581.123	98	5.930		
	Total	583.640	99			
Sexual problems	Between Groups	.792	1	.792	.067	.797
	Within Groups	1149.956	97	11.855		
	Total	1150.747	98			

According to the results, the null hypothesis that marital status does not affect the coping of rape victims is not rejected at the 0.05 level of significance. Therefore, coping strategies of rape victims are generally not affected by marital status. However, marital status was found to affect the variable "I try to put problem out of my mind" at the 5% level of significance.

In the above ONE-WAY ANOVA, marital status was used as a factor of Dissociation, Anxiety, Depression, Sexual abuse trauma index, Sleep disturbance, Sexual problems and TSC total score (TSCTOTALSCORE), to test its effect on these variables.

According to the results, the hypothesis that single women who are victims of rape will report less negative emotional reactions and will consequently cope better than those who are married should be rejected. We should accept the hypothesis that single women who are victims of rape will not report less negative emotional reactions and will consequently not cope better than those who are married.

## T-Test

Emotional reactions were compared between single and married women using the regression analysis above and the t-test. The table 5.12 below shows the t-test results. The results below also indicate that there is no significant difference in emotional reactions between single women and married women. TSC total score (TSCTOTALSCORE) and all subscales (i.e., Dissociation, Anxiety, Depression, Sexual abuse trauma index, Sleep disturbance and Sexual problems) do not differ between single women and married women. This is indicated by the corresponding Sig. Values (the P-values) being higher than Alpha (i.e., 0.05), the level of significance. Therefore, single women who are victims of rape will not report less negative emotional reactions and will not consequently cope better than those who are married.

Table 5.13

### Group Statistics

	maritalD	N	Mean	Std. Deviation	Std. Error Mean
TSCTOTALSCORE	.00	8	75.7500	14.17997	5.01337
	1.00	83	81.9880	12.97699	1.42441
Dissociation	.00	8	7.8750	1.55265	.54894
	1.00	88	9.3864	2.89840	.30897
Anxiety	.00	9	12.8889	2.31541	.77180
	1.00	91	14.7143	3.45538	.36222
Depression	.00	9	20.5556	3.53946	1.17982
	1.00	91	20.9451	4.15094	.43514
Sexual abuse trauma index	.00	9	15.4444	1.87824	.62608
	1.00	91	16.2527	2.50596	.26270
Sleep disturbance	.00	9	14.5556	2.45515	.81838
	1.00	91	15.1099	2.43334	.25508
sexual problems	.00	9	18.3333	3.35410	1.11803
	1.00	90	18.0222	3.45103	.36377

Table 5.14

*Independent Samples Test*

		t-test for Equality of Means		
		t	df	Sig. (2-tailed)
TSCTOTALSCORE	Equal variances assumed	-1.289	89	.201
	Equal variances not assumed	-1.197	8.171	.265
Dissociation	Equal variances assumed	-1.451	94	.150
	Equal variances not assumed	-2.399	12.040	.033
Anxiety	Equal variances assumed	-1.547	98	.125
	Equal variances not assumed	-2.141	11.861	.054
Depression	Equal variances assumed	-.272	98	.787
	Equal variances not assumed	-.310	10.307	.763
Sexual abuse trauma index	Equal variances assumed	-.940	98	.350
	Equal variances not assumed	-1.191	11.034	.259
Sleep disturbance	Equal variances assumed	-.651	98	.516
	Equal variances not assumed	-.647	9.622	.533
Sexual problems	Equal variances assumed	.258	97	.797
	Equal variances not assumed	.265	9.774	.797

Some sample sizes are too small (8 or 9), which is a concern because this might cause the results to be invalid. Small sample sizes tend to inflate sample variances resulting in making the mean an unreliable estimate of the population measure of central tendency. This is one of the study limitations.

### 5.1.6 Comparing coping strategies of less traumatised rape victims with those of highly victimised rape victims.

According to the results of the TSC-40, 53% of the victims were highly traumatised with 47% of them being less traumatised. In the following analysis, the hypothesis that rape victims who are less traumatised will cope better than those who are highly traumatised was tested. ONE-WAY ANOVA was performed in which case, coping strategies were compared between the less traumatized group and the highly traumatised group of rape victims. The different trauma variables and constructs that measure trauma were used as factors of coping.

Table 5.15

#### ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
I make a plan of action and follow it	Between Groups	1.553	1	1.553	1.936	.167
	Within Groups	75.406	94	.802		
	Total	76.958	95			
I look for the silver lining or try to look on the bright side of things	Between Groups	1.532	1	1.532	2.158	.145
	Within Groups	66.708	94	.710		
	Total	68.240	95			
I try to spend time alone	Between Groups	1.728	1	1.728	2.452	.121
	Within Groups	66.231	94	.705		
	Total	67.958	95			
I hope the problem will take care of itself	Between Groups	3.721	1	3.721	6.826	.010
	Within Groups	51.238	94	.545		
	Total	54.958	95			
I try to let my emotions out	Between Groups	1.842	1	1.842	2.203	.141
	Within Groups	78.565	94	.836		
	Total	80.406	95			
I try to talk about it with a friend or family	Between Groups	1.935	1	1.935	3.635	.060
	Within Groups	50.054	94	.532		
	Total	51.990	95			
I try to put problem out of my mind	Between Groups	.280	1	.280	.500	.481
	Within Groups	52.678	94	.560		
	Total	52.958	95			
I tackle the problem head on	Between Groups	.963	1	.963	1.547	.217
	Within Groups	58.526	94	.623		
	Total	59.490	95			
I step back from the situation and try to put things into perspective	Between Groups	.327	1	.327	.720	.398
	Within Groups	42.663	94	.454		
	Total	42.990	95			
I tend to blame myself	Between Groups	.026	1	.026	.043	.836
	Within Groups	57.463	94	.611		
	Total	57.490	95			
I let my feelings out to reduce the stress	Between Groups	1.156	1	1.156	1.660	.201
	Within Groups	65.469	94	.696		
	Total	66.625	95			
I hope for a miracle	Between Groups	.289	1	.289	1.176	.281
	Within Groups	23.117	94	.246		
	Total	23.406	95			

I ask a close friend or relative that I respect for help and advice	Between Groups	.564	1	.564	.934	.336
	Within Groups	56.769	94	.604		
	Total	57.333	95			
I try not to think about the problem	Between Groups	.865	1	.865	1.803	.183
	Within Groups	45.124	94	.480		
	Total	45.990	95			
I tend to criticize myself	Between Groups	6.688	1	6.688	11.385	.001
	Within Groups	55.219	94	.587		
	Total	61.906	95			
I keep my thoughts and feelings to myself	Between Groups	4.444	1	4.444	6.706	.011
	Within Groups	62.295	94	.663		
	Total	66.740	95			
TSCTOTALSCORE	Between Groups	5070.660	1	5070.660	43.269	.000
	Within Groups	10429.758	89	117.188		
	Total	15500.418	90			
Dissociation	Between Groups	467.372	1	467.372	147.864	.000
	Within Groups	297.117	94	3.161		
	Total	764.490	95			
Anxiety	Between Groups	371.728	1	371.728	48.003	.000
	Within Groups	727.928	94	7.744		
	Total	1099.656	95			
Depression	Between Groups	105.596	1	105.596	6.960	.010
	Within Groups	1426.238	94	15.173		
	Total	1531.833	95			
Sexual abuse trauma index	Between Groups	152.943	1	152.943	33.321	.000
	Within Groups	431.463	94	4.590		
	Total	584.406	95			
Sleep disturbance	Between Groups	36.308	1	36.308	6.530	.012
	Within Groups	522.650	94	5.560		
	Total	558.958	95			
sexual problems	Between Groups	66.201	1	66.201	5.848	.018
	Within Groups	1052.746	93	11.320		
	Total	1118.947	94			

According to the results, the hypothesis that rape victims who are less traumatised will cope better than those who are highly traumatised was rejected for some trauma variables but it was not rejected for others at the 0.05 level of significance. The trauma variables that were found to affect coping strategies are:

- Dissociation
- Anxiety
- Depression
- Sexual abuse trauma index
- Sleep disturbance, and
- Sexual problems

This means that:

- Rape victims with less levels of dissociation will cope better than those who have higher levels of dissociation.

- Rape victims with less anxiety levels will cope better than those with higher anxiety levels.
- Rape victims who are less depressed will cope better than those who are more depressed.
- Rape victims with less levels of sexual abuse trauma will cope better than those with higher levels of sexual abuse trauma.
- Rape victims with less sleep disturbance will cope better than those with higher levels sleep disturbance.
- Rape victims with less sexual problems will cope better than those with more sexual problems.

## 5.2 DISCUSSION

The questionnaires were administered to a hundred rape victims who were willing to participate in the study and were all returned. These women were found at selected rape crisis centres in the Gauteng province. They filled in the questionnaires as requested by the researcher and each questionnaire was numbered to avoid revealing the victim's identity. A hundred women participated in the study and even though the study was directed to women between the ages of 18 and above the respondents were only between 18 to 30 years old. This was the age range of women who were willing to participate in the study. This was also the age range of women that were reported by the managers of the rape crisis centres to be frequenting the centres. The majority of the participants were African and 57% of them were unemployed. Only 9% of them were married with the rest being single.

According to the interpretation of the data collected with the use of the TSC-40, 53% of the victims had a higher trauma and had significant negative emotional reactions with 47% of the victims reporting lower levels of trauma. The TSC-40 had six subscales and all of which yielded scores that were higher than the mean, which indicated the level of occurrence for each subscale.

The majority of participants (75%) reported to experience flashbacks more often and 43% reported memory problems. Hence on the other side participants (54%) reported to have never experienced "feeling that things are unreal" and 36% never experienced the item about feeling that they are not always in their body. Only a limited number of participants (3% & 11%) reported that often they feel that things are unreal and feel that they are not always in

their body's respectively. About 44% of participants scored above the total dissociation mean of 9.26 (SD=2.38) with the majority of participants (56%) having low symptoms of dissociation.

The results revealed that 56% and 33% of participants reported to have experienced headache sometimes and often respectively. Majority of participants (66%) reported to experience fear of men more often and none showed to fear women more often. Anxiety attacks were reported to be experienced by participants in both sometimes (35%) and often (49%). Participants reported to feel tense all the time at sometime (50%) and often (30%). Majority of participants (53%) reported symptoms of anxiety as they had scored higher than the mean score of 14.55 (SD=3.40) on the total anxiety.

Participants reported to often experience insomnia (73%), low sex drive (77%) and sadness (67%), hence they reported that they sometimes experience waking up early in the morning (50%) and uncontrollable crying (48%). The desire to physically hurt self was reported as never experienced by 25% of the participants. Most participants (65%) scored higher than the mean of 20.91 (SD=4.08) on total depression score with the maximum score of 27.

Participants reported that they often experienced sexual problems (69%), flashbacks (75%), fear of men (66%) and mostly bad thoughts or feelings during sex (81%). Approximately 51% of participants scored higher than the mean score of 16.18 (SD=2.45) on total SATI score with the maximum score of 21.

Majority of participants reported to experience insomnia (73%), restless sleep (68%) and not feeling rested in the morning (55%) more often. About 50% of participants reported to wake up in the middle of the night and to wake up early in the morning and couldn't get back to sleep at sometime. Hence when it comes to the total sleep disturbance score the majority of the participants (56%) scored above the mean 15.06 (SD=2.42).

Participants revealed that they often experienced sexual problems (69%), low sex drive (77%), not feeling satisfied with their sex life (66%), having sex that they didn't enjoy (87%), bad thoughts and feelings during sex (81%) and being confused about their sexual feeling (60%). Results showed that there was a high number of participants (65%) who never experienced sexual over-activity and only about 7% of participants who experienced sexual over-activity. About 51% of participants scored higher than the mean score of 18.05 (SD=3.42) on total sexual problems with the maximum score of 24.

The majority of the mean values for each variable of the TSC-40 was greater than 2 which indicated that on average, the rape victims experienced negative emotional reactions often. The results above were an indication that there is a relationship between rape and the negative emotional reactions.

The hypothesis that single women who are victims of rape will report less negative emotional reactions and will consequently cope better than those who are married was tested. The results indicated that coping strategies of rape victims are generally not affected by marital status. However, marital status was found to affect only a few of the variables at the 5% level of significance. The results also indicated that the emotional reactions of rape victims are not affected by marital status. The hypothesis that rape victims who are less traumatised will cope better than those who are highly traumatised was also tested and according to the results the rape victims who have less trauma will indeed cope better than those who have high levels of trauma.

The hypothesis that rape victims who are younger will report less negative emotional reactions and will therefore cope better than those who are older was tested and according to the results the emotional reactions of rape victims are not affected by age. The results also revealed that the coping strategies of rape victims are not affected by age.

An average of about 70% of the participants reported to rarely engaging in Problem-focused engagement with about 53% of them also rarely engaging in Problem-focused disengagement. About 42% participants reported to often engaging in Emotion-focused engagement with about 51% reporting to be often engaging in Emotion-focused disengagement. And according to these results the victims often used emotion focused coping and rarely engaged in problem-focused coping. This was also an indication that rape does induce a number of coping strategies. An average of about 52% of the victims who were less traumatised were found to be engaging often in problem-focused engagement.

The majority of the women who participated in this study who were more traumatised had higher levels of depression and anxiety and had difficulties interacting effectively within their environment. Most of them had a fear of men and no longer enjoyed sexual intercourse. The literature found in Slaikeu (1990) and Pickup et al., (2001) confirm similar results. These women also suffered from headaches, had trouble sleeping and had flashbacks or nightmares about their experience. They had suicidal ideations, cried constantly and had feelings of shame and guilt, and this is supported by the literature found in Nevid et al., (1990).

The victims who were more traumatised had trouble controlling their temper; and also experienced dissociation, this is confirmed by Rautio (2008). They felt isolated from others and did not want to talk about their ordeal, which was supported by James & Gilliland (2005).

They also had higher levels of PTSD which is an indication that they were experiencing rape trauma syndrome, and this is supported by the literature found in Karmen (1990).

The more traumatised victims were found to employ coping strategies such as blaming themselves for the rape, this is supported by Kleinke (1998) and Novello & O'Sullivan (2008); not talking about this experience with other people, isolating themselves from others and this is confirmed by Meyer & Taylor's study cited in Kleinke (1998) . These victims were found to be in denial and this is supported by Horowitz; Janoff-Bulman & Timko's study cited in Frieze & Bookwala (1996). They also did not seek any assistance from others.

Most of the women that were less traumatised were those that indicated that they used problem focused coping strategies such as communicating effectively with their friends and family members and seeking help and advice from them, this was supported by the literature found in Frieze & Bookwala (1996). They were also more optimistic than their more traumatised counterparts and had the ability to express their emotions.

This study has indeed proven that women who are victims of rape experience negative emotional reactions and that those who are more traumatised engage more in emotion focused coping than problem focused coping strategies.

The researcher also continued using the same research instruments to collect the data for this study because they were found to be both valid and reliable.

It must be pointed out that non-probability samples were inevitably used and some of the sub-sample sizes were too small – when the two samples being used to compare populations were not of equal size. It would have been a great struggle to obtain probability samples and large sub-samples due to mainly practical problems and other problems such as limited time and budget.

### **5.3 CONCLUSION**

According to the interpretation of the collected data the researcher is able to conclude that the rape victims have negative emotional reactions and that those who are more traumatised resort to emotion focused coping strategies. The victims that were more traumatised had higher symptoms of dissociation, depression, a fear of men and no longer enjoyed sexual intercourse. They also engaged in negative thinking and were pessimistic about the future. A high percentage of those who are less traumatised were found to be engaging more in problem focused coping strategies.

The most significant factor between these two groups is that the latter communicated effectively with people in their immediate environment and were optimistic about the future. This could be an indication that rape victims who talk openly about their ordeal with those they trust or receive counselling have a better prognosis than those who do not.

### **5.4 SUGGESTION FOR FURTHER RESEARCH**

Through the interpretation of the data collected the researcher has recognised that rape victims who were found to be more traumatised were less expressive than their counterparts. It is therefore, recommended that the rape victims must receive counselling which will be aimed at assisting them to express their emotions and to deal effectively with their negative symptoms and to lead effective lives. More research should also be conducted on what needs to be done to encourage rape victims to go for counselling and also to remove the stigmatisation of rape victims within our societies.

For further study, it would be better if the samples used are probability samples and large sample sizes are used.

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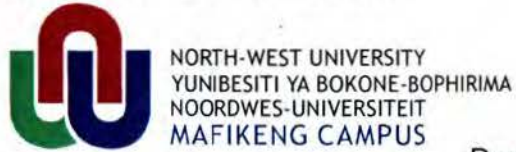
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**APPENDIX A: LETTER TO REQUEST FOR PERMISSION FROM THE RAPE  
CRISIS CENTRES TO CONDUCT THE STUDY**



Department of Psychology  
Private Bag X2046  
Mmabatho 2735  
(018) 389-2160

**THE MANAGER  
RAPE CRISIS CENTRE  
GAUTENG**

**RE: PERMISSION TO USE YOUR CLIENTS AS PARTICIPANTS IN MY  
RESEARCH.**

My name is Tiisetso Nkomo, a Masters student in the Department of Psychology at the North-West University. I am conducting a study on: "**Psychological effects of rape and coping strategies of rape victims in the Gauteng Province.**" The purpose of this study is specifically aimed at exploring the psychological impact that rape has on victims (see attached research proposal).

I do hereby apply for permission to sample from your clients as subjects in my study. It is important to point out that the researcher undertakes to maintain confidentiality regarding the identity of the participants in this research project. The participants will be assured about the voluntary nature of this study and further that they are free to withdraw from the study at any time should they wish to do so.

The questionnaire that will be given to the subjects will consists of three (3) sections: Section 1 deals with the personal information; Section 2 deals with the symptoms associated with traumatic experiences; and Section 3 looks at the coping strategies.

I hope that my request will be honoured.

Sincerely

---

Mrs. T. N. Nkomo  
Masters Clinical Psychology Student

---

Dr. C. Oduaran  
Supervisor

## APPENDIX B: LETTER TO OBTAIN CONSENT FROM PARTICIPANTS



NORTH-WEST UNIVERSITY  
YUNIBESITI YA BOKONE-BOPHIRIMA  
NOORDWES-UNIVERSITEIT  
MAFIKENG CAMPUS

Department of Psychology  
Private Bag X2046  
Mmabatho 2735  
(018) 389-2160

Dear Participant

### INFORMED CONSENT

Thank you for demonstrating interest in this study that focuses on the impact of rape on victims in the Gauteng Province. The purpose of this study is to assess the effects that rape has on you.

Your responses to this questionnaire will remain strictly confidential. The researcher will not attempt to identify you with your responses to the questionnaire or to name you as a participant in the study. Please be advised that this survey is voluntary and that you have the right to terminate your participation in the study at any time.

This questionnaire consists of three (3) sections: Section 1 deals with your personal information; Section 2 deals with your symptoms associated with traumatic experiences; and Section 3 looks at your coping strategies.

Kindly answer all the questions and reflect your true reaction. Your participation in this research is very important. Thank you for your time

Yours sincerely

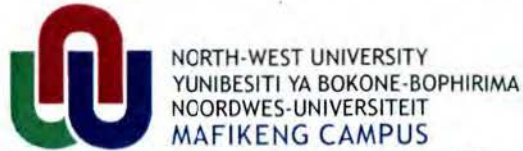
\_\_\_\_\_  
T. N. Nkomo  
Masters student

Date: \_\_\_\_\_

\_\_\_\_\_  
Dr. C. Oduaran  
Supervisor

Date: \_\_\_\_\_

## APPENDIX C: CONSENT FORM TO BE SIGNED BY PARTICIPANTS



Department of Psychology  
Private Bag X2046  
Mmabatho 2735  
(018) 389-2160

### CONSENT FORM

I \_\_\_\_\_ hereby agree to participate in this Masters Research project that focuses on the psychological impact of rape on victims.

The purpose of the study has been fully explained to me. I further understand that I am participating freely and without being forced in any way to do so. I also understand that I can terminate my participation in this survey at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project, whose purpose is not necessarily to benefit me personally. I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Place: \_\_\_\_\_

**APPENDIX D**

**SECTION 1**

**BIOGRAPHICAL DATA OF THE RESPONDENT**

This section refers to some basic biographical information about yourself. Please mark with “X” on the relevant options or fill in the blank space where applicable.

1. How old are you?

--	--

2. Race group

African	White	Coloured	Indian	Other (Specify)
1	2	3	4	..... 5

3. What is your nationality?

South African citizen	1
Other (specify): .....	2

4. What is your home language? (Language spoken most often at home)

Afrikaans	01	Setswana	09
English	02	Tshivenda	10
Isindebele	03	Xitsonga	11
Isiswati	04	Other African language	12
Isixhosa	05	Other European language	13
Isizulu	06	Indian language	14
Sesotho sa borwa	07	Other (specify): .....	15
Sepedi	08		

5. What is your occupation?

---

---

6. Marital status:

Married    Single

## SECTION 2

### The Trauma Symptom Checklist-40 (TSC-40)

How often have you experienced each of the following in the last two months?

0 = Never    3 = Often

	Never	Rarely	Sometimes	Often
1. Headaches	0	1	2	3
2. Insomnia (trouble getting to sleep)				
3. Weight loss (without dieting)				
4. Stomach problems				
5. Sexual problems				
6. Feeling isolated from others				
7. "Flashbacks" (sudden, vivid, distracting memories)				
8. Restless sleep				
9. Low sex drive				
10. Anxiety attacks				
11. Sexual over-activity				
12. Loneliness				
13. Nightmares				

14. "Spacing out" (going away in your mind)				
15. Sadness				
16. Dizziness				
17. Not feeling satisfied with your sex life				
18. Trouble controlling your temper				
19. Waking up early in the morning and can't get back to sleep				
20. Uncontrollable crying				
21. Fear of men				
22. Not feeling rested in the morning				
23. Having sex that you didn't enjoy				
24. Trouble getting along with others				
25. Memory problems				
26. Desire to physically hurt yourself				
27. Fear of women				
28. Waking up in the middle of the night				
29. Bad thoughts or feelings during sex				
30. Passing out				
31. Feeling that things are "unreal"				
32. Unnecessary or over-frequent washing				
33. Feelings of inferiority				

34. Feeling tense all the time				
35. Being confused about your sexual feelings				
36. Desire to physically hurt others				
37. Feelings of guilt				
38. Feelings that you are not always in your body				
39. Having trouble breathing				
40. Sexual feelings when you shouldn't have them				

### SECTION 3

#### **Coping Strategies Inventory Short Form (CSI-SF)**

**Please Read these Instructions Carefully:** People often react in different ways when they are faced with a difficult, challenging, or stressful issue in life. This questionnaire invites you to respond to how frequently you cope in the ways the statements suggest in terms of what you do or feel when you experience a stressful or challenging issue in your life. It is to be expected that the type of issue you face in a given situation may change the way you react so answer the following questions from the viewpoint of what you generally do or feel most of the time. Please respond to every item and report what is true or mostly true for you, not what you believe other people would do in a similar situation facing the same issue. Use the following scale and respond to each statement by placing a number in the blank space next to each item.

**Never=1 Rarely=2 Sometimes=3 Often=4 Very Often=5**

- 1. I make a plan of action and follow it
- 2. I look for the silver lining or try to look on the bright side of things
- 3. I try to spend time alone
- 4. I hope the problem will take care of itself
- 5. I try to let my emotions out
- 6. I try to talk about it with a friend or family
- 7. I try to put the problem out of my mind
- 8. I tackle the problem head on
- 9. I step back from the situation and try to put things into perspective
- 10. I tend to blame myself
- 11. I let my feelings out to reduce the stress
- 12. I hope for a miracle
- 13. I ask a close friend or relative that I respect for help or advice
- 14. I try not to think about the problem
- 15. I tend to criticize myself
- 16. I keep my thoughts and feelings to myself

**Thank you very much for participating in this study.**