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**Below is the extended version of the above article  
that was published as a brief report**

**Treating the psychological sequelae of proactive drug-facilitated sexual assault: Knowledge building through systematic case based research**

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**Introduction**

Drug facilitated sexual assault (DFSA) -- on victims who are too intoxicated to be aware of their surroundings or exercise any control of the situation -- has emerged as a distinct category of sexual victimisation. DFSA has been identified as a significant public health concern, particularly among college students, with the majority of victims being women (McCauley, Ruggiero, Resnick, & Kilpatrick, 2010; Zinzow, Resnick, McCauley, Amstadter, Ruggiero, & Kilpatrick, 2010). Exact rates remain uncertain due to significant under-reporting (Du Mont, Macdonald, Rotbard, Asslanni, & Bainbridge, 2010; Lawyer, Resnick, Bakanic, Burkett, & Kilpatrick, 2010). *Opportunistic* DFSA, also called *incapacitated rape* (Lawyer et al., 2010; Zinzow et al., 2010), is the most common form and refers to assaults on women who have voluntarily consumed an excessive amount of alcohol (Lovett & Horvath, 2009). In *proactive* DFSA (called *drug facilitated rape* by Lawyer et al., 2010 and *drug-alcohol facilitated rape* by Zinzow et al., 2010), perpetrators deliberately incapacitate victims by plying them with alcohol or covertly administering an incapacitating drug such as Flunitrazepam (Rohypnol) or Gamma-hydroxybutyrate (GHB) to victims with the intention of sexually assaulting them (Hall & Moore, 2008).

DFSA regularly precipitates post-traumatic stress disorder (PTSD) (Brown, Testa, & Messman-Moore, 2009; Zinzow et al., 2010) with its characteristic symptoms of intrusive re-experiencing, increased physiological arousal and cognitive and behavioural avoidance of trauma reminders and memories (American Psychiatric Association, 2000). However, few studies have examined

whether there are distinct psychological aspects of PTSD caused by DFSA in contrast to non-DFSA or what the implications are for treatment planning and clinical intervention.

A notable exception is the work of Gauntlett-Gilbert et al. (2004) who used Ehlers and Clark's (2000) cognitive therapy (CT) (Clark & Ehlers, 2005; Ehlers, Clark, Hackmann, McManus, & Fennell, 2005) to treat PTSD following DFSA and found evidence for its effectiveness. Three points in particular emerged from their study: (1) they found that although the trauma memory was compromised by partial or complete amnesia, intrusive memories were present and took the form of visual intrusions of parts of the trauma for which the victim was conscious and of affect without recollection; (2) they stressed the importance of establishing a sense of safety for clients and; (3) they noted the following problematic assumptions that needed to be targeted (a) that remembering was necessary for recovery (which prompted ruminative replaying of the trauma and maintained PTSD), (b) that they were gullible because they were drugged in a familiar location (e.g. a pub or a night club) by a person they knew and trusted, and (c) they were to blame especially where they voluntarily consumed alcohol beforehand or accepted drinks from the perpetrator -- this in turn was aggravated by negative responses from others which was more likely to occur if the victim had voluntarily consumed alcohol prior to the assault. Gauntlett-Gilbert et al.'s (2004) conclusions were based on cases from their clinical experience. The aim of the present research, which focuses on proactive DFSA, was to use the data from three systematic case studies conducted in South Africa to evaluate them and, if appropriate, to refine and expand them by identifying additional points likely to be salient for these types of case. The data from these new cases thus provided an opportunity to contribute to the development and refinement of empirically grounded clinical knowledge (Salkovskis, 2002) in this area.

## **Method**

### **Systematic case study research**

Systematic case study research offers a more nuanced understanding of experiences and processes that typically evade research involving surveys (Zinzow et al., 2010) and group comparisons (Brown et al., 2009). It contributes to the creation of grounded theory (or "case law", Bromley, 1986) which includes "generalizations [that] are lawful relationships between operationalized phenomena that have been observed and replicated" (Edwards, Dattilio, & Bromley, 2004, p. 502). The method offers a complementary means of developing and refining

the theory on which clinical practice is based (Dattilio, Edwards, & Fishman, 2010; AB, 2010; Iwakabe & Gazzola, 2009). The present cases formed part of a wider project in which a series of systematic case studies was used to evaluate the transportability of Ehlers and Clark's (2000) CT for PTSD to South African conditions. Several of these have been published or are available as online dissertations (Boulind & Edwards, 2008; Davidow & Edwards, 2005; Karpelowsky & Edwards, 2005; Laas, 2009; Payne & Edwards, 2009; Smith, 2006; Swartz, 2007; van der Linde, 2007). Seven case studies on the treatment of PTSD following rape were written by the first author (AB, 2010) including the three cases of DFSA used here.

### **Participants**

Participants were sought through community organisations and placing posters in public spaces. Volunteers were screened by interview to determine suitability: inclusion criteria (age >14, meet DSM-IV-TR [APA, 2000] criteria for PTSD related to the rape and, understand English) and exclusion criteria (suffering from psychosis). Following the University's ethical procedures, participants signed informed consent forms for treatment and for information obtained to be used in reports and publications (in which pseudonyms were used). The three cases of DFSA involved white women. Two were South African: Lori (21), a student, and Anna (43), a health professional. The third, Emmy (21), was an exchange student from North America. Participants differed in: age; socio-cultural, economic and educational background; time period between occurrence of trauma and presentation for therapy and; relationship to the perpetrator.

### **Procedure and data collection**

Cases were assessed and treated by AB (who had basic training and supervised practice in Cognitive Therapy), supervised by CD, a certified cognitive therapist and schema therapist who was familiar with Ehlers and Clark's CT. All sessions were voice recorded. Following a comprehensive clinical assessment (step 1), a diagnosis and case formulation were written (step 2) which informed the treatment plan (step 3). Treatment was based on Ehlers and Clark's (2000) CT. This flexible, formulation-driven model is implemented in two phases. The assessment phase involves investigating the nature of the trauma memory, identifying the main cognitive themes (i.e. problematic appraisals of the traumatic event and/or its sequelae) and problematic cognitive/behavioural strategies that need to be targeted. It also includes provision of psychoeducation about PTSD and mechanisms underlying the disorder and a rationale for

treatment. The treatment phase involves modifying excessive negative appraisals of the trauma, reducing re-experiencing through further elaboration of the trauma narrative and discrimination of triggers and helping the client drop dysfunctional behaviours/cognitive strategies. Experiential engagement with the trauma memory through reliving serves to identify problematic peri-traumatic appraisals which are addressed in various ways including imagery rescripting within reliving (Arntz, Tiesema, & Kindt, 2007; Grey, Young, & Holmes, 2002). This involves guiding the client to provide a detailed verbal narrative of the trauma, in the present tense, while remaining emotionally engaged and heightening awareness of visual, auditory, and other sensory cues. This allows salient appraisals to be identified that may be missed in a more detached narrative. Once alternative and more adaptive appraisals have been generated, through for example traditional cognitive restructuring, the client practices these appraisals. Then, during a subsequent reliving, the client is guided to insert these appraisals at the appropriate points in the trauma memory, a process termed cognitive restructuring within reliving (Grey et al., 2002).

We implemented CT in line with the recommendation of Holmes, Arntz and Smucker (2007) to work actively to restructure images, and of Grunert, Weis, Smucker and Christianson (2007, p. 317) to “find the best CBT ‘treatment fit’ for the specific trauma characteristics of each patient.” Because depression is a common associated feature of PTSD, and is often maintained by the same negative trauma-related appraisals and avoidant coping that maintains the PTSD, targeting of the PTSD can be expected to impact on the depression. When obstacles were encountered, additional interventions were drawn from other approaches to complex trauma (Edwards, 2009) including schema therapy (Young, Klosko, & Weishaar, 2003).

The case studies were based on the following data sources:

*Audio recordings and transcripts:* Verbatim transcriptions were made of all sessions from voice recordings. The transcript of one session from each completed treatment was compared with the recording by an independent assessor who completed a form identifying additions, distortions or omissions. All additions and omissions were due to typographical errors and did not impact on the intended meaning of the communication.

*Self-report scales:* were administered repeatedly during the assessment and treatment process.

*Post-traumatic Diagnostic Scale (PDS) - Part 3* (Foa, Cashman, Jaycox, & Perry, 1997) comprises 17 items assessing the nature and severity of PTSD symptoms. *Beck Depression Inventory (BDI-II):*

Beck, Steer, & Brown, 1996) is a 21-item measure of clinical symptoms of depression and anxiety respectively.

*Session Records:* generated from memory shortly after each session, summarised the events in the session and included information about the therapist's experience of the session and reflections on the client's process and observations relevant to the research aims.

*Supervision notes:* on issues discussed and suggestions made during case supervision.

## **Data processing**

Five data reductions were generated:

- *Assessment summary:* a concise, thematic synopsis of the information obtained during the assessment phase including points relevant to the research aims (e.g. factors influencing the client's engagement with the therapist, inclusion of interventions during this phase).
- *Case formulation:* organised in terms of predisposing, precipitating and maintaining factors.
- *Treatment narrative:* a synoptic and thematic account focusing on the unfolding process of interaction between client and therapist and on themes or patterns relevant to the research aims, including those identified by Gauntlett-Gilbert et al. (2004). For each participant, an independent assessor compared the narrative of a selected session with the transcript using an evaluation form and judged whether it was representative of the main features of the session, whether theme(s) identified were accurately presented and whether anything significant was missing that was relevant to the research aims. The assessor's feedback was used to further enhance the accuracy of the narratives.
- *Interpretive thematic cross case review of factors salient in the treatment of DFSA:* These factors were identified *a priori* from Gauntlett-Gilbert et al.'s (2004) work and *post hoc* from the material of the current cases. The material of each case was examined for material relevant to each factor which was synthesised into cross-case comparisons.
- *Graphical representations of self-report measures.*

## **Results part 1:**

### ***Synoptic case narratives***

The case summaries below are abbreviated from extended narratives in AB (2010). Only a brief summary of the case of Anna is provided since treatment of PTSD was only one of several

components of an extended therapy process and a separate case study article is in preparation. Parts of the narratives that feature in the thematic cross-case review are presented in the next section, including details of the intrusions and how they were addressed.

### **Case 1: Emmy**

Emmy, an exchange student from North America, had been in South Africa for ten months before seeking treatment. The DFSA had occurred two months before her move but was not a factor in her enrolling in the exchange program. Emmy was raised in a loving and protected home and this had contributed to her developing an extremely positive world view. She believed that she was invulnerable to harm and capable of protecting herself, that the world was a safe place and that other people were trustworthy. Emmy was also from a conservative and religious family and believed that being a virgin was sacred and sexual intimacy was reserved for committed relationships.

Emmy reported having been raped by an acquaintance after attending a party at her local varsity. She remembered arriving at the party by late afternoon, socialising with her friends and the perpetrator and consuming alcohol. She had no memory of leaving the party or returning to the house she had shared with two other students. Her next memory was of entering her bedroom and feeling extremely disoriented and seeing the perpetrator in her room. She felt very confused upon seeing him and wondered what he was doing in her room and how he had entered the house. Emmy had one brief memory of the rape itself and this involved waking up and seeing the perpetrator on top of her and feeling confused and physically paralysed. She reported having experienced her body as being "limp". Emmy's memories for the period after the trauma were slightly less fragmented. She reported that she had woken up the next morning feeling confused and disoriented and immediately upon waking she noticed the perpetrator discreetly attempting to leave her bedroom. She recalled that he appeared shocked upon noticing that she had awoken and rapidly left her room. Emmy then realised that she was completely naked and she experienced discomfort in her vaginal area and some bruising on her body. She attributed her amnesia and physical reactions during the rape to her excessive consumption of alcohol.

Emmy's amnesia for the night of the rape, her sense of confusion and disorientation prior to the trauma and her paralysis during the rape led to the clinician suspecting she had been drugged. Before communicating this to Emmy, the clinician, through close questioning, re-examined her

physiological reactions that night and investigated her alcohol tolerance levels and her sleeping patterns. Emmy believed she had a “good” alcohol tolerance level and was able to remain awake and mobile even after she had consumed alcohol to the point of intoxication. She had never previously experienced the sense of disorientation or physical paralysis she had felt the night of the rape and had never previously experienced amnesia after consuming alcohol. Emmy had a ritual, which she consistently undertook, for nights when she drank alcohol: once she returned home, she would prepare a large meal for herself and drink large quantities of water before she went to bed. This ritual was aimed at preventing hangovers. She had no memory of having performed these rituals the night of the trauma. She also reported that she was a very light sleeper, even when intoxicated, and could easily be roused from sleep even after consuming alcohol. Based on this information, the clinician concluded that Emmy had, in all likelihood, been drugged prior to the rape.

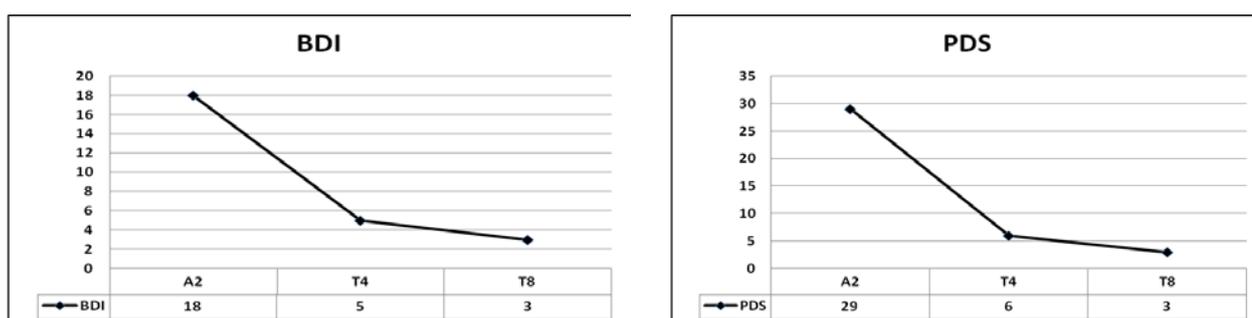
Following the rape, an intrusive memory was triggered when Emmy lay down on her bed and she experienced hyperarousal and hypervigilance. She kept the trauma a secret and suppressed all thoughts and memories and her symptoms diminished but did not resolve.

In South Africa, she became involved in a committed relationship with Farai who, after their first sexual intercourse, suspected that Emmy had not been a virgin as she claimed. His questioning led to Emmy disclosing the rape and, with triggering of the trauma memory, her PTSD symptoms intensified. She felt a deep sense of loss, believing the rape had compromised her experience of herself as “pure” and a virgin and her ability to decide when and with whom she would first be sexually intimate. Rumination on how she could have prevented the rape was an obstacle to her accepting that the trauma had occurred and was in the past. Farai encouraged her to seek help and her first session occurred three weeks later. She was distressed that, after two months, she would have to return to North America to reside again in the house where the trauma occurred (at least until she found different accommodation). Believing she would have no social support as her family was unaware of the rape, she feared she would not be able to cope.

Emmy met diagnostic criteria for PTSD (PDS: 18). She experienced one intrusive memory of the rape that involved a visual image of the perpetrator lying on top of her and raping her and the experience of her body as being “limp”. This intrusion was triggered by Emmy lying down on her bed at night. She experienced symptoms of hyper-arousal at night and was more vigilant and

easily startled and had difficulty sleeping. She met criteria for Major Depressive Disorder (MDD): an episode (moderate), her first, had been precipitated by her disclosure to Farai (who continued to support her through the treatment). She felt sad and despondent, often cried, and had difficulty concentrating on her work which troubled her as she had to prepare for exams. Her low mood was exacerbated by the loss of her identity as a virgin and her self-blame for drinking alcohol.

**Treatment Plan and response to therapy:** There were 5 assessment (A1 to A5) and 8 therapy (T1 to T8) sessions. Goals for treatment, developed collaboratively, included: addressing her PTSD; preparing for her return to the site of the trauma; enhancing her social support back home and constructing an adaptive world view. During the assessment, psycho-education normalised symptoms and a comprehensive narrative of the events was constructed. Emmy's self-blame was addressed by building more flexible and adaptive meaning structures, described in Results part 2, below. During T1-T4 maladaptive beliefs were addressed (e.g. "I won't be able to cope with returning to [the site of trauma]") through imaginal rehearsal, problem-solving, cognitive restructuring and building social support. To help her grieve the loss of her identity as a virgin she was encouraged to speak about the meaning and value she had accorded her virginity and her expectations for her first sexual experience and to engage with her sadness and loss. This led to her accepting (T4) that she could not reclaim her virginity and she decided to take action to make



**Figure 1: Emmy's scores on BDI and PDS**

the perpetrator accountable for the harm caused. Treatment led to complete remission of symptoms as shown in Figure 1.

**Case 2: Lori**

Lori's DFSA occurred five months prior to her referral. Her childhood family environment was unstable and she could not clearly recall events before age 11. Her father often brutally assaulted her mother and Lori was possibly also subjected to abuse as a child. When she was 4, her mother divorced her father and remarried a year later. When her father relocated to a different city and had limited involvement in her life thereafter, she felt abandoned and "not good enough". She was positive about her step-father and felt grateful for his love and support. However, conflicts between him and her mother left Lori feeling alone, helpless and "numb". Aged 13, Lori began cutting herself to "reaffirm [she] was alive." Her mother suffered from episodes of severe depression and her step-father, feeling powerless to help her, often turned to Lori for support. Lori believed she "needed to be there" for her parents and put her own needs and feelings aside. During adolescence, her mother, believing Lori was overweight, placed her on several diet programmes. Lori started binge-eating in secret, especially when distressed. She had difficulty with anger and would punch walls to cope with it. She believed she was inherently deficient, unworthy of support or protection, could not rely on others to meet her needs and, if she expressed herself, she would be hurt or abandoned. From late adolescence, she had a series of unstable relationships with self-serving and manipulative men and women in which she took a self-sacrificing role.

Lori was raped by a male friend she met at a night club. He bought her several drinks and offered to walk her home. She gratefully accepted as she lived 7 kilometres away and had no transport. After arriving home, she made coffee for both herself and her friend and spent some time chatting to him. However, after a few minutes, she began to feel extremely drowsy and indicated to her friend that she was tired and needed sleep and he should see himself out. Her last memory was of walking into her bedroom and changing into her pyjamas. She awoke the next morning feeling nauseous and disoriented. She was shocked to find she was only partially clothed, felt vaginal discomfort and had bruises on her body. She realised she had been raped.

As with Emmy, the clinician suspected that Lori's rape had been a DFSA. She would not have been able to manage a 7 kilometre walk home if she was severely inebriated and her actions upon arriving home (e.g. preparing coffee, having a conversation, changing into her pyjamas) indicated that she was quite lucid. Further questioning revealed that Lori was also a very light sleeper and

awoke if she heard any noises in or around her house. In addition, she had never experienced such physical reactions (i.e. nausea and disorientation) or amnesia on prior occasions when she had consumed alcohol.

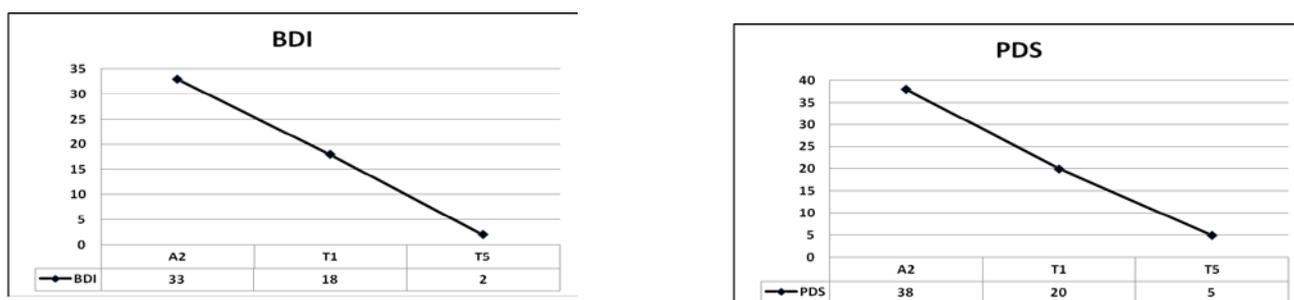
Lori assumed that her amnesia and related physical symptoms were due to alcohol intoxication. She felt responsible for the rape believing that (i) by accepting drinks from the perpetrator she had rendered herself vulnerable and facilitated the rape, and (ii) since he had been a friend, she should have been able to “read his intentions” accurately. She feared others would also hold her responsible for the rape and kept the trauma a secret for five months. In due course, her step-father noticed the change in her mood and encouraged her to share her difficulties. She disclosed the rape and he and her mother were supportive and encouraged her to pursue therapy.

Lori met criteria for PTSD (PDS: 38). She experienced an intrusive memory of the rape involving a feeling of pressure on her chest that she described as a “heavy weight pressing down” on her. This sensation was accompanied by a feeling of being suffocated and was triggered whenever she lay down on her bed at night. Her sleep was disturbed as she was overly alert, awoke at any noise, and repeatedly checked the source of any sounds and that all doors were locked. The intrusion was also triggered by distressing dreams (not of the rape) and visiting the night club. To cope with these distressing reactions, she suppressed the memories, avoided night clubs and speaking about the trauma. After disclosing the rape, troubled by her inability to remember, Lori started ruminating on the rape in an attempt to access a fuller memory. She met criteria for MDD (recurrent, moderate). Previous depressive episodes had been precipitated during adolescence by her parents’ marital conflicts. Since the rape, she had experienced sadness, dejection, guilt and shame and often isolated herself in her room and cried. A lack of energy made it difficult to attend to academic work and daily tasks. She stopped physical exercise and withdrew socially. Lori had several Borderline Personality traits: a history of intense, unstable relationships; an intense fear of abandonment; a tendency to shift between idealising and devaluing others; difficulty controlling anger and; previous self-harming behaviors.

***Treatment plan and response to therapy:*** Lori was seen for 7 assessment (A1 to A7) and 5 therapy (T1 to T5) sessions. The treatment plan, developed collaboratively, involved addressing her PTSD symptoms. Although, given her background and borderline traits, AB recommended

long-term treatment Lori only wanted to address the impact of the rape. During A1-A7, psycho-education about PTSD and DFSA normalised her symptoms and helped resolve her self-blame (see Results part 2). The therapist asked Lori if she could identify features that would enable one to identify a potential rapist from a benign person, which helped her realise that she could not have been able to 'read his intentions' and this resolved her sense of gullibility. She was encouraged to actively access social supports and a comprehensive verbal narrative of the trauma was built. During T2-T4, her intrusion was targeted with imaginal reliving. She still had sleep difficulties but unexpectedly stopped therapy to prepare for exams. At T5, six weeks later, her symptoms had completely resolved. Figure 2 which shows the marked decline in symptoms over the course of assessment and treatment. Probably an important contributing factor was her having moved to a different house, thereby eliminating the triggering effect of being in the room in which the rape occurred.

**Figure 2: Lori's scores on the BDI-II and PDS**



### Case 3: Anna

Anna's DFSA had occurred 25 years earlier. Raised by a neglectful father and a narcissistic mother who persistently criticised and shamed her at home and in public, Anna sought companionship with her older brother who was frequently punitive and vindictive towards her. Anna believed that she: could not trust other people; was unlovable; socially undesirable and; would be ridiculed or shamed if she entered social situations or established close relationships.

Aged 18, Anna attended a party at a holiday resort and, while at the party she drank one soft drink, spent time on the dance floor and tried to interact with some of the people present. She was subsequently approached by an older man and recalled having been asked numerous questions by him including her age and whether she was alone at the function. Anna's next memory was of momentarily regaining consciousness and realising that she was being raped by this man in her hotel room. She had no memory of returning to her room or of how he had

gained access to her room. During the assault Anna had felt disoriented, confused and physically paralysed and at one point she had experienced sexual arousal. Upon waking, she felt intensely nauseous and disorientated and had difficulty standing or walking. She also felt confused about what had happened and disclosed the rape to no-one. However, in her early twenties, she conducted her own investigations and researched the symptoms she experienced the night of the rape (e.g. amnesia, disorientation, physical paralysis) and learnt that they corresponded to the reactions encountered in victims subjected to drug facilitated rapes.

Anna met diagnostic criteria for PTSD. She experienced one intrusive memory that had persisted for twenty-five years, involving an image of the party scene that occurred prior to the rape. It was triggered when Anna entered social settings and so she avoided social situations. She felt overly alert, jumpy and had difficulty sleeping. She felt: sad and disappointed at the impact of the rape on her life; guilty for the sexual arousal she experienced during the assault and; angry that she had been raped and that there had been no one for her to turn to for care and support. In addition to PTSD (PDS=30), Anna met criteria for Social Phobia (generalised), Avoidant Personality Disorder (APD) and MDD (recurrent), the current episode having lasted for a month (BDI=20).

***Treatment plan and response to treatment:*** Unlike Lori, Anna wanted to address a range of issues including her social avoidance and unresolved grief over the death of her brother. There were 11 sessions that were primarily assessment (A1 to A11), followed by 33 treatment sessions (T1 to T33). The PTSD was addressed from A2 to T7 through psycho-education, building a detailed verbal account of the trauma and imaginal reliving. By T8, the PTSD seemed to have resolved, however, symptoms returned some ten sessions later due to thematic and affective links between the trauma memory and her early experiences of victimisation within her family (detailed in AB, 2010). From T19 to T33 she was treated with schema therapy and her symptoms resolved (BDI = 6; PDS = 5).

## **Results part 2:**

### ***Thematic cross-case review of aspects of treatment salient in DFSA***

A review of the case narratives led to identification of aspects that were particularly salient for these three clients and cross-case examinations of the role each played are presented in the following paragraphs. The first two are an important part of CT for PTSD from other sources.

**Psychoeducation orients clients to work for change**

Psychoeducation is a central feature of the model and was used in all therapies. In addition to the examples already given, it was important in addressing Anna's belief that something was inherently wrong with her body because she had become sexually aroused during the rape. For years after the rape, she forced herself to engage in sexual intimacies "to check whether [she] was normal or not, whether [she] had normal reactions," but her guilt and shame remained unresolved. Such sexual arousal frequently occurs in non-DFSA cases and survivors often experience disgust, shame and guilt believing they have repulsive sexual desires or that something is inherently wrong with them (Dunmore, Clark, & Ehlers, 1999). After the therapist explained that sexual arousal was not indicative of her wanting to experience sex through rape and, that since she had been drugged, her reactions were involuntary, Anna reported that hearing this from someone else validated her tentative assumption that her reactions were normal. Her guilt and shame then resolved. Another use of psychoeducation was for Emmy's rumination on ways in which the trauma might have been averted. Such counterfactual thinking (Kubany, Haynes, Abueg, Manke, Brennan, & Stahura, 1996) is a common maintaining factor in PTSD because it prevents acceptance of the fact that the trauma occurred (Ehlers & Clark, 2000). This was explained to her and by session A4, she was able to say, "I don't dwell on what the possibilities could have been. It's just simply yes, it did happen yes, he did rape me".

**Social support undercuts shame and increases motivation to change**

Building or re-establishing social support is also an important aspect of CT for PTSD. For Lori and Emmy this helped address the shame and guilt which often leads to social withdrawal following rape. Lori was helped to identify genuinely supportive others and encouraged to share her experiences. She disclosed the rape to a female friend whose anger at the perpetrator's actions further challenged her self-blame and led to her fully accepting that "drinking alcohol was not an invitation to be raped". She also reported "if other people clearly don't blame me, why should I keep blaming myself". Emmy had Farai's support but would have to tackle disclosing the rape to her family and best friend when she returned to North America. She was guided to consider how she would approach them and what responses she anticipated. She believed they would initially be shocked and angry on her behalf but, after absorbing the news, would be supportive and help her prosecute the perpetrator. AB investigated the resources available to her upon returning to

her old campus and guided her to establish how she would go about accessing supportive others within her campus community. Anna's social phobia predated the rape, but was exacerbated thereafter, as she avoided several social situations which might trigger the trauma memory, increasing her social isolation. This meant that building social support also involved addressing the social phobia/avoidant personality, which was done with a combination of CT for social phobia (Clark & Wells, 1995) and schema therapy (Young et al, 2003). By the end of treatment she had established meaningful friendships and no longer met criteria for social phobia or APD.

Next we focus on aspects of treatment particularly pertinent to the treatment of PTSD following DFSA, some of which were identified by Gauntlett-Gilbert et al. (2004).

### **Survivors may not realise the rape was drug-facilitated**

These three women were initially unaware they were victims of DFSA. This aspect, not identified by Gauntlett-Gilbert et al. (2004), has specific implications for treatment. Since alcohol can produce symptoms similar to that of drugs used in DFSA, not only survivors but also clinicians may mistakenly attribute symptoms to alcohol intoxication. Where rape has occurred against the backdrop of alcohol consumption and victims present with amnesia, clinicians need to assess for DFSA. Emmy, for almost a year, and Lori, for five months, had both believed their amnesia and other physical reactions were the result of alcohol consumption and only discovered during the assessment that they had been deliberately drugged. Information about the types of drugs used to perpetrate rape and the associated physiological symptoms (Hall & Moore, 2008; Stark & Wells, 1999) was valuable as a basis for close questioning about their physiological reactions prior to, during and after the rape. Anna had researched her symptoms nearly 20 years before she entered treatment and already knew her rape was drug facilitated. But for the previous six years she had felt confused as she had not consumed alcohol and had no knowledge of DFSA.

Psycho-education about the effects of DFSA drugs was very important for Lori and Anna. "But that changes everything!" Lori exclaimed, as she started questioning the basis of her self-blame. Anna valued the validation of her conclusion that her rape had been a DFSA as it normalised her confusion. Initially the impact on Emmy, with her extremely positive beliefs about safety and security in the world, was different. Recognition that the rape was DFSA shattered her belief in personal control: "to consider that I was drugged as well... I don't know.... I guess it kinda helped

the fact that I can blame myself... I had some control but then if I was drugged and raped then it's... I become a complete victim". Considerable attention was directed towards Emmy's self-blame. Psycho-education about schemas and the challenge posed by traumatic events to pre-existing positive assumptions about the self, world and other people led to her berating herself for "being so naïve". Guided discovery helped her appreciate that because she had been raised in a sheltered environment she had no reasons for suspecting the world was not a safe place or that she was vulnerable to harm. The therapist emphasized that the rape represented one instance in which she had been rendered unable to defend herself owing to the actions of another person. This did not generalise to other areas of her life as she could identify several instances in which she had coped courageously with difficult life circumstances. The therapist also reflected that the rape did not imply that her world was entirely malevolent and helped her to identify positive experiences with people in different parts of the world to emphasize this point. These interventions helped Emmy to realise that people were trustworthy but within limits and that she possessed weaknesses but was also courageous.

The therapist also firmly advocated that the perpetrator was entirely responsible for the rape, emphasising that Emmy had been unconscious during the assault and not a willing participant in sexual intimacy and that the perpetrator had been aware that she was unconscious and had acted deliberately. This led to Emmy remarking that she needed to re-evaluate her assumptions. By T4 she concluded that drinking alcohol excessively had enhanced her vulnerability to predatory individuals and this was something that she "[could] change in the future but what actually happened, what he actually did to [her] was completely not under [her] control, it was his fault, was his wrong doing."

Promote safety and security especially when DFSA is perpetrated in the survivor's home  
Gauntlett-Gilbert et al. (2004) briefly touch on the negative impact of DFSA on a victim's sense of safety and security. They identify two characteristics of DFSA that enhance the victim's experience of vulnerability following the trauma. The first is that DFSA is usually perpetrated by someone known to the victim and this, in combination with the premeditated nature of the attack, can lead to the victim feeling gullible and questioning their own judgement. The second is that victims are usually drugged in a familiar location which can result in the victim feeling overly alert in places that they previously regarded as safe. Although these characteristics apply to non-

DFSA cases leading to enhanced feelings of vulnerability, the degree of premeditation involved in DFSA is a distinctive feature of this crime.

In the case series, enhanced feelings of vulnerability were not the result of the assault having been drug facilitated and premeditated. Instead, the familiar location in which DFSA was perpetrated led to feelings of vulnerability. Lori and Emmy were raped in their bedrooms and experienced intrusions and hyperarousal in this setting. As suggested by Gauntlett-Gilbert et al. (2004), therefore, promoting a sense of safety is an important focus of treatment. Lori rearranged her room to minimise any association with the rape and, during a home visit, no obvious triggers could be identified. Work on the trauma memory (imaginal reliving and restructuring within reliving) and restructuring her nightmares led to a marked reduction in her reported symptoms of hyperarousal but she still found it difficult to sleep at night. She reported that, lying in bed at night, her thoughts largely revolved around the possibility of an intruder entering her home and harming her. During T4, careful reality testing helped her appreciate that she lived in a very secure neighbourhood with three other female students and was rarely alone at night. Subsequently, she was able to challenge her fearful thoughts at night and this led to some reduction in her reported symptoms of anxiety. However, it is probable that some residual triggering from cues in her room was contributing to the maintenance of her symptoms because, three weeks later, she relocated to a different house and her residual symptoms completely resolved. For Emmy, away in another country, the thought of returning to the site of the trauma evoked fears of not being able to cope. To address this, she was guided to imaginally rehearse returning to the trauma site. This helped her to anticipate the emotions she might experience and how she could deal with them. During a second imaginal rehearsal, she visualised her father walking beside her. This contributed to an enhanced sense of security and protection.

### **Enhance physical agency and empowerment**

The helplessness typically experienced by rape victims was exacerbated by the drug induced physical paralysis and it was important to reaffirm physical agency. Imagery rescripting played a significant role in all three cases. Emmy was guided to visualise herself pushing the rapist away and returning to a place of safety. This imagery work, described in 4.6., enhanced her sense of agency. Lori believed that because the perpetrator had physically immobilised her, she needed a physical means of reasserting her agency and found it helpful to re-engage with physical exercise

and resume attending a gym. She was helped to feel more physically assertive through restructuring of recurrent nightmares in which she was physically paralysed (Krakow et al., 2001). For example, in one, she watched her friend hurl herself from a cliff edge and was unable to move to prevent this. The therapist guided Lori to visualise being released from her paralysis, walking towards this friend, offering comfort and support, holding her hand and guiding her away from the cliff edge. Afterwards, Lori reported feeling relieved and surprised that she had been able to move and walk as she had felt completely paralysed in the nightmare. Anna's experience of herself as helpless and powerless was embedded in childhood schemas that were addressed through imagery rescripting and other schema therapy interventions. The empty chair technique (Young et al. 2003) was also used in which Anna was guided to express her anger by first imagining the rapist sitting in a chair across from her.

Another avenue of empowerment is to support clients in taking legal action. However, cases of DFSA are especially difficult to prosecute due to survivors' amnesia and time delays in reporting. This can exacerbate powerlessness/helplessness. Only one DFSA case in South Africa has ever resulted in conviction (and a sentence of ten years imprisonment) (Ellis, 2001). The victim reported the incident to the authorities within 24 hours and the medical report and psychologist's report secured the case. Lori was assisted in investigating her legal options. She discovered that irrespective of the time delay in reporting, a survivor could submit an affidavit to the police detailing the crime. This would serve as evidence if the perpetrator committed a similar offence. Lori did this and reported experiencing it as empowering and helping her to achieve "closure". Emmy believed the legal options available in North America would ensure that she was able to make the perpetrator accountable for his crime. The therapist encouraged her to consult with her university's Legal Aid centre when she returned to determine how best to proceed and prepared her for disclosure to this centre. Legal action was not an option for Anna since the incident had taken place in a different province so long ago and the perpetrator was unknown to her.

### **Address amnesia within the trauma memory**

The present cases all featured the partial (Anna, Emmy) or complete (Lori) amnesia highly prevalent among survivors of DFSA (Gauntlett-Gilbert et al., 2004). Such amnesia does not protect against PTSD which also regularly occurs in patients with post-traumatic amnesia

following traumatic brain injury (TBI). DFSA drugs produce amnesia for explicit memories during the period of amnesia but implicit memories can still be encoded through data-driven processing (Ehlers & Clark, 2000). In addition there may be islands of memory for moments when consciousness briefly returns and post-hoc reconstruction of events (Harvey & Bryant, 2001). Patients with PTSD often have difficulty in recovering trauma memories as a result of psychological mechanisms variously referred to as data-driven processing (Ehlers & Clark, 2000), dissociation (Van der Hart & Nijenhuis, 2001), repression (McNally, Clancy, Barrett, & Parker, 2004) or emotional numbing (Mechanic, Resick, & Griffin, 1998). Although the resultant fragmented recall leaves clients confused about what actually happened, this effect can be reversed through psychotherapy. This means that fuller recovery of the memory can be a goal of treatment. However, amnesia due to drugs or TBI cannot be reversed. This becomes a problem when, as emphasized by Gauntlett-Gilbert et al. (2004), survivors believe they need to remember in order to recover from the trauma and start to ruminate in an attempt to retrieve the memories. This was the case with Lori, as described above. It was effectively addressed through psychoeducation and, once she no longer believed that remembering was a pre-requisite for recovery, she stopped ruminating.

### **Address intrusions, especially somatic intrusions**

Gauntlett-Gilbert et al. (2004) reported that in DFSA cases intrusions were either visual or “affect without recollection” described as “surges of emotion in response to a specific cue in the absence of a specific memory” (p. 218). They give as an example a “survivor [who] experienced intrusions of the feeling of hair on her face, and overwhelming distress associated with a specific smell”. This example includes a *somatic* intrusion (the feeling of hair) and an *olfactory* intrusion. We would therefore not consider this an example of affect without recollection, but an intrusive memory without a visual component, but with recollection in other sensory modalities. Such intrusions in the form of somatic memories are reported following exposure to other traumatic events (Michael, Ehlers, Halligan, & Clark, 2005). All three women experienced intrusions and somatic intrusions were particularly prominent. The treatment approach, which included restructuring within and outside reliving as described by Grey et al. (2002), will be described below.

Anna had two intrusions that were predominantly visual. The first had resolved some years after the rape. However, in A3 she reported that it had recurred when a patient who consulted her had facial features similar to the rapist's. It brought a sense of helplessness and anger which she described during an imaginal reliving aimed at identifying problematic appraisals.

A: I see him and I see him on top of me, I can't say that I see him in the room, I don't really see the room

AB: And what do you feel?

A: Anger, pure anger, and also a certain amount of, not so much fear but a sense of a lack of control, a lack of being able to say what to do at that point.

This was addressed through psycho-education about triggering which helped her appreciate why being near some men evoked anxiety and helped reduce her anxiety in these situations. In addition, outside reliving, she was invited to identify characteristics that differentiated the perpetrator from men that she had met subsequently to train her to discriminate between the "then and now" (Ehlers & Clark, 2000, p. 340). After this, the intrusion did not recur.

When asked about the content of the flashback, she described the second intrusion:

A: It's to the party of the night that I, the whole event happened, that's it.

AB: And what do you see?

A: Lots of people, dancing....I'm in a group of people....dancing....and lights, disco lights, that I have a distinct image of...and a lot of people close, not my favourite situation....and I feel as though I am back there.

This was still triggered in social settings so she normally avoided them. It was initially addressed by having her draw a layout of the room. Then, during a reliving, appraisals were identified: (1) "it put the stamp on any mistrust that I did have of social settings" (which was already considerable); (2) a belief that the rape had ruined her hope of a better future, was associated with sadness and disappointment. Socratic questioning helped Anna to appreciate that despite the rape she had still managed to fulfil various life goals (e.g. becoming a health professional). Connecting with the sadness led to her recovering childhood memories of being victimised by her mother and brother and rescripting of these broke the links to her intrusion and she was able to see the rape as a discrete incident.

Lori experienced a somatic intrusion of a feeling of a heavy weight on her which she relived in session T1:

AB: ... You're in your room... you're lying in your bed.....you're feeling as though there is a weight on top of you... and it's very heavy and you can't move (*Lori's breathing becomes faster, her face appears flushed and she looks frightened*)...What are you feeling?

L: Scared... (*Appears distraught*)

AB: What are you thinking?

L: That I'm not entirely sure what is going on, I don't want the weight on me any more (*distraught*).... I can't breathe... I just want it to stop (*starts crying*).

Her peri-traumatic appraisals reflected her confusion - "I'm not entirely sure what is going on" ... "I can't breathe...I just want it to stop" ... "I don't know why I can't wake up". After the role of these appraisals in maintaining her PTSD was explained, she was guided, in a second reliving, to update the memory with corrective information that answered these questions and concerns:

AB: ...you can't move and you're feeling very scared....you're stuck there and you're feeling very trapped and very suffocated....what do you now know is happening to you?

L: I'm....being raped [*sobbing*]

AB: It's okay Lori... you're being raped and what do you know now about why you can't move, why you can't wake up?

L: That I've been drugged

After this, AB helped Lori establish a sense of safety and the intrusion did not recur. One of Emmy's intrusions was primarily somatic, described here during the imaginal reliving session (T4):

E: It's just him on top of me, not that I even see his face clearly...maybe just him inside me that's woken me up

AB: Is there a physical sensation, do you feel anything in your body?

E: Feeling of him inside me...painful ...I think that's what originally made me wake up, the pain of him inside me.

This stopped after she had given a detailed verbal account of her ordeal in A2 and A3. However, the possibility that this intrusion could be triggered when she returned to the site of the trauma prompted her decision to undergo imaginal reliving to facilitate further processing. This took

place in session T4. Emmy's peri-traumatic appraisals were similar to Lori's - "what's going on, what's going on... I don't know what's going on... what's he doing?" Emmy was badly shaken by the reliving and safe space imagery (walking along a forest trail close to her home accompanied by her best friend) was used to stabilise her. This intrusion was updated in a similar manner to that of Lori's:

AB: ....You're lying in your bed...and you feel something...something wakes you up...what are you seeing?

E: I don't know what happened before hand...I'm naked and he's naked and on top of me.

AB: What are you feeling?

E: I can just feel the weight of him pressing against me.

AB: What are you thinking in that moment?

E: What the heck is going on?

AB: What do you know now about what's going on?

E: That he's trying to get inside me...he's trying to rape me...

After this, Emmy was disturbed by a second intrusion, which was entirely somatic: her body feeling "limp" associated with disgust/contamination related to the perpetrator compromising her experience of herself as pure. She described it in T5:

E: ... feeling disgusted because there's this violator, gross, this disgusting guy came in and violated me but he was inside of me and that's where... the penetration that I felt... and that's where all the disgusting feelings arise from...because he penetrated me, I was contaminated. It's something that I withheld for years and years and he just comes in one night and ruins all of it.

AB: Tell me more about how your body feels when that sense of contamination comes through.

E: It's just a sense of wanting to wash it out, wanting to rinse it out, wanting to somehow remove the action.

AB firstly intervened by actively arguing that Emmy was not a disgusting person and no part of her body was disgusting and emphasising that she was still good and worthwhile. In a rescripting intervention, Emmy visualised herself being released from her paralysis, pushing the perpetrator away, chasing him out and then returning to a friend's room and being tightly held by the friend. This triggered another memory: two months after the rape, Emmy was sexually intimate with an acquaintance but had forcefully pushed him away from her before any genital contact could occur. Feeling disgusted and ashamed and fearing she might have contracted a sexually

transmitted disease (STD), she had coped by suppressing the memory. When AB asked her how she would react to a friend in a similar situation, she appreciated that she needed to forgive herself for not acting in accordance with her values. She could also recognise that, since there had been no genital contact, she could not have contracted an STD. She was also actively encouraged to share her experiences with her friends and, when she did this, she realised that her friends also engaged in sexual behaviour that “they were not proud of”. This intrusion did not recur.

### **Discussion and Conclusions**

These cases studies corroborate and expand on the findings of Gauntlett-Gilbert et al. (2004) summarised earlier. First, they confirm the importance of dealing with amnesia in the trauma memory and bring into focus the need to understand and rescript somatic intrusions. Secondly, they confirm the importance of establishing a sense of safety. Third, the assumptions they identified were found in some of the present cases: Lori was ruminating in an attempt to recover a fuller memory, and she also blamed herself for being gullible; Lori and Emmy blamed themselves because of their alcohol consumption. However, none of them had been a victim of critical responses from others. Although the case narratives show how important it is to identify idiosyncratic personal meanings, the seven themes drawn out in the thematic cross-case review were particularly salient for the present cases.

An examination of flashbacks showed that they were coherent memories of aspects of what had happened which could be addressed therapeutically despite the absence of full episodic recall. For several, the primary sensory modality was somatic but this phenomenon is not exclusive to DFSA (Michael et al., 2005) and such flashbacks can be worked with in the same manner as those in other sensory modalities. They typically represented moments at which there was a heightened sense of threat and the associated peri-traumatic appraisals could be identified and targeted. In Anna’s case, intrusions persisted due to thematic and affective links to earlier negative experiences that needed to be uncovered and addressed for symptoms to resolve (Ehlers & Clark, 2000; Lee, 2006).

Interventions aimed at building social support, restoring a sense of agency and building a vision of a life beyond the trauma are part of the CT model for PTSD following any form of trauma, and were significant components of treatment in all the present cases. The limited likelihood of

prosecuting the perpetrator in DFSA means that alternative avenues of empowering a client need to be a focus of treatment. One option available to victims of DFSA in South Africa is submitting an affidavit to the police detailing the crime. Interventions to promote clients' capacity to protect themselves in the future also contribute to the enhancement of agency.

Taken in conjunction with other cases in the series, these case studies provide evidence for the adaptability and transportability (Schoenwald & Hoagwood, 2001) of Ehlers and Clark's CT, which proved to have the flexibility for treatment to be tailored to the specifics of each case (Edwards, 2009). They also provide evidence for the effectiveness of CT in the treatment of PTSD following DFSA. In contrast to efficacy research, which is often best conducted using controlled group comparison trials, effectiveness research is concerned with whether efficacious treatments work in a range of clinical contexts (Westbrook, & Kirk, 2005). Rich documentation of the process of the case, as found in systematic case studies, can provide sources of evidence with respect to whether it was the treatment that led to change or some other extraneous factors. Criteria for this have been summarized by Elliott (2002). Although a full examination in terms of these criteria is not offered here, the following are examples of evidence within the cases for the role of treatment in bringing about therapeutic gains.

First, each of the clients believed that therapy had been beneficial in producing change and that without treatment, symptoms would have remained. Lori believed that therapy had helped her achieve her goal of reclaiming her life from the trauma. Emmy was tearful at the last session, reporting that she "could not imagine how [she] would have coped without" therapy and expressed her gratitude to the therapist for helping her. Anna brought the therapist a gift and thanked her for "exorcising" the negative memories and voices that had constrained her life. She reported that she felt "lighter" and was "more open and receptive to the world". Second, there is evidence that enhancing social support was significant in resolving self-blame. Lori's and Emmy's self-blame only completely resolved once their social support base was enhanced.

Finally, in all three cases there was evidence that before treatment the memory of the rape had not spontaneously integrated into autobiographical memory. Anna had been having flashbacks for 25 years, Lori for 5 months, and although Emmy's symptoms had remitted, they returned in force shortly before she entered therapy, a year after the rape. After imaginal reliving and

updating in T1, Lori's somatic intrusion ceased. Emmy's severe visual intrusion which she had been experiencing almost daily ceased after retelling in A1. Emmy reported the somatic intrusion in T5 and, at T8, it had resolved following interventions that included imaginal reliving and rescripting. Anna reported visual intrusions of the perpetrators face in T5 (PDS = 17) and following imaginal reliving and 'then vs. now' differentiation (T6, T7), there were immediate reductions in symptoms (T8 PDS = 10). These changes make sense in the context of the therapeutic interventions, and it is improbable that they are due to extraneous factors. In each case, therefore, there is evidence that treatment was promoting the integration of the memory into autobiographical memory and that this contributed to symptom reduction.

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