

Exploring stigmatised loss in adult women who experienced child sexual abuse

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DEDICATION

This dissertation is dedicated to my beloved grandparents.

Thank you for many years of unconditional love and continual inspiration.

Your memory is my greatest treasure, to hold in my heart forever.

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First and foremost, I thank the Almighty for giving me the strength and ability to complete this dissertation and for the continuous blessings He has granted me.

I must express my sincere gratitude to my husband, Yasin. Your love, unconditional support, acceptance, patience and encouragement is what made this possible. Thank you for staying up with me through all those late nights and believing in me. You always pushed me to be the best I can be and believed that I could accomplish all that I set out to do. Your positive outlook on life has given me the strength to do it all. I love you.

To my parents. Without your everlasting love, I would not have been where I am today. You have taught me so much about sacrifice and discipline. Thank you for your guidance, unwavering support and allowing me to follow my dreams. I love you both.

A special thank you to my sister Zareefah. You have been a constant cheerleader through every venture in my life. Your kind and gentle soul has always taught me to trust and believe. Thank you for being my ray of sunshine and for keeping me laughing.

Without the following people, the successful completion of this study would not be possible:

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- To my colleagues in the Psychology Department. Your support and kind words every single day did not go unnoticed and greatly assisted me in this process.
- Cecilia van der Walt for the language editing of this dissertation.

DECLARATION

I declare that the study “Exploring stigmatised loss in adult women who experienced childhood sexual abuse” is my own work, and that I followed the referencing and editorial style as prescribed by the Publication Manual (6th edition) of the American Psychological Association (APA) to indicate and acknowledge all sources used in this dissertation.



Baaqira Kays Ebrahim

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14/02/2018

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PREFACE

The reader is kindly requested to take note that the article format was chosen for writing this dissertation. The researcher, Ms Baaqira Kays Ebrahim conducted the research and wrote the manuscripts within this dissertation under the guidance of Dr Hayley Walker-Williams (supervisor) and Prof Ansie Fouché (co-supervisor).

THIS DISSERTATION CONSISTS OF THREE SECTIONS:

SECTION A: Overview of the study

SECTION B: Manuscript 1 (Stigmatised loss in childhood sexual abuse: A scoping review)

Manuscript 2 (Childhood sexual abuse: Emerging stigmatised losses in adult women survivors)

SECTION C: Conclusions, limitations, recommendations and a combined reference list for sections A, B, and C.

Section A provides an overview of this study. Section B consists of two manuscripts. Manuscript one delineates phase I of the study, including a scoping review. Manuscript two covers phase II of the study, and discusses the qualitative secondary analysis conducted on preexisting data sets of the Survivor to Thrive (S2T) collaborative strengths-based group intervention programme. Each manuscript includes its own research objectives and related methodology used to answer specific research questions. The manuscripts are written in the article format according to the NWU policy related to this method of presentation, and prepared for specific journals of which the author

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guidelines are provided at the beginning of each manuscript. However, the technical style of these manuscripts remains consistent throughout this dissertation.

Finally, Section C provides the conclusions drawn from the study, with specific focus on the contributions and limitations of the study, and recommendations for future research.

Considering the overall purpose of the study, it should be noted that some duplication of content across the three sections can be expected.

EDITOR DECLARATION



1 November 2017

I, **Ms Cecilia van der Walt**, hereby confirm that I took care of the editing of the dissertation of Ms Baaqira K Ebrahim titled *Exploring Stigmatised Loss in Adult Women who Experienced Childhood Sexual Abuse*.

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ABSTRACT

The objective of this study was to explore what is known from literature and practice about stigmatised loss in female adult survivors of childhood sexual abuse (CSA). The current study was conducted in two phases using exploratory qualitative research with Bloom's model of stigmatised loss as a conceptual framework. During phase one, a scoping review of 19 studies was conducted. Thematic analysis of the studies identified in the scoping review recognised three stigmatised losses, namely: a loss of safety; deprivation of fundamental psychological needs; and a loss of sexual capacity. Hereafter a focus group discussion and individual interview with four helping professionals working with female adult survivors of CSA in practice was conducted to obtain input and/or identify any additional emerging stigmatised losses. Qualitative secondary analysis (QSA) was conducted in phase two using two sets of data collected during treatment sessions ($N = 15$) of the Survivor to Thriver (S2T) collaborative strengths-based group intervention programme for female survivors of CSA. All three stigmatised losses found in phase one were identified in the transcripts as well as an additional stigmatised loss: a loss of true self emerging. Further research is suggested to verify and expand on the findings of this study so as to inform treatment interventions for CSA survivors in South Africa.

Keywords: childhood sexual abuse, female, qualitative, South Africa, stigmatised loss, survivors

OPSOMMING

Die hoofdoel van hierdie studie was om ondersoek in te stel na wat uit die literatuur en die praktyk reeds bekend is aangaande gestigmatiseerde verlies by volwasse vroue wat seksuele misbruik tydens hul kinderjare ervaar het. Die huidige studie is in twee fases uitgevoer aan die hand van ondersoekende kwalitatiewe navorsing met Bloom se model van gestigmatiseerde verlies as 'n konseptuele raamwerk. Tydens fase een is 'n bestekoorstig van 19 studies uitgevoer. Drie gestigmatiseerde verliese is deur middel van die tematiese analise van die geïdentifiseerde studies tydens die bestekoorstig uitgeken, naamlik: 'n verlies aan veiligheid, ontneming van basiese psigologiese behoeftes; en 'n verlies aan seksuele bevoegdheid. Daarna is 'n fokusgroepbespreking en 'n individuele onderhoud met vier professionele persone wat met volwasse vroue wat seksuele misbruik tydens hul kinderjare ervaar het in hul praktyke werk om insette te bekom en/of enige bykomende gestigmatiseerde verliese te identifiseer. Kwalitatiewe sekondêre analise is tydens fase twee uitgevoer deur gebruik te maak van twee stelde data wat tydens behandelingsessies van die Survivor to Thriver (S2T) medewerkende sterktegebaseerde groep-intervensie program vir volwasse vroue wat seksuele misbruik tydens hul kinderjare ervaar het, ingesamel is. Al drie die gestigmatiseerde verliese wat tydens fase een aangetref is, is in die transkripsies geïdentifiseer, met 'n bykomende gestigmatiseerde verlies wat na vore gekom het: 'n verlies aan ware self. Verdere navorsing word voorgestel om die bevindinge van hierdie huidige studie te verifieer en daarop uit te brei om daardeur behandelings-intervensies vir volwasse vroue wat in Suid-Afrika seksuele misbruik tydens hul kinderjare ervaar het, op die hoogte te stel.

Sleutelwoorde: gestigmatiseerde verlies, kinderjare seksuele misbruik, kwalitatiewe, oorlewendes, Suid-Afrika, vroue

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SECTION A

OVERVIEW OF THE STUDY

The following section includes an overview of the background and rationale for this study, the literature overview, conceptual framework, research questions, aim and objectives, and the research methodology. The ethical considerations, summary of findings, limitations and contributions of this research study are also provided. Lastly, the layout of this study is presented.

1.1 Background and rationale for the study

Childhood sexual abuse (CSA) is a universal social problem and recognised as a complex trauma with devastating long-term, negative outcomes for the victim (Ullman, Peter-Hagene, & Relyea, 2014; Webster, 2001). Literature indicates a high prevalence of mental health problems (depression, anxiety, and personality disorders); intra-interpersonal difficulties (insecure relationships and lack of trust) and sexual problems (intimacy problems) (Hodges & Myers, 2010; Mathews, Abrahams, & Jewkes, 2013; Singh, Parsekar, & Nair, 2014; Trickett & Putnam, 1993) among survivors of CSA. Several authors argue that CSA could be seen as a complex trauma due to the long-term impact and unique contributing trauma-causing factors (Finkelhor & Browne, 1985; Kendell-Tackett, Williams, & Finkelhor, 1993).

Earlier researchers, Finkelhor and Browne (1985) and Summit (1983), attempted to explain the unique trauma-causing factors present in CSA. Finkelhor and Browne (1985) illustrate four dynamics present in CSA which make the trauma unique and different from other childhood traumas. These factors are identified as: (a) traumatic sexualisation (sexuality is shaped in developmentally inappropriate and dysfunctional ways); (b) stigmatisation (shame, guilt and self-blame surrounding the abuse); (c) betrayal (trust and vulnerability manipulated); and (d)

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powerlessness (child feels unable to protect self and halt the abuse). In addition, Summit (1983) also attempts to explain these trauma-causing factors and coined the term “Child Sexual Abuse Accommodation Syndrome”. The description of this syndrome attempts to improve the understanding of how a child views, responds and attempts to cope with the CSA. It encapsulates five categories: (1) secrecy (manipulation into keeping it a secret); (2) helplessness (fear of hearing the consequences of disclosure); (3) entrapment and accommodation (child tries to figure out the situation and survive); (4) delayed disclosure (often seen as unconvincing); and (5) retraction (withdraw after disclosure due to feelings of guilt) (Summit, 1983).

Another trauma-causing factor, not identified by Finkelhor and Browne (1985) and Summit (1983), and which has received little attention in literature, is loss. Loss is defined as not having something or having less of something or as a shortcoming caused by someone leaving or by something being taken away (“Loss”, 2017). Death is the event that is most often connected to loss but there are many other traumatic incidents associated with loss and the effects thereof, such as CSA. Losses can thus be personal, interpersonal, symbolic and/or psychological (Harvey & Weber, 1998). Loss is followed by grief. Grief is seen as the “continuing process of experiencing the psychological, behavioural, social and physical reactions to the perception of loss” (Miller, Cardona, & Hardin, 2006, p. 3). Normally a person who has experienced a loss, such as death, would be supported by society and allowed and encouraged to grieve openly. However, in the case of CSA societal norms are void due to the secrecy and stigma underpinning the CSA. Consequently, this may negatively affect how a victim of CSA experiences and processes loss. Stigma is defined as a “distinguishing mark” of social disapproval (Brosnan, 2013, p. 6). Many CSA victims grieve secretly due to guilt and the fear of being stigmatised, blamed or labelled for being a victim of CSA. This is described by Bloom (2007) as stigmatised loss. Stigmatised loss

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can be defined as unacknowledged loss where mourning is complicated, when losses or their causes are disenfranchised or hidden due to the attached social stigma or the perceived collaboration with the perpetrator (Brosnan, 2013; Doka, 1997).

Bloom (2007) further indicated that stigmatised loss as a result of CSA might lead to delayed grief, as such delayed grief can be defined as a postponed reaction to the loss often causing more intense grief reactions. Hence specific aspects of loss in relation to CSA make the process of healing unique. Seen from the loss perspective, the impact of CSA is understood as stigmatised loss experienced by victims, namely losses secondary to the sexual abuse such as loss of a sense of safety, loss of their attachment relationship, and loss of a normal innocent childhood. Due to the secrecy surrounding CSA, delayed grief prevails, because for these victims to survive, they need to adjust and move on but this causes them to not deal with the CSA losses immediately or appropriately. As such, these issues remain unresolved and come to the fore during a crisis later on during their adult lives. In summary, their losses are thus not recognised and therefore becomes seen as stigmatised loss (Bloom, 2003, 2007). Individuals who do not grieve or who show little signs of working through their loss will then suffer delayed grief reactions and when delayed grief surfaces it is usually as powerful and traumatic as if the loss had just occurred then (Bonanno & Field, 2001).

Due to the complexity and long-term impact of CSA and, specifically the presence of stigmatised loss and delayed grief, therapeutic intervention is thus imperative for survivors of CSA. However, to effectively treat survivors of CSA, therapeutic interventions need to acknowledge and incorporate empirical findings regarding factors such as stigmatised loss and delayed grief. To date, most therapeutic interventions have focused on alleviating symptoms but little attention is given to addressing the issues of stigmatised loss and delayed grief (Bloom, 1994; Bloom &

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Vargas, 2007; Sofka, 1999; Walker-Williams & Fouché, 2017). Similarly, in South Africa, little is documented on loss in the context of CSA and within therapeutic interventions, and no known scoping review could be found regarding this topic.

As such, the need arises to conduct both literature and empirical studies to explore what is known about stigmatised loss in female survivors of CSA, and specifically within the South African context so as to ultimately inform treatment practice.

However, due to the known secrecy surrounding CSA and the underreporting of this phenomenon (Mathews et al., 2013), gaining access to this population may be challenging and ethically restricting. Hence, the empirical part of this study explored the stigmatised losses reported by two groups of adult survivors of CSA who attended a collaborative strengths-based group intervention programme titled “Survivor to Thriver” (S2T) by employing qualitative secondary analysis (QSA) of existing and available transcripts of recordings taken during these group treatment sessions. These treatment groups were only attended by women, and this collaborative strengths-based group intervention programme was empirically developed specifically for this vulnerable female population. By conducting QSA, any possible harm, secondary trauma, or overresearch of this secluded and vulnerable population could be counteracted (Irwin & Winterton, 2011; Tripathy, 2013).

The main aim of this study was thus twofold: firstly, to explore what is known from literature about reported stigmatised loss in adult female survivors of CSA by conducting a scoping literature review, and secondly to conduct a focus group and one interview with helping professionals working in practice with CSA survivors and secondly, to employ QSA of existing data sets

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collected during two S2T collaborative strengths-based group intervention programmes with adult female survivors of CSA.

1.2 Literature overview

1.2.1 Child sexual abuse defined.

No universal definition for CSA exists. Internationally, CSA has been defined as inappropriate sexual activities occurring with a child before the age of 18 that were perceived as unwanted, intrusive sexual activities that include touching parts of the child under or over clothing, kissing, fondling, penetration, oral or genital contact (Brown, Reyes, Brown, & Gonzenbach, 2013; Godbout, Sabourin, & Lussier, 2009; Putnam, 2003; Zinzow, Seth, Jackson, Niehaus, & Fitzgerald, 2010). In South Africa CSA has been defined in the Children's Act 38 of 2005 (RSA) as:

(a) sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted; (b) encouraging, inducing or forcing a child to be used for the sexual gratification of another person; (c) using a child in or deliberately exposing a child to sexual activities or pornography; or (d) procuring or allowing a child to be procured for commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child. (p. 16)

For purposes of this study, CSA will be understood in light of the last-mentioned definition.

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1.2.2 Prevalence.

A number of meta-analyses have been conducted to determine the worldwide prevalence of CSA.

The findings of these studies are illustrated below and are followed by a brief discussion.

Table 1

Prevalence of CSA worldwide

Author	Year	Study	Countries	Studies	Gender distribution
Barth et al.	2013	Systematic review and meta-analysis	24*	55	9% girls ^a 3% boys ^a 15% girls ^b 8% boys ^b 31% girls ^c 17% boys ^c 13% girls ^d 6% boys ^d 0 to 69% girls ^e 0 to 47% boys ^e
Ji, Finklehor, & Dunne	2013	Meta-analysis	1 (China)	27	15.3% women ^e 13.8% men ^e
Stoltenborgh, Van IJzendoorn, Euser, & Bakemans-Kranenburg	2011	Meta-analysis	Not specified*	217	18% women ^e 7.6% men ^e
Pereda, Guilera, Forns, & Gómez-Benito	2009	Meta-analysis	22*	100	19.7% women ^e 7.9% men ^e
Hébert et al.	2009	Multivariate analysis	1	<i>N</i> = 804	22.1% women ^e 9.7% men ^e

Note. * denotes including Africa; ^a denotes forced intercourse; ^b denotes mixed sexual abuse; ^c denotes non-contact abuse; ^d denotes contact abuse; ^e denotes total CSA

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As indicated above, the global prevalence of CSA among girls is reported to be between 8 and 31% and for boys between 3 and 17%. The studies on reported CSA in adults are found to be higher among women than among men, with prevalence rates of 18 - 22.1% and 7.6 - 13.8% respectively (Barth et al., 2013; Hébert et al., 2009; Ji et al., 2013; Pereda et al., 2009; Stoltenborgh et al., 2011).

In their meta-analysis, Pereda et al. (2009) predicted that the prevalence rate might be even higher in Africa. As such, a recent study in the Eastern Cape Province of South Africa reported the prevalence to be 39.1% for women and 16.7% for men (Jewkes, Dunkle, Nduna, Jama, & Puren, 2010). Furthermore, Jewkes and Abrahams (2002) provided evidence that 44.4% of children experienced rape and 52% experienced indecent assault during 2007/08 in South Africa. The findings reported above are indicative that South Africa forms a part of this global epidemic.

Retrospective data is however not reliable due to the fact that one has to rely on adult memory (Jewkes & Abrahams, 2002). In South Africa, official statistics are provided by the South African Police Service (SAPS). According to the SAPS, 62 649 cases of sexual crimes were reported to SAPS for the year 2013/2014 (South African Police Service, 2014), of which 22 781 were sexual offences against children. This figure is estimated to be even higher since it is estimated that only one out of nine cases of CSA is reported to the police (Mathews et al., 2013).

The most recent nationally representative study published by Artz et al. (2016) indicates the prevalence to be 36.8% for boys and 33.9% for girls; thus reporting a higher prevalence in boys than among girls. Although this study will only focus on female survivors it by no means disputes the alarming impact on male survivors.

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1.2.3 Impact of CSA.

CSA has long-term effects on an adult's functioning due to its damaging and traumatic nature. CSA is associated with many adverse outcomes in adulthood and affects adult functioning in various ways. Often survivors of CSA are not even aware of these effects (Buckley-Willemse, 2011). According to Gilmartin (as cited in Buckley-Willemse, 2011, p. 133), "If left untreated, the impact of childhood sexual abuse does not just go away; it is eventually felt, and in many cases the long-term effects can be serious and even life threatening". CSA is associated with a wide range of mental health and sexual problems, as well as intra- and interpersonal difficulties. These are depicted in Table 2 and followed by a brief discussion of each.

Table 2

Mental health difficulties, sexual problems/dysfunctions and intra- and interpersonal difficulties

Category	Findings	Country	Sample	Author
Mental health difficulties	Depression	USA South Africa	Children Women	Kendall-Tackett et al., (1993) Mathews et al., (2013)
	Anxiety	USA South Africa	Children Women	Kendall-Tackett et al., (1993) Mathews et al., (2013)
	PTSD	Germany	Women	Priebe et al., (2013)
Sexual problems / dysfunctions	Sexual risk behaviour	USA South Africa	Children Women	Stock et al., (1997) Mathews et al., (2013)
	Sexual victimization	Australia South Africa USA	Women Women Children	Cashmore & Shackel, (2013) Mathews et al., (2013) Kendall-Tackett et al., (1993)
	Sexual dysfunctions	USA	Women Women	Rellini, Elinson, Janssen, & Meston (2011) Schloredt & Heiman, (2003)
Intrapersonal difficulties	Low self-esteem	USA	Women Children	Singh et al., (2014) Kendall-Tackett et al., (1993)
	Self-concept	USA UK	Children Women	Stock et al., (1997) McAlpine & Shanks, (2010)

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Interpersonal difficulties	Loss of interpersonal resources	USA	Women Women	Lamoureux, Palmieri, Jackson, & Hobfall, (2012) Singh et al, (2014)
	Relational Problems	USA	Women Women	Briere & Elliot, (1994) Richter et al., (2013)
	Social conflict	USA	Women	Lamoureux et. al., (2012)

The consequences of CSA have been consistently linked with, but not limited to poor mental and psychological health outcomes such as depression, anxiety, suicidal ideation, suicidal attempts, self-mutilation, substance abuse, eating disorders, posttraumatic stress disorder, low self-esteem, marital dissatisfaction, gender-based violence, sexual assault in adulthood, disrupted and unhealthy attachments, and general relationship problems (Boden, Horwood, & Fergusson, 2007; Cutajar et al., 2010; Frazier, West-Olatunji, Juste, & Goodman, 2009; Griffing et al., 2006; Kendall-Tackett et al., 1993). Adult survivors of CSA exhibit a more complex and severe condition compared to individuals whose posttraumatic stress disorder developed after a single traumatic event in adulthood (Priebe et al., 2013).

Furthermore, there is a strong association between CSA and adult sexual functioning. Significant studies have documented how sexual victimisation during childhood impacts a victim's sexuality. Sexual risk-taking behaviours linked to CSA include unplanned pregnancies and sexual problems. It was also found that adult survivors of CSA were likely to report sexual dysfunctions and to engage in sexually risky behaviour (Colangelo & Keefe-Cooperman, 2012; Phillips & Daniluk, 2004; Rellini et al., 2011; Schloretdt & Heiman, 2003; Senn & Carey, 2010; Senn, Carey, & Coury-Doniger, 2011; Senn, Carey, & Vanable, 2008; Sweet & Welles, 2012).

Intrapersonal difficulties, low self-esteem (Hodges & Myers, 2010; Kendall-Tackett et al., 1993; Sigurdardottir & Halldorsdottir, 2012; Singh et al., 2014) and poor self-concept (Davis & Petretic-

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Jackson, 2000; Kerlin, 2013; McAlpine & Shanks, 2010; Stock et al., 1997) are frequently indicated in research as long-term outcomes of CSA on the lives of adult female survivors of CSA. An immense impact prevails on interpersonal relationships, evident in the inability to trust others (Briere & Elliot, 1994; Hodges & Myers, 2010; Penning & Collings, 2014; Singh et al., 2014) which ultimately leads to relational problems (Briere & Elliot, 1994; Richter et al., 2013; Shi, 2013; Singh et al., 2014). The previous information mainly considers the impact of CSA on adult functioning. As seen above, few studies mention the experiences of loss associated with CSA and the importance of grief work with a view to enhance the recovery process for adult female survivors of CSA. Hence, it is important to understand loss within the context of CSA.

1.2.4 Models of loss and CSA.

Losses associated with CSA are not as tangible as in the case of death; therefore they are often not socially recognised or validated by others. As such, survivors often struggle with the task of grieving and creating meaning from their experiences. It is important to note that CSA losses do not need to necessarily be acknowledged by others for it to be experienced as valid and these losses could be more difficult to cope with than other losses. Overall, CSA deprives the child survivor of her/his innocence, severely disrupts her/his developing self-worth and will later distort the adult survivor's functionality and ability to form healthy attachments (Boyd, 2010; Fleming & Bélanger, 2001).

A widely recognised model explaining 'general' loss has been proposed by Kübler-Ross's (1969) five stages of grief. Three models in the context of CSA are: Bowlby's (1982) internal working model, Sofka's (1999) components of grief work and common goals and Bloom's (2007) model

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on loss. A brief discussion of each will follow after which the focus will shift to Bloom's (2007) model, which served as the conceptual framework for this study.

1.2.4.1 Kübler-Ross's (1969) Stages of Grief.

Kübler-Ross's (1969) model of the five stages of grief is based on research and work with terminally ill patients. The model categorises five stages of death and dying. It can be applied to people who are faced with death or with people who have an emotional bond with the dying person. The five stages – denial, anger, bargaining, depression and acceptance – are responses to loss experienced by many individuals. Grief here is emphasised as individual and unique (Kübler-Ross, 1971).

Although Kübler-Ross's (1969) model focuses on real loss and death, it does not address stigmatised loss as experienced by female survivors of CSA. Next Bowlby's (1982) model will be discussed.

1.2.4.2 Bowlby's (1982) Internal Working Model.

Bowlby (1982) advances that when developing a secure attachment bond, one learns to develop a sense of security and, should this bond be hindered, a child would develop a loss of worthiness and trust. CSA could lead to insecure attachments as the attachment bond is damaged by the mistreatment or neglect, and so the child develops a loss of protection or security (Bowlby, 1982). Bowlby (1982) further explains that grief and mourning could be activated when these secure attachment bonds are broken and emphasises the importance of grieving individuals to work through the negative thoughts and emotions attached to this loss so as to restore their secure attachments (Alexander, 1992; Bowlby, 1982). In addition, according to Bowlby (1982) these individuals could have a need to express their reactions to the loss and to talk freely and at length

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about the circumstances leading up to the loss and their experiences following the loss (Bonanno & Field, 2001). It is thus important that helping professionals are assisting in the recovery, are aware of these losses and know how to address them during the treatment process of CSA survivors. The loss of an attachment could create intense emotions and produce psychological changes as the person struggles to accept the finality of the loss (Shear & Mulhare, 2008). Bowlby (1982), however, does not focus on the unique losses associated with CSA. Next Sofka's (1999) components will be discussed.

1.2.4.3 Sofka's (1999) components of grief work.

Sofka (1999) found that complicated or overwhelming grief may be present when the awareness of multiple losses has not been consciously recognised or actively grieved through. Sofka (1999, p. 130) points out that "clients may be baffled by symptoms indicative of grief reactions seemingly unrelated to current events". Sofka (1999, p. 125) further states:

in addition to grieving the loss of a normal, innocent childhood, adult survivors of CSA may experience emotional pain due to subsequent losses in adulthood precipitated by the consequence of abuse, for example difficulty in developing and maintaining healthy intimate relationships or the loss of mental health.

Clark, Cole, and Enzle (as cited in Sofka, 1999, p. 126) add that it is further found that unresolved grief tends to be unaddressed in both clinical and nonclinical populations and that an "increased vulnerability to complicated grief reactions has been associated with a history of sexual abuse".

The limitation to this model is that, although Sofka (1999) mentions loss and grief in relation to CSA and although she has acknowledged complicated grief, she does not indicate how attachment

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could affect loss as described by Bloom (2007). Therefore Bloom's model (2007) was chosen as the conceptual framework for this study.

1.3 Conceptual framework: Bloom's (2007) model on loss

Bloom (2007) emphasises that adults who were abused as children carry around with them the impact of delayed, unresolved and stigmatised loss. This impact includes the situation of abuse, context of abuse, loss of a secure relationship or attachment and social denial of the magnitude of the problem. Furthermore, the losses are sustained in adulthood due to the fact that no clearly established or socially acceptable pathway to grief resolution exists. Bloom (2000a) further states that these CSA losses cannot even be acknowledged as real losses and instead are often seen as a blemish to the survivor's character and thus are not recognised in adulthood as legitimate reasons for grief, thus denying survivors the right to be acknowledged as legitimate mourners. Although survivors of CSA may not always be able to name the losses, Bloom (2000a, p. 5) explains that these "non-validated" losses occur in the context of a long-standing pattern characterised by the impact of these stigmatised losses. This then means that survivors of CSA experience these losses as being interwoven in their overall way of life and so they negatively affect general adaptive functioning and quality of life. Thus, as Bloom (2000b) argues, it is imperative for survivors of CSA to grieve these events from the long-buried past and indeed grieve the events that may not be considered appropriate causes for grief.

Limitations of Bloom's (2007) model include the fact that few empirical studies have been conducted using this model.

1.4 Losses in relation to CSA

In summary, it appears that the overall stigmatised losses relating to CSA as seen in the literature pertain to the loss of self and safety, followed by the loss of the attachment relationship and then the loss of a normal innocent childhood.

It is thus imperative to gain insight into these losses associated with CSA as experienced by a sample of South African women. This knowledge could provide helping professionals with better insight and potentially contribute to current CSA intervention programmes. The researcher is of opinion that practitioners need to understand the experiences of their clients so that survivors can better engage in the therapeutic experience of recovery while making meaning of their losses resulting from the CSA. This can only be achieved when one seeks to understand the experiences of loss associated with CSA within the South African context containing many diverse cultures.

Identifying the losses experienced by survivors of CSA is invaluable. When these losses are not grieved, it could give lead to serious implications for the individual and society. Thus, understanding and identifying the losses associated with CSA could have implications for intervention services enabling survivors to recover from the effects of CSA more effectively. As such, the problem remains: limited research and no documented studies exist within the South African context about stigmatised loss experienced by adult female survivors of CSA; therefore, the need arose for the current study and for conducting a scoping literature review and in doing so, to provide a summary of what is known in the literature and to subsequently link this to practice. The findings of this study could potentially contribute to the global knowledge base on stigmatised loss and to ultimately inform treatment practice (Bonanno, 2004; Miller et al., 2006).

1.5 Research questions

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In view of the rationale of this study, the following main research question was formulated:

- What is known from literature and practice about stigmatised loss in adult female survivors of CSA?

The following secondary research questions were formulated to aid in answering the primary research question:

- 1) What could be learned from previous studies in literature about stigmatised loss in adult female survivors of CSA?
- 2) What input or additional issues relating to stigmatised losses can be identified by a panel of helping professionals working within the scope of CSA in practice?
- 3) What stigmatised loss due to CSA emerged in a group of adult female survivors of CSA participating in two S2T collaborative strengths-based group intervention programmes?
- 4) What findings relating to stigmatised loss due to CSA could further inform S2T treatment practice for adult female survivors of CSA?

1.6 Aim and objectives of the study

The main aim of this study so as to answer the primary research question is:

- To explore what is known from literature and practice about stigmatised loss in female survivors of CSA.

To answer the secondary research questions, the following objectives were formulated:

- To conduct a scoping literature review to identify available literature and provide a summary of evidence from a variety of studies on stigmatised loss in adult female survivors of CSA.
- To present the findings of the scoping literature review to a panel of helping professionals working within the scope of CSA in practice and explore whether they agree with what was

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found in this current research or have identified any additional emerging issues regarding stigmatised loss in female survivors of CSA.

- To perform QSA of data sets from two groups of women attending the S2T collaborative strengths-based group intervention programme, over a 2-year period, aiming at exploring emerging reports of stigmatised loss in this population.
- To contextualise findings on stigmatised losses in order to inform future S2T treatment practice.

1.7 Research methodology

1.7.1 Paradigmatic perspective.

A paradigm is a philosophical and theoretical framework that incorporates specific theories, related to a scientific school or discipline and is composed of multiple belief categories such as their ontological, epistemological, and methodological assumptions (Labonte & Robertson, 1996; “Paradigm”, 2017). This study makes use of the constructivist paradigm which argues that human beings construct their own social realities through social interaction and that this reality is subjective and experiential (Grix, 2002; Labonte & Robertson, 1996; Sarantakos, 2005). Constructivist methodology focuses on people’s lived experiences and is concerned with meaning through knowledge as understanding. Individuals’ subjective meanings are assumed to be the core motivation behind their thoughts and actions. In constructivist methodology, the researcher forms an essential part of the inquiry (Krauss, 2005; Labonte & Robertson, 1996; Patel, 2012).

1.7.2 Research approach.

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Qualitative studies are useful in exploring the individual meaning of the complexity of a particular situation (Creswell, 2007). The research approach used for this study was an exploratory qualitative research approach. A qualitative research approach is concerned with the understanding of processes, culture and social context underlying various behavioural patterns, and exploring this type of data is considered to be deep and rich (Denzin & Lincoln, 2000; Merriam & Tisdell, 2016; Nieuwenhuis, 2011b). Qualitative research has five major characteristics as set out by Denzin and Lincoln (2000): (1) concern with the richness of descriptions; (2) capturing the individual's perspective; (3) the rejection of positivism and the use of postmodern perspective; (4) adherence to the postmodern sensibility; and (5) examination of the constraints of everyday life. The study was conducted in two phases. The first phase involved a scoping literature review of existing literature and a focus group discussion and one individual interview with helping professionals working in practice within the scope of CSA, with a view to answer the first and second research questions. As mentioned earlier, in phase two, QSA was conducted using data sets of two groups of South African female adult survivors of CSA, collected during the S2T collaborative strengths-based group intervention programme. The methodology of phase 1 (scoping literature review and focus group discussion and individual interview) will be discussed, after which phase 2 (an explanation of QSA) will follow.

1.7.3 Phase 1: Scoping literature review.

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1.7.3.1 Research design.

The purpose of conducting a scoping literature review is to provide a summary of evidence from a variety of studies in order to illustrate the extent and depth of a field of enquiry. A scoping literature review entails an investigation into published research to provide an outline of the extent and quantity of available research on a specific topic of interest, and can identify gaps in the literature so as to gather succeeding research inquiries (Levac, Colquhoun, & O'Brien, 2010; Mashamba-Thompson & Khuzwayo, 2015).

Arksey and O'Malley (2005) developed a methodological framework which will be utilised in this study. This framework identifies six stages: (1) the research question was formulated, which was: "What could be learned from previous studies on stigmatised loss in adult female survivors of CSA?"; (2) and (3) during these stages the researcher searched electronic databases, reference lists as well as scientific journals for relevant literature to the study (Levac et al., 2010); (4) during this phase the data that explained stigmatised loss in CSA female survivors were extracted and mapped in the data charting form (Addendum D); (5) during this phase the research findings were thematically analysed to identify, analyse and describe themes relating to stigmatised loss in female survivors of CSA within the selected studies (Braun & Clarke, 2006), scientific software was utilised (Atlas.ti 7.0, 2012) in the analysis process and the protocol followed is available in Addendum A; and lastly in phase (6) consultation with stakeholders (helping professionals working in practice within the CSA scope) was conducted to obtain additional understandings beyond those found in the literature (Levac et al., 2010).

Arksey and O'Malley's (2005) methodological framework has the following limitations: (1) research questions can be too broad; (2) creating a balance between completeness of the study and

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viability of resources; (3) the decision-making process concerning which studies to include is unclear; (4) the total of how many studies to extract is unclear; (5) multiple steps are combined as one framework stage; and (6) the integration of stakeholders' information with study findings. This framework also possesses key strengths: (1) the insight and depth of knowledge each professional brings to the study; (2) time efficiencies; and (3) it can provide a clear and apparent outline in a minimal space of time. This allows the researcher to identify the gaps in a concise and accessible format. The strengths seem to far exceed the limitations and thus made its use ideal for the current study (Levac et al., 2010).

1.7.3.2 Search strategy.

Database and journal search

The researcher searched electronic databases, reference lists and scientific journals, as indicated by Levac et al. (2010), for studies to include in the scoping literature review. Studies selected for the review was analysed using the Atlas.ti software programme and the findings written up in a distinct manner in order to provide strong evidence of stigmatised loss of survivors of CSA as found in previous studies. Databases included were: EbscoHost (Academic Search Premiere; Africa-Wide Information; E-Journals; ERIC; PsycARTICLES; PsycINFO; SocINDEX), SAePublications, and Science Direct (Social Sciences and Humanities). Academic journals that were reviewed are: *Child Abuse & Neglect*; *Child Abuse Research in South Africa*; *Child Abuse Review*; *Journal of Child Sexual Abuse*; *Sexual Abuse: A Journal of Research and Treatment*; and *Trauma, Violence and Abuse: A Review Journal*.

Inclusion criteria

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Studies that reported on stigmatised loss in female adult survivors of CSA qualified for inclusion. Publications between 1983 and 2016 were accepted, and only publications in English were retrieved. The inclusion criteria for the selected studies were based on a keyword search which included *stigmatised loss*, *child sexual abuse*, *survivors*, *adult women* and *South Africa*. As recommended by Levac et al. (2010), feasibility for inclusion should be checked by members with context expertise so as to assist with the decision making process. The researcher consulted regularly with supervisors who are helping professionals working in the field of CSA survivors to assess whether the studies selected were comprehensive of the purpose of the scoping literature review. Studies included for review were empirical studies, including published and unpublished doctoral dissertations and research designs accessed were quantitative designs (quasi-experimental studies, retrospective cohort studies, analytical cross-sectional studies), qualitative designs (phenomenology, grounded theory, ethnography, feminist research, case studies), and mixed method designs.

Exclusion criteria

Studies that reported on males, children under the age of 18 as victims of the CSA, and sexual offenders were excluded. Publication types not accepted for this scoping literature review were training manuals or updates, systematic and literature reviews, meta-analyses, secondary analysis of data, book reviews or sections, policy or government documents, summaries of judgments or papers, volume content or table of contents, conference programmes, reference to blogs, reference books, newspaper or magazine articles.

1.7.3.3 Study selection process.

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Data collection in scoping literature reviews involves the extraction of data from the selected studies which forms part of stage four in Arksey and O'Malley's framework (Levac et al., 2010). Initially, 13 343 database articles and 4 801 journal articles were identified in accordance with the search terms. Altogether they added up to 18 144 publications for further analysis. 65 articles were sourced from reference lists of each database and journal article. After duplicates were removed and exclusion criteria was applied 3 126 articles were screened for possible inclusion by reading through the abstracts. A total of 384 articles were screened for full-text review and eventually, 19 articles were selected for inclusion in the review (see Section B, Figure 1, p. 65, for flow diagram), which include 4 quantitative ($n = 4$), 14 qualitative ($n = 14$), and 1 mixed method ($n = 1$) studies. As recommended by Levac et al. (2010), feasibility inclusion should be checked by members with context expertise so as to assist with the decision-making process. Thus, the researcher consulted regularly with her supervisors who are experts in the field of CSA survivors and an independent coder (an experienced qualitative researcher) to assess whether the studies selected are comprehensive to the purpose of the scoping literature review.

1.7.3.4 Charting the data.

In this stage, the researcher developed a data-charting form (Levac et al., 2010) to determine which data to extract, and only data that explains stigmatised loss of survivors of CSA were mapped in the data-charting form with the following headings: author, publication year, title, country, research approach, method, participants, contextual factors of sample background, themes, subthemes and open-ended coding and only findings and conclusions were extracted from these said sources (Levac et al., 2010). A quality assessment of studies included in this scoping literature review was not needed, since a scoping literature review typically does not include a quality appraisal of studies, as is the case with systematic reviews. Articles were reviewed to

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answer the research question. The findings and conclusion section of each article was subjected to thematic analysis as described below.

1.7.3.5 Data analysis: Collating and summarising results.

Thematic analysis was used to identify and analyse the themes related to stigmatised loss in the studies that were selected for the scoping review. Braun and Clarke's (2006) six phases were followed. Firstly, the researcher familiarised herself with the data by immersing herself in the transcribed data and noting down initial codes. Preliminary codes were then identified followed by an interpretive analysis of the codes. The themes were then reviewed by refining the initial themes. Next an ongoing analysis was done to further enhance the themes and then finally completing the analysis into an interpretable report. The scientific software programme, Atlas.ti 7.0 (2012) was also used to assist in the data analysis process (Levac et al., 2010). Codes were assigned to key features within the data related to stigmatised loss. Codes were then created as subcategories, and these were grouped under potential themes. Atlas.ti 7.0 (2012) was used to draw a report and extract the themes present. Each theme was reviewed and coded in accordance with a written investigation of the data to assess the central significance of each theme. An independent coder (an experienced qualitative researcher) was used to assess the eligibility of the included studies for inclusion and help verify the codes and the analysis. Initially four main themes with eleven subthemes were identified. However, after a consensus discussion with supervisors and an independent coder the themes were reduced to three main themes and nine subthemes.

1.7.4 Phase 1: Focus group and individual interview.

Phase 1 reported on the findings of a focus group discussion with three participants and one individual interview with helping professionals working within the scope of CSA in practice. The

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aim of these discussions was to answer the secondary research question of this study, “What input or additional issues related to stigmatised loss in adult female survivors of CSA can be identified by a panel of helping professionals working within the scope of CSA in practice?” The researcher facilitated the focus group discussion and individual interview in an environment suitable for the purpose of the discussion and also at a suitable and convenient time for the participants (Marshall & Rossman, 2016). Evidence from the focus group discussion and individual interview on stigmatised loss in survivors due to CSA was compared with the data extracted from the scoping literature review study and included in the writing up of the findings. For this study the researcher identified agreements and differing trends in the helping professionals working within the scope of CSA opinions relating to stigmatised loss in survivors of CSA with the aim to draw comparisons between the findings of the scoping literature review and the focus group discussion and individual interview. As such, a positive aspect of focus group interviews as indicated by Marshall and Rossman (2016) is that it allows for networking, which was found to be very useful in this study since all helping professionals worked with this vulnerable female CSA population.

Certain challenges posed by this method of inquiry include: (1) the researcher should have the skills to facilitate a focus group discussion where power dynamics might be observed between the stakeholders; (2) irrelevant issues might be discussed that could lead to time delay; and (3) the context in which stakeholders’ comments are given is important in order to understand their responses, therefore data analysis could be difficult (Marshall & Rossman, 2016). However, these limitations are counterbalanced by a number of distinct advantages offered by this method of data generation, which include creating a conducive environment for the discussions, focused questions should be asked to facilitate a discussion where the stakeholders can provide and express opinions

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and personal views that might differ with regards to experience and/or findings from own studies (Marshall & Rossman, 2016).

1.7.4.1 Sampling and participants

Nieuwenhuis (2011a) explains that the success of a focus group discussion relies on purposeful sampling of group members who will represent the intended target population. As such, an independent facilitator (an experienced qualitative researcher) approached prospective helping professionals who are known for their expertise in working with survivors of CSA, and enquired about their willingness to participate in the focus group discussion. The independent facilitator then invited four of those helping professionals working within the scope of CSA for the focus group discussion. As the purpose of this focus group discussion was to explore if helping professionals working within the scope of CSA agree on the findings from the scoping literature review or are able to identify any additional emerging issues related to CSA, only one focus group discussion was conducted. Due to the unavailability of one of the participants, an individual interview was also conducted. Inclusion criteria included a minimum of three years practice experience in working with childhood sexual abuse survivors, and that they had to be qualified as a registered social worker or clinical psychologist working at trauma clinics, child protection organisations, or in private practice.

1.7.4.2 Data collection

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Semi-structured interviews were conducted in English guided by a predetermined interview schedule starting with a broad question to get stakeholders actively involved and then progressing to probing questions to steer the discussion in the direction of the main research question (Nieuwenhuis, 2011a). This is called a funnel structure (Nieuwenhuis, 2011b). To collect the relevant data from the study's focus group discussion and the individual interview, the interviews were digitally recorded with the consent of the participants, and notes were taken by the researcher. The transcripts of the recordings were done in a question-by-question format in order to distinguish between the answers given to each question (Creswell, 2008). The role of this focus group discussion and individual interview was to reflect on and debate the findings of the scoping literature review. Additionally, the focus group discussion and individual interview reflected on any other practice experience related to CSA.

1.7.4.3 Data analysis

The audio recordings of the focus group discussion and individual interview were transcribed and thematic analysis was conducted where themes were identified, analysed, and reported on (Braun & Clarke, 2006). The analysis followed six phases as outlined in Braun and Clarke (2006): (phase 1) the researcher familiarised herself with the data through transcribing the data, and making notes while reading and rereading the data; (phase 2) initial coding was generated to identify interesting features of the data that could be meaningfully assessed concerning the phenomenon; (phase 3) the list of codes were sorted into potential themes, where all the significant coded data extracts were organised within each identified theme; (phase 4) the identified themes were reviewed and refined to consider whether the coded data extracts form a clear pattern, and also to assess the validity of each theme to the entire data set; (phase 5) defining and further refining of themes was done where a detailed written analysis of the data within each theme was

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conducted in order to identify the core meaning of each theme and (phase 6) the final analysis and writing of the report was done to provide a summarised, logical, and motivating account of the story central to the data. Sufficient evidence of the themes was supported by data extracts and written up. For the purpose of the study, data related to stigmatised loss in survivors of CSA was coded and grouped together in themes to illustrate the agreement and additional identified losses reported by helping professionals working within the scope of CSA. The data from the focus group discussion and individual interview were transcribed and coded to group each significant part of the data under a specific theme (Nieuwenhuis, 2011a).

In writing up the findings from Manuscript 1, the results from the focus group discussion and individual interview were provided after each stigmatised loss as set out in the scoping literature review. Data extracts from the focus group discussion and individual interview were used to provide evidence of the stigmatised loss of female survivors of CSA that emerged in treatment practice. The data illustrated an agreement of the identified stigmatised losses in female survivors of CSA in the scoping literature review. Bloom's (2007) model on loss was expanded upon after the scoping literature review so as to develop a coding framework in order to inform the second phase of this study (Addendum E).

1.7.5 Phase 2: Qualitative secondary analysis (QSA).

1.7.5.1 Research design.

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Five types in which existing data sets could be analysed in QSA were pointed out by Heaton (2008), that is reanalysis (the reexamining of data to confirm and validate findings of a primary study), amplified analysis (comparison or combination of two or more existing qualitative data sets for purposes of secondary analysis), assorted analysis (secondary data analysis in conjunction with the collection and analysis of primary qualitative data for the same study), supplementary analysis (to get a more in-depth understanding of an aspect or aspects not addressed in the original study), and supra analysis (aim and focus of secondary study exceed those of the original research). The latter form of analysis was used in the study as it will exceed the original research that examined the efficacy of the S2T intervention programme, by looking at stigmatised loss in survivors of CSA. It therefore goes beyond the objective of the original study to answer new empirical and conceptual questions (Heaton, 2008; Leech & Onwuegbuzie, 2008). Secondary analysis is the reuse of preexisting qualitative data collected from previous studies (Heaton, 2008). This data comprises of material such as semistructured interviews, responses to open-ended questions in questionnaires, field notes and research diaries (Heaton, 2008). Thus, QSA entails the use of already produced data to develop new questions (Heaton, 2008; Irwin & Winterton, 2011) and can be used for two key purposes: it can be used to study new or additional research questions, or it can be used to confirm the findings of former research (Heaton, 2008). This study will attempt to answer additional questions to that of the primary study.

The advantages of using QSA contribute to its potential as a useful method for scientific inquiry (Szabo & Strang, 1997) and include: (1) eliminating sample selection and data collection so more effort can be placed on analysis and interpretation of findings; (2) being cost-effective and convenient; (3) being a credible method of generating knowledge that will contribute to the primary study; (4) allowing for research to continue on an area without having to find additional

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participants therefore making maximum use of data; and (5) analysts have the chance to view the data set from an unbiased viewpoint. The limitations of QSA appear to be in the interpretation of the data as the researcher is not directly involved in producing the data. QSA also requires a change in attitudes to anonymity or confidentiality, where confidential obligations extend to the data as well as the protection of subjects (Camfield & Palmer-Jones, 2013). While these limitations are acknowledged the strengths of QSA appear to outweigh the limitations.

Written permission was obtained from the principal investigators in the primary study (Dr Walker-Williams, clinical psychologist, & Prof Fouché, social worker) and from the participants in the first and second S2T groups (2013/2014-2015) to use the qualitative data for the study. The primary research study was the collaborative strengths-based group intervention programme for South African women who experienced CSA (Walker-Williams & Fouché, 2017). The researcher also signed an ethical declaration that all data will be kept confidential, as required by the Health Professions Act 56 of 1974 (Department of Health, 2006).

1.7.5.2 Background on the S2T collaborative strengths-based group intervention programme.

The primary study evaluated the benefits of a Survivor to Thrive (S2T) collaborative strengths-based group intervention programme to facilitate posttraumatic growth in female survivors of CSA (Walker-Williams & Fouché, 2017). The S2T intervention programme follows a collaborative strengths-based approach which focuses on adult female survivors' strengths in order to facilitate posttraumatic growth from their traumatic CSA experiences (Walker-Williams & Fouché, 2017). This intervention covers four treatment outcomes (Walker-Williams & Fouché, 2017, p. 196):

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(1) providing a supportive space for sharing the trauma story, experiencing heightened emotional awareness, and validating the group members' experiences (drawing on cognitive-behaviour therapy (CBT) and cognitive-processing therapy (CPT) principles of cognitive processing); (2) normalising symptoms (emerging from the psychodynamic approach) and reframing trauma messages (CBT and post-traumatic growth (PTG) model); (3) active adaptive coping drawing on psychological inner strengths (psychodynamic and PTG model); and (4) transforming from meaning making to personal growth by resharing the trauma story "for a change" from a new perspective (PTG model).

Participants were women who experienced CSA residing in the Vanderbijlpark region and surrounding areas within the larger Gauteng province in South Africa. A quasi-experimental design was employed during a pilot study conducted in 2013/2014 (Walker-Williams & Fouché, 2017). To further test the benefits of this strengths-based intervention, the researchers recommended longitudinal research over a three year period. A second group commenced in 2014/2015 of which the data from this group will be analysed for the study. Inclusion criteria for the group were: a minimum age of 18 years; disclosure of the CSA; that the women had received some form of crisis intervention (as child/adult); could understand and respond to English/Afrikaans; and were willing to participate voluntarily and partake in the S2T intervention sessions at a central community location.

The participants of both groups experienced contact sexual abuse and the abuse was done by a known perpetrator. 18 participants in total commenced with both group sessions, after which six withdrew. 15 group intervention sessions were held with 12 participants (aged 18 to 52 years) across the two groups over a three year period. The table below indicates the biographical

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information of the groups and research procedure of the S2T intervention programme of Walker-Williams and Fouché (2017).

Table 3

Biographical Information of S2T Group Members

Participants	Total				Race	Average age
	Initial	Post-test	Delayed test	post-		
Group 1 (pilot study, 2013/2014)	10	7	5		5 Black; 5 White	36 years
Group 2 (2014/2015)	8	5	5		5 Black; 3 White	25 years
Research procedure						
Ethics number	NWU 00041-08-A1 (Group 1, pilot study, 2013/2014)					
	NWU 00041-08-A1 (Group 2, 2014/2015)					
Ethics	Informed consent (Group 1, pilot study, 2013/2014)					
	Informed consent (Group 2, 2014/2015)					

1.7.5.3 Sampling and data collection.

Three modes of data collection can be used by QSA researchers, namely formal data sharing, informal data sharing, and self-collected data (Heaton, 2008). In this study, formal data sharing was used, mentioned in Heaton (2008) as a method where previous data was collected independently and which fulfilled all ethical requirements, such as obtaining consent for the reuse of data for secondary analysis.

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One of the benefits of conducting QSA is that participant sampling is not required, since existing data sets are used (Heaton, 2008). The researcher therefore only had to sample transcripts of the audio recordings for the current study. It was decided to utilise all the session transcripts for the current study ($N = 15$).

1.7.5.4 Data analysis.

The QSA was conducted in two phases. Firstly, a coding framework was developed from categories emerging from the scoping literature review as a guideline to conduct deductive thematic analysis (Elo & Kyngäs, 2008). Deductive thematic analysis was conducted to analyse the existing data from S2T treatment sessions in a new context (Elo & Kyngäs, 2008). Secondly, any aspects that did not fit the categories were then coded into their own concepts by applying inductive analysis principles (Elo & Kyngäs, 2008). Since the theoretical framework used in this study was Bloom's (2007) model of stigmatised loss, the thematic analysis of the transcripts was an iterative process whereby the researcher frequently moved back and forth between the data and Bloom's (2007) model to discern whether the data supports or differs from the theoretical framework (Nieuwenhuis, 2011a). The six phases of thematic analysis of Braun and Clarke (2006) were followed as with the focus group discussion and individual interview analysis. The Atlas.ti software programme was used as a tool in the data analysis process.

1.8 Trustworthiness

Strategies to ensure trustworthiness and the application of these to this study are summarised in Table 4.

Table 4

Strategies and Application of Trustworthiness

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Strategies of Trustworthiness	Application to this study
<p>Credibility: refers to the confidence that can be placed in the truth of the research findings. Credibility establishes whether or not the research represented plausible information gained from the original data and is correctly interpreted from the participants’ original views (Anney, 2014).</p>	<p>The researcher consulted with experts in qualitative data coding and supervisors in the field of CSA to verify the results of the QSA and to assert that data interpretations were clear and credible (Marshall & Rossman, 2016; Nieuwenhuis, 2011b).</p>
<p>Transferability: refers to the extent to which the results of qualitative research can be transferred to other contexts with other respondents (Anney, 2014).</p>	<p>Transferability was enhanced in this study by providing a detailed description of the researched topic, research methodology and procedure to provide other researchers with the necessary information to be able to evaluate transferability of the findings to other settings. A detailed description of the characteristics of the participants also aids transferability to other contexts.</p>
<p>Conformability: this refers to the extent to which the research findings can be confirmed or corroborated by others and Dependability: the extent to which research findings can be replicated with similar participants in a similar contexts (Anney, 2014). Dependability strategies: audit trail; stepwise replication; independent coding; peer review of findings (Anney, 2014).</p>	<p>Peer examination: findings were examined by experts in the field of CSA (supervisors), which enhanced the credibility of the inquiry (Anney, 2014). Conducting an assessment of integrity of research findings: This ensured that the data collected was valid and was conducted by experts in the field of CSA (supervisors) The research followed a stepwise process (two or more researchers analysed the same data and compared their results) (Anney, 2014).</p>

The study was conducted in such a manner that the researcher’s own judgment concerning the reality of stigmatised loss amongst adult women survivors of CSA is suspended, to explore the reality experienced by the participants as is evident from the existing data set. This bracketing out or suspension of the researcher’s experiences of a phenomenon is explained in Creswell (2009) as an effective method for understanding individuals’ personal experiences.

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The researcher consulted with helping professionals in qualitative data analysis (NWU Research Personnel) with regard to coding of the qualitative data to verify the results of the study (Nieuwenhuis, 2011a). Also, peer debriefing sessions with helping professionals in the field of CSA (supervisors) were conducted to assert that data interpretations are clear and credible (Marshall & Rossman, 2016). Considering all the above, the study's trustworthiness was ensured.

1.9 Design map

Table 5

Design map

Primary research question	What is known from literature and practice about stigmatised loss in adult female survivors of CSA?	
Secondary research questions	1) What could be learned from previous studies in literature about stigmatised loss in adult female survivors of CSA? 2) What input or additional issues relating to stigmatised loss can be identified by a panel of helping professionals working within the scope of CSA in practice?	3) What stigmatised losses due to CSA emerged in a group of adult female survivors participating in two S2T collaborative strengths-based group intervention programmes? 4) What findings relating to stigmatised loss due to CSA could further inform S2T treatment practice for adult female survivors of CSA?
Research design	Scoping literature review, focus group & one individual interview	Qualitative Secondary Analysis
Sampling, participants and data collection method	<ul style="list-style-type: none"> • Data base and journal search • Studies selected: quantitative, qualitative, and mixed method • Extraction of data on stigmatised loss due to CSA onto data extraction form • Purposive and snowball sampling • Three clinical psychologists, one social worker • Semistructured interviews • Audio-recordings and transcriptions. 	<ul style="list-style-type: none"> • Data sets from two S2T collaborative strengths-based group intervention programmes • Adult women survivors of CSA
Data analysis	<ul style="list-style-type: none"> • Thematic data analysis • Iterative process • Independent coding • Consensus discussion 	<ul style="list-style-type: none"> • Thematic data analysis • Iterative process • Independent coding • Deductive thematic analysis followed by inductive thematic analysis • Consensus discussions

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Outcome	Identified three stigmatised losses due to CSA in adult female survivors and developed a coding framework	Identified four stigmatised losses due to CSA in South African adult female survivors and a conceptual framework was developed
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1.10 Ethical considerations

Ethical clearance to conduct the study was obtained from the Humanities Health Research Ethics Committee (HHREC) of the North-West University Vanderbijlpark Campus to conduct this research (NWU-HS-2016-0047: Addendum F). Ethical considerations related to the study are noted as follows. In agreement with Mendelsohn et al. (2015), the scoping literature review in phase 1 of the study does not involve first-hand collection of data from participants as in a primary study, thus ethical clearance from HHREC of the NWU Vanderbijlpark Campus was not required for the scoping literature review. However, ethical clearance was obtained to conduct the focus group discussion and individual interview in phase 1 of the study, as well as for the QSA in phase 2. More specifically, the researcher obtained written informed consent from the helping professionals in the focus group discussion and individual interview stating the anonymous and confidential nature of the discussion, as required by the Health Professions Act 56 of 1974 (Department of Health, 2006). With regard to the QSA in phase 2, the researchers of the primary study obtained informed consent from the participants which indicated their voluntary participation in the research and that the data obtained may be used for QSA by other researchers. Regarding secondary analysis of data, Grinyer (2009) states that whenever consent was obtained from participants in the primary study to use data for future research, further demands on the participants to consent will be eliminated and additional anxiety would not be triggered. This is especially the case where sensitive information was shared by participants. In order to conduct the

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study by means of secondary analysis of existing data, the researcher obtained written consent from the researchers in the primary study for the use of the existing data sets from two groups of the S2T intervention. Anonymity and confidentiality was ensured in the primary study of S2T (2014/2015), since transcripts were anonymised and, as such the names of participants were not mentioned in the transcripts, and the audio recordings were kept in a secure location as stipulated in the Health Professions Act 56 of 1974 (Department of Health, 2006).

1.11 Summary of findings

1.11.1 Manuscript 1.

The findings from 19 studies that met the inclusion criteria and which provided evidence of stigmatised loss in CSA were used. Of the selected studies, 14 were qualitative ($n = 14$), four were quantitative ($n = 4$) and 1 was mixed-method ($n = 1$). Three stigmatised losses were identified in this scoping literature review (see Manuscript 1), namely: (1) loss of safety, (2) deprivation of fundamental psychological needs, and (3) loss of sexual capacity. The results of this study support and extend what has been reported by Bloom (2007). Losses that emerged from the focus group discussion and individual interview were a loss of intimacy, loss of living outwardly and a loss of years. The findings of this study indicate the need for these treatment interventions and understanding these losses could enable treatment interventions for female survivors of CSA. The limitations of this study include studies published in English and this could have excluded any other important research conducted in other languages and limited data could have been obtained from the focus group discussion and the individual interview due to the small sample of helping professionals that participated.

1.11.2 Manuscript 2.

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The QSA identified three stigmatised losses that corresponded with those documented in literature namely: loss of safety, deprivation of fundamental psychological needs and a loss of sexual capacity. An additional loss was identified by analysing the transcripts from the data sets of two groups of female adult survivors from the S2T collaborative strengths-based group intervention programmes namely a loss of true self. This additional factor could influence how helping professionals treat female adult survivors of CSA.

1.12 Limitations of the study

Only studies published in English were included for the scoping literature review and this might have excluded important research done in other languages. Due to the vulnerable population and small sample size of women the amount of data available for QSA might not have been representative. This contributed to the limitations of the study. However, the in-depth nature of the data collected from these participants via repeated engagements with them would likely mitigate this limitation to some extent. Another limitation could result because the research is conducted by QSA; the researcher is distant from the data but could also assist in the process since the researcher is unbiased in looking at the data. Also, given the age of the women in the group, the traumatic impact of their sexual experiences in childhood on their current lives might lack certain aspects and intensity of their losses, as it would be in an older age group (Coltart, Henwood, & Shirani, 2013; Finkelhor & Kendall-Tackett, 1997).

1.13 Contributions of the study

This study provided the first known summary of stigmatised loss in a group of South African adult women survivors of CSA. Despite the limitations of this study, the results support and extend on Bloom's (2007) conceptual model of loss in recognising three additional stigmatised losses,

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namely: the loss of safety; deprivation of fundamental psychological needs; and the loss of sexual capacity. The findings from the secondary analysis of data sets from two collaborative strengths-based group intervention programmes emphasise the importance of acknowledging that CSA and the associated stigmatised losses are realities for South African female survivors of CSA as depicted in the international arena.

Thus, these additional stigmatised losses in female survivors of CSA, which emerged in this study, advance the understanding of this devastating childhood phenomenon and the treatment process required for such survivors. Consequently, this study could potentially inform helping professionals in private practice working with this vulnerable population as to the specific scope to be utilised in treating stigmatised loss in adult female survivors of CSA, thus providing them with hope for the future. Additionally, as this study focuses on South African women, it is expected to highlight the fact that CSA is indeed a societal problem and that South African adult women survivors of CSA are not excluded from the international arena regarding the trauma and impact caused by CSA. Practice of the S2T intervention programme could also inform treatment practice.

1.14 Layout of the study

Table 6

Layout of the study

Section A	Overview to the study	
Section B	Manuscript 1	Manuscript 2
	Phase 1: - Scoping literature review - Focus group discussion with three helping professionals and one	Phase 2: Qualitative secondary analysis

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	individual interview with a fourth professional	
Journal publication	Sexual Abuse: A Journal of Research and Treatment	Journal of Child Sexual Abuse
Section C	Conclusions, limitations, recommendations and combined reference list	
Addenda		

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SECTION B

PHASE I

PREFACE

MANUSCRIPT 1 – Stigmatised loss in childhood sexual abuse: A scoping review

This manuscript forms part of a larger study, which comprises two phases:

- Phase I – Scoping review
- Phase II – Qualitative secondary analysis (QSA)

The manuscript that follows reports on phase I “Stigmatised loss in childhood sexual abuse: A scoping review” and consists of a scoping review conducted to identify and summarise available literature on the stigmatised losses found in CSA, with integrated findings from a focus group discussion and individual interview with four helping professionals who are treatment specialists in the field of CSA.

Two secondary research questions drove this part of the study:

- What could be learned from previous studies in literature about stigmatised loss in adult female survivors of CSA?
- What input or additional issues relating to stigmatised losses can be identified by a panel of helping professionals working within the scope of CSA in practice?

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MANUSCRIPT 1

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE: A SCOPING REVIEW

Sexual Abuse: A Journal of Research and Treatment - Instructions to contributors

Manuscript style

Type double-spaced using generous margins on all sides. The entire manuscript, including quotations, references, figure-caption list, and tables, should be double-spaced. Number all pages consecutively with Arabic numerals, with the title page being page 1. In order to facilitate masked (previously termed "double-blind") review, leave all identifying information off the manuscript, including the title page and the electronic file name. Appropriate identifying information is attached automatically to the electronic file. Upon initial submission, the title page should include only the title of the article.

An additional title page should be uploaded as a separate submission item and should include the title of the article, author's name (no degrees), and author's affiliation. Academic affiliations of all authors should be included. The affiliation should comprise the department, institution (usually university or company), city, and state (or nation) and should be typed as a footnote to the author's name. This title page should also include the complete mailing address, telephone number, fax number, and e-mail address of the one author designated to review proofs.

An **abstract** is to be provided, preferably no more than 250 words.

A **list of 4–5 key words** is to be provided directly below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

Illustrations (photographs, drawings, diagrams, and charts) are to be numbered in one consecutive series of Arabic numerals and cited in numerical order in the text. Photographs should be high-contrast and drawings should be dark, sharp, and clear. Artwork for each figure should be provided

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on a separate page. Each figure should have an accompanying caption. The captions for illustrations should be listed on a separate page.

Tables should be numbered (with Roman numerals) and referred to by number in the text. Each table should be typed on a separate page. Center the title above the table, and type explanatory footnotes (indicated by superscript lowercase letters) below the table.

List **references** alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. References should include (in this order): last names and initials of all authors, year published, title of article, name of publication, volume number, and inclusive pages. The style and punctuation of the references should conform to strict APA style.

Abstract

Childhood sexual abuse (CSA) is a complex trauma with devastating long-term, negative effects on survivors. Unique trauma-causing factors are reported in literature. However, little attention has been given to stigmatised loss, which can be defined as unacknowledged losses, hidden due to social stigma or collaboration with the perpetrator. In the current study, a scoping review was conducted using publications between 1983 and 2016, in which data from 19 studies were extracted. The findings of the thematic analysis acknowledged and extended on Bloom's model of stigmatised loss: a loss of safety; deprivation of fundamental psychological needs and loss of sexual capacity. It is recommended that further research be conducted to confirm these findings so that they may be included in CSA treatment interventions.

Keywords: childhood sexual abuse, female adult, scoping literature review, South Africa, stigmatised loss, survivors

2.1 Introduction

Childhood sexual abuse (CSA) is a complex, intergenerational, and devastating universal social problem. The global prevalence of CSA among girls is reported to be between 8 - 31% and for boys between 3 - 17%. Studies on reported CSA in adults found the prevalence rates to be 18 - 22.1% and 7.6 - 13.8% respectively (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Hébert, Tourigny, Cyr, McDuff, & Joly, 2009; Ji, Finkelhor, & Dunne, 2013; Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh, Van IJzendoorn, Euser, & Bakemans-Kranenburg, 2011). Pereda et al. (2009) predicted that the prevalence rate might even be higher in Africa. For example, a recent study in the Eastern Cape Province of South Africa reported a prevalence of 39.1% for women and 16.7% for men (Jewkes, Dunkle, Nduna, Jama, & Puren, 2010). The first National Representative Survey on the prevalence of CSA in South Africa, which included 9 730 adolescents stratified between household and school, indicated that one in three young people reported an experience of sexual abuse in their lifetime. The prevalence was found to be 33.9% in girls and 36.8% in boys (Artz et al., 2016). The above findings indicate that South Africa indeed forms part of the global psychosocial crisis, namely CSA, and that this trauma has devastating long-term negative effects for survivors.

CSA is associated with a wide range of mental health problems (eg., depression, anxiety, post-traumatic stress disorder, personality disorders and substance abuse), sexual problems (eg., sexual aversion and avoidance, sexual risk-taking behaviours, and difficulties with intimacy), interpersonal difficulties (eg., distrust towards others, feelings of social incompetence, and less satisfaction in relationships) and intrapersonal difficulties (eg., low self-esteem and poor self-concept) in adulthood (Briere & Elliot, 1994; Sofka, 1999; Ullman, Peter-Hagene, & Relyea, 2014; Webster, 2001).

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A body of research points to CSA as a complex trauma due to the documented long-term negative outcomes and unique contributing trauma-causing factors (Banyard, Williams, & Siegel, 2001; Dube & Rishi, 2017; Finkelhor & Browne, 1985; Kendell-Tackett, Williams, & Finklehor, 1993). The seminal work by Finkelhor and Browne (1985) and Summit (1983) proposed a traumagenic dynamics framework comprising of four trauma-causing factors seen as contributing to the trauma of CSA victims. These factors are identified as: (a) traumatic sexualisation (sexuality is shaped in developmentally inappropriate and dysfunctional ways) (b) stigmatisation (shame, guilt and self-blame surrounding the abuse) (c) betrayal (trust and vulnerability manipulated) and (d) powerlessness (child feels unable to protect self and halt the abuse). Another possible trauma-causing factor not identified by Finkelhor and Browne (1985) and Summit (1983) which has been reported in literature but has received little attention, is “stigmatised loss”.

Loss in general, is mostly associated with death but there are also other stressful occurrences that can be connected to loss such as personal, interpersonal, symbolic and psychological losses (Ahuja & Singh, 2017; Harvey & Weber, 1998). A person who experiences a loss, such as death, is generally allowed to grieve openly and the grief is acknowledged by family and other support structures. However, due to the stigma surrounding sexual abuse, losses experienced by CSA victims are often not acknowledged openly which ultimately negatively affects how the victim processes these losses (Bloom, 2000a; 2000b; Bonanno, 2008; Miller, Cardona, & Hardin, 2006). In this regard, Bloom (2000a) indicated that due to the stigma attached to CSA, victims appear to grieve secretly because of the guilt experienced, as well as the fear of being labelled. This constitutes stigmatised loss and can be defined as unacknowledged loss where mourning is complicated and when losses and their causes are disenfranchised or hidden because of the social stigma attached to the relationship with the perpetrator (Brosnan, 2013; Doka, 1997). Bloom

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(2007) maintains that CSA victims are impacted by stigmatised loss which may also manifest as secondary losses such as a loss of a sense of safety or security, a loss of their attachment relationship and a loss of a normal childhood development. The effects of such losses are often carried over into adulthood and often seen by others as character flaws and are thus not acknowledged as real losses that may affect the overall functioning and quality of life. A long-term manifestation of stigmatised loss appears to be a delayed grief reaction which causes a more intense and complex trauma response (Bloom, 2007; Brosnan, 2013). Due to this delayed response, survivors do not deal with the losses immediately; consequently, their losses remain unresolved and arise as complicated issues in adulthood which then often mandate treatment (Bonanno & Field, 2001; Brosnan, 2013).

Treatment interventions should acknowledge and address issues of stigmatised loss and delayed grief in their treatment outcomes (Bloom, 1994; Bloom & Vargas, 2007; Sofka, 1999; Walker-Williams & Fouché, 2017). However, limited studies mention the experiences of loss associated with CSA and the importance of such grief work in enhancing recovery in adult survivors of CSA (Alaggia, 2005; Bloom, 2007; Bonanno, Papa, & O'Neill, 2002; Doka, 1997; Harvey & Weber, 1998; Miller et al., 2006; Murthi & Espelage, 2005; Sofka, 1999). As such, the need was identified to conduct a scoping literature review to provide a summary of what is known from literature and practice about stigmatised loss experienced by female survivors of CSA.

The purpose of this study is twofold. Firstly, a scoping literature review will provide a summary of what is known from literature about CSA and stigmatised loss in female adult survivors of CSA. Secondly, a panel of helping professionals were consulted to provide input on the findings of the scoping review or any additional information relating to emerging issues of stigmatised loss in female survivors of CSA. The findings will ultimately contribute to theory and treatment practice.

2.2 Methodology

A scoping literature review was conducted to provide a summary of evidence from a range of studies and to investigate the extent and depth of published research. This creates an outline clarifying the extent and quantity of available research on a specific topic of interest and in doing so, identifies the gaps in literature so as to gather subsequent research inquiries (Levac, Colquhoun, & O'Brien, 2010; Mashamba-Thompson & Khuzwayo, 2015).

Arksey and O'Malley's (2005) methodological framework with guidelines for a scoping literature review were used in this study. The framework identifies six stages: (1) identifying the research question to cover the extent of the literature, (2) identifying relevant studies from various sources, (3) study selection which involves inclusion and exclusion criteria, (4) charting the data by extracting it from the included studies, (5) analysis of the data by providing a descriptive thematic analysis, and (6) consultation with stakeholders to obtain additional understandings beyond those in the literature (Levac et al., 2010).

The above framework posed the following limitations: (1) research questions could not be too broad, (2) a balance needed to be created between completeness of the study and the viability of resources, (3) the decision-making process with regard to which studies to include had to be clear, (4) the total of extracted studies was also clear, (5) multiple steps had to be combined as one framework stage, and (6) lastly, the stakeholders' information had to be integrated with the findings of the study. The framework also posed key strengths, such as: (1) the insight and depth of knowledge each professional brought to the study (2) it was time efficient (3) it could provide a clear and apparent outline in a short space of time, (4) and, lastly it allowed the researcher to

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identify the gaps in a concise and accessible format. Overall, the strengths of this framework far outweighed the limitations and thus made it an ideal framework for this study (Levac et al., 2010).

2.2.1 Research questions.

This study is guided by two research questions, namely: “What could be learned from previous studies in literature about stigmatised loss in adult female survivors of CSA? and “What input or additional issues relating to stigmatised loss can be identified by a panel of helping professionals working within the scope of CSA in practice?”

2.2.2 Search strategy: Scoping review.

Databases and journal search

Electronic databases, reference lists as well as scientific journals were used to search for appropriate literature for the study (Levac et al., 2010). The databases consulted were EbscoHost (Academic Search Premiere; Africa-Wide Information; E-Journals; ERIC; PsycARTICLES; PsycINFO; SocINDEX), SAePublications, and Science Direct (Social Sciences and Humanities). Academic journals reviewed were: *Child Abuse & Neglect*; *Child Abuse Research in South Africa*; *Child Abuse Review*; *Journal of Child Sexual Abuse*; *Sexual Abuse: A Journal of Research and Treatment*; and *Trauma, Violence and Abuse: A Review Journal*. Only studies that reported on stigmatised loss in female adult survivors of CSA were retrieved and thus qualified for inclusion.

Inclusion criteria

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The inclusion criteria for studies to be selected for this scoping review were based on a search of keywords which included *stigmatised loss*, *child sexual abuse*, *survivors*, and *adult female*. Only publications between 1983 and 2016 were used, and only publications in English were accepted. The researcher consulted regularly with supervisors, who are helping professionals working in the field of female CSA survivors, with a view to assess whether the studies selected were inclusive to the purpose of this scoping review.

Exclusion criteria

Any studies that included males, children under the age of 18 and sexual offenders were excluded. Literature reviews, meta-analyses, secondary analysis of data, book reviews, policy documents, reference books, blogs and newspaper or magazine articles were also excluded.

2.2.3 Study selection process.

During the analysis 13 343 data base articles and 4 801 journal articles were selected for the scoping review in accordance with the search terms, which added up to 18 144 publications for further analysis. Then 65 articles were sourced from reference lists of each database and journal articles initially identified using the following Boolean/phrase: (*child sexual abuse* OR *childhood sexual abuse*) AND (*stigmatised loss* OR *stigmatized loss*) AND (adult women survivors OR adult female survivors). Ultimately, 18 209 articles in total were exported to EndNote X7.7.1 (2016), and were then grouped together under the database or journal name. After duplicates were removed and exclusion criteria was applied 3 126 articles were screened for possible inclusion. Then, the titles and abstracts of 570 articles were reviewed for applicability and 186 publications were excluded which did not meet the criteria. Thereby 384 articles were selected for full-text review. After a thorough analysis of the 384 articles, 19 met the inclusion criteria of

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reporting on stigmatised loss of adult female survivors of CSA. These 19 articles were selected for inclusion in the review.

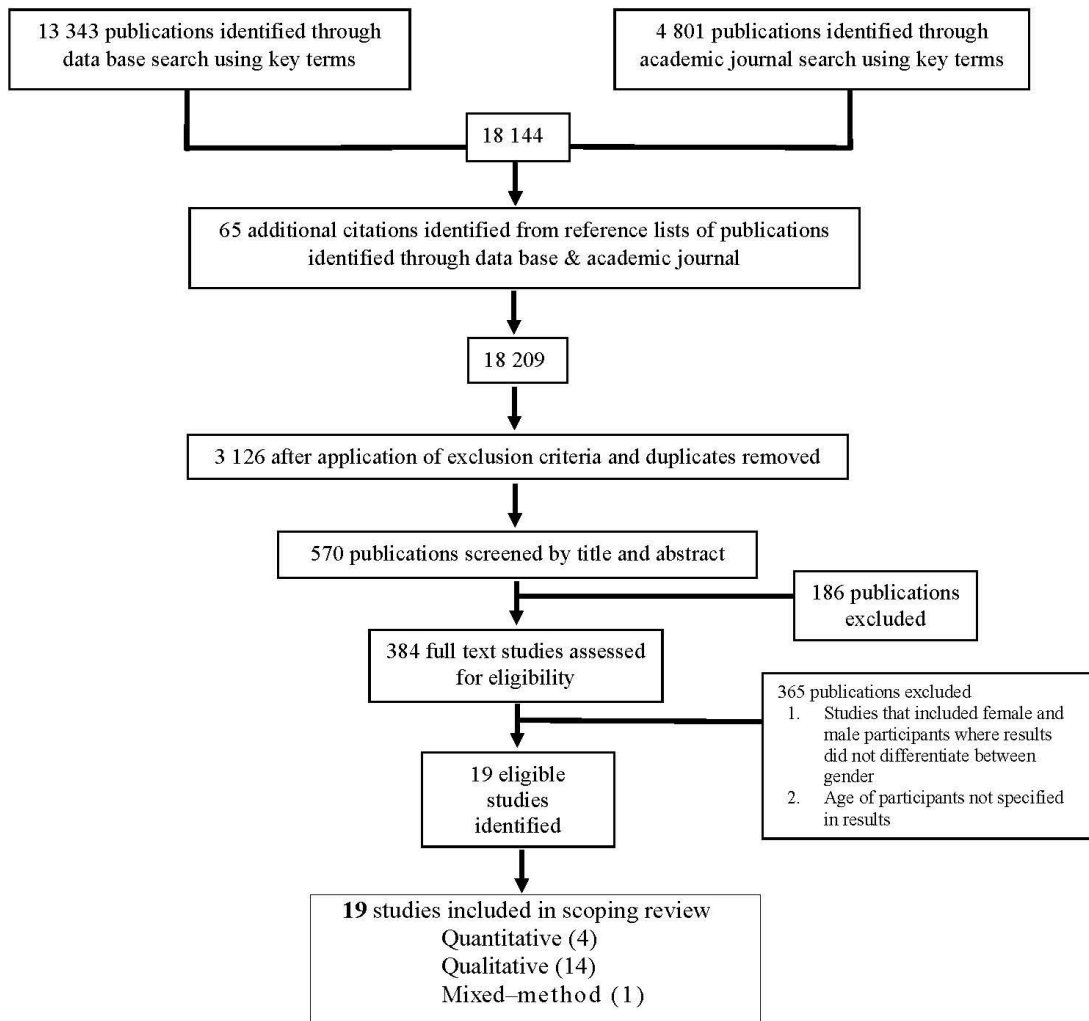


Figure 1. Study selection process – flow diagram

2.2.4 Charting the data.

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A data-charting form (Addendum D) was used to determine which data to extract, and only the data that explained stigmatised loss of female survivors of CSA were included in the data-charting form (Levac et al., 2010). Thematic analysis was employed in this study to focus on exploring themes and discovering the “rich” descriptions of the data set. Coding was used to develop themes which were then interpreted to capture the complexities of meaning within the data sets (Nieuwenhuis, 2011a). The Atlas.ti 7.0 (2012) software programme was used as a tool in the data analysis process. A quality appraisal was not included in this scoping review since a scoping review does not require a quality assessment as is vital for a systematic review.

2.2.5 Data analysis: Collating and summarising results.

Thematic analysis was used to identify and analyse the themes related to stigmatised loss in the studies selected for the scoping review. Braun and Clarke’s (2006) six phases were followed. Firstly, the researcher familiarised herself with the data by immersing herself in the transcribed data and noting down initial codes. Preliminary codes were then identified, followed by an interpretive analysis of the codes. The themes were then reviewed by refining the initial themes. Next an ongoing analysis was done to further enhance the themes and then, finally, the analysis was transformed into an interpretable report. The scientific software programme, Atlas.ti. 7.0 (2012), was also used to assist in the data analysis process (Levac et al., 2010). Codes were assigned to key features within the data related to stigmatised loss. Codes were then created as subcategories, and these were grouped under potential themes. Atlas.ti 7.0 (2012) was used to draw a report and extract the themes present. Each theme was reviewed and coded accordingly with a written investigation of the data to assess the central significance of each theme. An independent coder (experienced qualitative researcher) was used to assess the eligibility of the included studies for inclusion and to assist in verifying the codes and performing the analysis. Initially, four main

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themes with eleven subthemes were identified. However, after a consensus discussion with supervisors and an independent coder, the themes were reduced to three main themes and nine subthemes. Once themes were finalised these core categories were contextualised within Bloom's (2007) model of loss.

2.2.6 Focus group and interview of helping professionals in practice.

To answer the secondary research question, a focus group discussion and one individual interview was conducted with helping professionals working in practice with CSA. The secondary research question was: "What input or additional issues related to stigmatised loss can be identified by a panel of helping professionals working within the scope of CSA in practice?" (Arksey & O'Malley, 2005). Marshall and Rossman (2016) suggest that during a focus group discussion the researcher should select a minimum of four people with experience related to the research question who are not familiar with one another. Questions should be posed to assist the discussion where the helping professionals can provide their opinions and expertise and help in verifying the findings of the study. The findings emanating from the focus group will be presented separately in the findings section in order to differentiate between the scoping literature review and empirical section of this manuscript.

2.2.7 Sampling and participants.

An independent facilitator (an experienced qualitative researcher and helping professionals) was used to enquire whether other helping professionals would be willing to participate in the focus group discussion. They were recruited with the criteria of them having a minimum of three years' practice experience in working with female survivors of CSA, be qualified as a registered social worker or clinical psychologist working at trauma clinics, child protection organisations, or in

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private practice. Thus purposive sampling was employed. It is important to note that the aim of these discussions was not similar to that of an entire study that relies on more than one focus group for the collection of data for a primary study (Nieuwenhuis, 2011a).

The sample included three clinical psychologists and one social worker, of whom three were White, and one was Indian. Participants were between 37 and 61 years of age. The average age of the participants was 48. One participant, however, did not fill in a date of birth in the biographical questionnaire. The participants had an average of 22 years' practice experience in working with adult female survivors of CSA. As the purpose of these discussions was to gain input from helping professionals on the findings from the scoping literature review or to identify any additional emerging issues relating to CSA, only one focus group discussion was held and one additional individual interview was conducted as this suited one professional best due to logistical constraints.

2.2.8 Data collection.

Semistructured interviews were conducted in English guided by a predetermined interview schedule (see Addendum C). Informed consent was obtained from the participants to digitally record the discussion. A broader question was posed as an introduction to the discussion. Opening questions were then asked to obtain the helping professionals' practice experiences and input concerning CSA losses. In doing so, the researcher remained objective by applying a funnel structure and did not impose any preconceived ideas on the participants pertaining to the question posed. The aim was to elicit information targeted at the stigmatised loss identified in literature, with a view to obtain expert opinions on whether these factors are also observed in treatment practice (Creswell, 2008). As such, the reported losses and core factors found in literature in the

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scoping literature review were presented, namely (1) a loss of safety (2) deprivation of fundamental psychological needs and (3) a loss of sexual capacity. Participants were invited to provide feedback and input based on their practice experience. A discussion followed that provided evidence of stigmatised loss due to CSA which impacted survivors of CSA.

2.2.9 Data analysis.

The audio recordings of the focus group discussion and of the individual interview were transcribed, and thematic analysis was used to identify themes, which were then analysed (Braun & Clarke, 2006; Nieuwenhuis, 2011b). The procedure similar to that used in the scoping review analysis was followed, namely Braun and Clarke's (2006) six phases of thematic analysis.

2.2.10 Trustworthiness.

In the scoping literature review, focus group, and the interview clear guidelines were followed pertaining to the study selection strategy, inclusion and exclusion criteria, and data analysis to establish trustworthiness. The researcher held consensus discussions with experts in qualitative research and an independent coder (an experienced qualitative researcher) to verify the results of the QSA and to validate that the data analyses were clear and credible (Marshall & Rossman, 2016; Nieuwenhuis, 2011b). Transferability was improved during this study by providing a thorough account of the researched topic and research methodology, and the credibility of the study was further enhanced in that experts in the field of CSA (supervisors) examined the findings. Supervisors also ensured that the data collected were valid and that the research followed a stepwise process (Anney, 2014). Consultations with study supervisors were constantly held throughout the process to finalise themes, and an independent coder (an experienced qualitative researcher) was used to verify the data analysis process and to confirm clear interpretations

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(Burnard, Gill, Stewart, Treasure, & Chadwick, 2008; Marshall & Rossman, 2016; Merriam, 2009).

2.3 Findings

The findings are discussed in two sections. First, the findings from the scoping literature review will be presented and depicted in a flow diagram and table. Thereafter, a summary of findings from the expert interviews will be presented.

In terms of the scoping review, the findings from 19 studies that met the inclusion criteria and provided evidence of stigmatised loss in CSA were used. Of the selected studies 14 were qualitative ($n = 14$), four were quantitative ($n = 4$) and one was mixed method ($n = 1$). In the following section, three stigmatised losses were identified in this scoping review, which focus on (1) a loss of safety, (2) deprivation of fundamental psychological needs, and (3) a loss of sexual capacity.

2.3.1 Loss of safety.

A total of seven studies indicated an association between a loss of safety and CSA. A loss of safety can be defined as not being safe from harm or danger, where one's personal space is invaded (Bloom, 2007; Gidycz, Coble, Latham, & Layman, 1993; Miller et al., 2006). This can also include distrust where one feels threatened or vulnerable in an individual's presence. This loss of safety is experienced as a direct result of the sexually traumatic event (Gidycz et al., 1993). The core factors to a loss of safety are: 1) where personal boundaries were violated and/or disrespected and 2) a loss of trust in others.

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There was a clear indication in three studies that *personal boundaries were violated and/or disrespected* during the CSA abuse (Chopra, 2006; Schwerdtfeger & Wampler, 2009; Thomas & Hall, 2008). Personal dignity is insulted and this is experienced as traumatic, which could often lead these women to feel dependent on the abuser, as the abuser allowed them to feel cared for and protected (Liem, O'Toole, & James, 1992). These women had not yet established a complete self-identity and this invasion of their space could further verify the loss of an “inside-outside boundary” (Chopra, 2006, p. 494). Due to the fact that a majority of women who were abused as children were abused in their own homes by known perpetrators, the vulnerability and loss experienced are amplified as they were deprived of the security and safety one would assume to receive from a family home (Chopra, 2006; Hightower, Smith, & Hightower, 2006).

Studies also reported that abused women's relationships were adversely impacted after the sexual abuse and this withdrawal from others resulted in a general loss of a sense of safety (Schwerdtfeger & Wampler, 2009; Thomas & Hall, 2008). A *loss of trust in others* was also evident in the CSA studies (Colarusso, 2009; Liem et al., 1992; McEvoy & Daniluk, 1995; Oz, 2005; Schwerdtfeger & Wampler, 2009). McEvoy and Daniluk (1995), Oz (2005), and Schwerdtfeger and Wampler (2009) indicated that children develop a sense of trust as they experience the world around them, and their interactions with those around them dictates to what degree they trust further. CSA survivors begin to question their ability to trust and it becomes safer not to trust anyone. They often question whether their trust has been misplaced or when it will be violated. As such, CSA survivors found it hard to trust others following the CSA trauma. Consequently, if the abuser was a trusted parent or friend, they would grieve the loss of the relationship as well as further lose their trust in the world around them. This further emphasises the loss of trust and belief in people and

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in safe nurturing, intimate relationships (Chopra, 2006; Hightower et al., 2006; Schwerdtfeger & Wampler, 2009).

Further evidence of this loss was also found in the fear CSA survivors experienced when trying to affirm their own needs as this often led to rejection by others and resulted in a loss of valued relationships which often affirmed their identity (Liem et al., 1992). Additionally, the *loss of faith in religion and God* is also emphasised in the studies as a loss of spiritual safety in that some victims felt they had been abandoned by God (Colarusso, 2009). Traumatic events such as CSA may challenge a survivor's core beliefs such as their religion and spirituality. Survivors may attribute the CSA to punishment because of past sins or mistakes and as such the CSA may pose a stronger threat to their faith which could eventually play out in destructive coping. This loss of faith which includes anger and rebelling against God has been linked to depression and anxiety (Durà-Vilà, Littlewood, & Leavey, 2013).

2.3.2 Deprivation of fundamental psychological needs.

The majority of the studies ($n = 15$) indicated an association between deprivation of fundamental psychological needs and CSA. Deprivation of fundamental psychological needs can be defined as a lack of the following core factors which are needed in maintaining individual and societal well-being. These factors include 1) a loss of sense of agency or control, 2) a loss of trust in self, 3) a loss of sense of identity, 4) a loss of emotional control, and 5) a loss of childhood innocence. When these fundamental needs are not met, an individual can experience disturbances in emotional, cognitive and interpersonal development (Benight & Bandura, 2004; Finkelhor & Browne, 1985; Lamoureux, Palmieri, Jackson, & Hobfoll, 2011). Survivors of CSA may feel a *loss of a sense of agency or control*. Research suggests that sexual abuse is never just about the sexual act but is

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often an effort to gain power over their victims (McEvoy & Daniluk, 1995). This generally leaves victims feeling powerless and in no control of their own lives (Combs, Jordan, & Smith, 2014; Nusbaum, 2000; Oz, 2005; Romans, Gendall, Martin, & Mullen, 2001; Talbout, 1996).

Combs et al. (2014), Goldman and Bode (2012), and McEvoy and Daniluk (1995) further suggest that female survivors of CSA experience a *loss of trust in their self*. This includes aspects such as a loss of self-esteem, a loss of self-belief, a loss of self-efficacy, and a loss of trust and confidence in themselves. It appears that survivors of CSA experience a decrease in self-esteem, mastery, and agency and their self-efficacy diminishes. Consequently this kind of internal stigmatisation may damage an individual's overall self-identity and their desire to face adverse circumstances (Goldman & Bode, 2012).

Further evidence of this loss describes a *loss of sense of identity*, which includes factors such as a loss of an internal representation of self, a loss of self-respect and dignity, a loss of self-regard, a loss of the idealised self and a loss of one's core sense of self (Blizard & Bluhm, 1994; Chopra, 2006; Classen, Field, Atkinson, & Spiegel, 1998; McEvoy & Daniluk, 1995; Noll, Trickett, & Putnam, 2003; Schwerdtfeger & Wampler, 2009; Talbot, 1996). Loss of internal representation may result in depression, suicidal urges and feelings of worthlessness, which may cause self-destructive behaviour and this could impact on how survivors view their current self, compared to how they view their future self. Additionally, a loss of one's core sense of self and self-integration can be associated with anxiety and depression. Blizard and Bluhm (1994), Chopra (2006), Noll et al. (2003), and Schwerdtfeger and Wampler (2009) indicated that female survivors of CSA have difficulty accepting themselves; hence they develop an identity associated with feelings of

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worthlessness and being dirty – they often see themselves as weaker than others and not being able to take care of and protect themselves.

Schwerdtfeger and Wampler (2009) point out that a loss of identity can lead to profound feelings of not being good enough or feeling that they do not deserve any good. As such, CSA survivors constantly seek approval from external sources as they lack the internal structures of self-affirmation (Blizard & Bluhm, 1994; Classen et al., 1998; McEvoy & Daniluk, 1995; Noll et al., 2003; Schwerdtfeger & Wampler, 2009). A *loss of emotional control* was also evident in the findings. This included a loss of control when disclosing including the stigma attached during disclosure (Del Castillo & O'Dougherty Wright, 2009). Del Castillo and O'Dougherty Wright (2009) report that survivors experienced confusion and anxiety following the disclosure, and the associated stigmatisation attached to the abuse when disclosing, had an overwhelming devastating impact. Another finding which was evident was the *loss of childhood innocence* which included a loss of childhood, a loss of innocence, a loss of fun and a loss of a safe ideal family. Several authors argue that children who experience CSA are thrown into an adult world of sex and then as adults feel as if they were deprived of their childhood (Classen, Koopman, Nevillmanning, & Spiegel, 2001; McEvoy & Daniluk, 1995; Oz, 2005; Turner, 1993).

2.3.3 Loss of sexual capacity.

Only five studies indicated an association between a loss of sexual capacity and CSA (Colarusso, 2009; Combs et al., 2014; Roth & Newman, 1992; Schwerdtfeger & Wampler, 2009; Talbot, 1996). A loss of sexual capacity can be defined by contributing factors such as: 1) a loss of normal sexual responses and, 2) a loss of sexual control. A *loss of normal sexual responses* include a loss of interest in sex, a loss of bodily control and also a loss of experienced sexual pleasure. Combs et

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al. (2014) and Talbot (1996) suggest that the impact of the abuse could lead to sexual revictimisation and this could then lead to survivors feeling like sexual objects and not being worthy of caring attention. The sexual abuse is often hidden and the survivor thus leads an unauthentic life.

The *loss of sexual control* is evident in themes such as a loss of control of sexuality and a loss of sexual control. Colarusso (2009) and Roth and Newman (1992) state that CSA survivors experience negative messages due to the abuse; this impacts on how they perceive sex and their own sexuality. Due to this, survivors may develop unhealthy behaviours and attitudes towards sex resulting in either repulsion to sex or promiscuous behaviour. Consequently, their attitudes towards sex are often that of being dirty and embarrassing. In addition, CSA survivors who are repulsed by sex are often scared of the act and believe that sex will result in a loss of respect for themselves and from friends (Colarusso, 2009; Noll et al., 2003; Schwerdtfeger & Wampler, 2009).

2.4 Professional perspectives on stigmatised loss

Quotations provided by the professional panel from the focus group discussion and individual interview are inserted to demonstrate the factors related to stigmatised loss. Input received from the helping professionals illustrate that they had encountered all three major stigmatised losses in their practices, as also reported in literature. Participant 1 and Participant 4 have also shared how these losses were presented by clients: With regard to the loss of safety the following quotations illustrate how some helping professionals had witnessed this in clients in practice: *“They are unaware of what safety means....you cannot allow anyone to interfere with your personal boundaries... the loss of trust and safety in the world.... which is a big thing for them.... Because they are not aware till that point as to what is it as to where’s my boundaries so I can’t trust ...”*

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(P1, line 22). *“There’s a loss of... trust in human beings... especially when the perpetrator is very known to the person... I mean what does that say in trusting human beings in general...”* (P4, line 6). *“The loss of safety lies within the loss of trust in authority figures. So there’s nobody to protect me...”* (P4, line 8).

From input received from helping professionals it is clear that they have perceived a deprivation of fundamental psychological needs in clients, as depicted in the following quotes: *“lost trust in myself identity because I’m different to others...with that my innocence goes...”* (P3, line 29). *“...who I am is only related to the abuse...throughout the child’s life they consistently losing a piece of who they are... there’s no identity they have no idea of who they are because they never had the chance to actually experience ... so the minute this happens you already mature...so you lost your childhood completely.”* (P1, line 31).

The helping professionals also agreed that a loss of sexual capacity emerged during interactions with CSA clients. As such, they found that clients did not experience normal sexual responses. *“a lot of my patients that come and see me have sexual dysfunctions, they struggle to get an orgasm and one of the most primary things is the inhibition of sexual desire”* (P4, line 22). *“they either promiscuous or they’re nuns... it’s almost like a punishment afterwards self-inflicted.”* (P2, line 68). *“you believe that’s its wrong when you do it in a normal circumstance so there’s the loss of full pleasure.”* (P1, line 69). *“But I also think what could be added here is your loss of intimacy because remember that a normal sexual act has to have intimacy between the two, many of these*

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women are scared to get intimate...it's almost as if the act is just a bodily function and a duty" (P1, line 74).

Additional losses identified by the helping professionals, which were not apparent in literature, include a loss of intimacy; loss of living outwardly (P4, line 6) and a loss of years (P4, line 26). A loss of intimacy is mentioned above, however, with regards to a loss of living outwardly: "*... that the confidence in yourself gets lost so that they actually don't excel at school, they don't use their talents. They turn inward and don't live outward so it's actually a loss of living outward. They so involved with the trauma that's happened inside that they don't live outward they don't do sport they don't do... you know excel in school so their normal talents their normal abilities are not developed. Or at the other hand it's over developed. So you get either an over compensation or an under compensation.*" (P4, line 6). In regard to a loss of years, Participant 4 added: "*I think that people with sexual abuse also struggle with is the loss of years. The loss of years in between when you were abused and when you get therapy and you experience that how many years have been lost. One patient of mine said to me Doctor I've lived in limbo... almost as if I was frozen.*" (P4, line 26).

2.5 Discussion

This study provides a summary of the stigmatised losses of female survivors of CSA reported in literature. Although it is acknowledged that the search strategy utilised in this study may have overlooked some studies, overall only 19 studies were identified regarding stigmatised loss in female survivors of CSA. The results of this study support and extend Bloom's (2007) model of stigmatised loss. Only one theme described by Bloom (2007) (loss of safety) was apparent. The remaining two losses identified by Bloom (2007), namely loss of attachment relationships and a

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loss of childhood, were included as core factors in a newly emerging theme: deprivation of fundamental psychological needs.

The fundamental psychological needs of an individual serve as an important link when interacting with the world. This link produces attachment and sense of connection with important figures in one's life and individuals; thus they rely on this attachment from an early stage of development (Benight & Bandura, 2004; Chen, 2016; Sims, Nelson, & Puopolo, 2014). Throughout one's life there is an on-going attachment of being loved and having one's safety and security needs fulfilled. These needs are seen as important for emotional well-being and are driven by a need to attain and maintain connection (Chen, 2016; Sims et al., 2014). When these needs are not fulfilled, individuals cannot function optimally and often resort to destructive and violent behaviour patterns which often lead to feelings of inferiority, a sense of worthlessness and helplessness (Benight & Bandura, 2004; Finkelhor & Browne, 1985; Lamoureux et al., 2011; Sims et al., 2014). Thus, when a child is sexually abused, the psychological trauma causes conflict and confusion regarding these needs, and so may directly impact on their personality development (Benight & Bandura, 2004; Chen, 2016). This could negatively affect them as adult women and may result in a difficulty to build and maintain intimate relationships (Benight & Bandura, 2004; Finkelhor & Browne, 1985; Lamoureux et al., 2011). Female survivors of CSA often experience a complete loss of control and sense of helplessness which results in an extreme fear and so they disconnect from others. They often unintentionally or vicariously reexperience the trauma and so try to avoid people or situations that were associated with the traumatic event (Chen, 2016; Chopra, 2006; Noll et al., 2003; Schwerdtfeger & Wampler, 2009).

Several authors concur that CSA could be linked to sexual difficulties in survivors (Briere & Elliot, 1994; Finkelhor & Browne, 1985; Sofka, 1999; Ullman et. al., 2014; Webster, 2001). Bigras,

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Godbout, and Briere (2015) state that CSA impacts the self-capacities of individuals. Self-capacity refers to the extent to which an individual is able to: (1) maintain a sense of personal identity and self-awareness across various experiences; (2) tolerate and control strong negative emotions without resorting to avoidance (i.e. being able to emotionally regulate); and (3) develop and maintain meaningful relationships with others where they are not disturbed by dysfunctional behaviour patterns or themes of rejection or abandonment (Bigras et al., 2015). Female survivors of CSA often fail to make intimate connections to fulfil their sexual needs and therefore develop a negative sense of self where they see themselves as dirty or bad. Due to this damaging perception experienced by CSA survivors they often have the expectation that others will reject or hurt them (Colarusso, 2009; Finkelhor & Browne, 1985; Roth & Newman, 1992). This destructive self-identity produces negative feelings towards sexual activity including hesitant feelings towards men and often dysfunctional couple relationships (Bigras et al., 2015; DiLillio, 2001).

The findings of this study thus highlight the need for CSA therapeutic interventions relating to stigmatised loss and specifically including the loss of fundamental psychological needs and the loss of sexual capacity. A better understanding of such CSA losses could better enable treatment interventions to fit the specific needs of female survivors.

The helping professional perspectives suggesting three additional losses not identified in the scoping literature review remains an interesting finding. However, due to the small sample size it should be seen as anecdotal and more research in this regard is needed as it only reports on the reflections of helping professionals working within the scope of CSA in practice and not the actual lived experiences of adult female survivors of CSA.

2.6 Limitations

Only studies published in English were used for the scoping review and this might have excluded any other significant research done in other languages. Additionally, the small number of helping professionals that participated in the focus group discussion and the one individual interview may have limited the data obtained. As such, other experts might have identified additional losses not included here.

2.7 Conclusions and recommendations

This study identified 19 studies on stigmatised losses present in the lives of female survivors of CSA. These studies corresponded with Bloom's (2007) model of CSA, and two additional themes of loss were identified in the literature, namely: the deprivation of fundamental psychological needs and the loss of sexual capacity. The findings of this study allow for a better understanding of what is important to include in such CSA treatment interventions so as to address the important trauma-causing dynamic of stigmatised loss. As such, these findings may be included in the refinement of the S2T collaborative strengths-based group interventions for female survivors of CSA and other treatments.

Now that we know what stigmatised losses are associated with female survivors of CSA, as documented in literature, we can further explore how these losses manifest in two groups of South African female survivors of CSA. A coding framework was developed from the key findings from

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the scoping literature review (Addendum E), and used in phase 2 of this study (Manuscript 2). However, due to the limitations of the focus group findings mentioned earlier, the losses identified in the focus group were not included in the coding framework.

The next manuscript reports on the findings from a qualitative secondary analysis (QSA) employed on data sets of two groups of S2T collaborative strengths-based group intervention programmes.

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SECTION B

PHASE II

PREFACE

MANUSCRIPT 2 – Childhood sexual abuse:

This manuscript forms part of a larger study which comprises two phases:

- Phase I – Scoping review
- Phase II – Qualitative secondary analysis (QSA)

The manuscript which follows is a report on phase II, “Childhood sexual abuse: Emerging stigmatised losses in adult women survivors”, and comprises a qualitative secondary analysis (QSA) with a view to explore the stigmatised losses reported by adult women survivors of CSA participating in an S2T collaborative strengths-based group intervention programme.

The third and fourth research question drove this part of the study:

- What stigmatised loss due to CSA emerged in a group of adult female survivors of CSA participating in two S2T collaborative strengths-based group intervention programmes?
- What findings relating to stigmatised loss due to CSA could further inform S2T treatment practice for adult female survivors of CSA?

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MANUSCRIPT 2

**CHILDHOOD SEXUAL ABUSE: EMERGING STIGMATISED LOSSES IN ADULT
WOMEN SURVIVORS**

Journal of Child Sexual Abuse – Instructions for authors

Manuscript Format: All manuscripts submitted to the Journal of Child Sexual Abuse must be written in English, APA format, and should not exceed 30 double-spaced pages, including abstract, references, tables, and figures. All parts of the manuscript should be typewritten in Times New Roman font, size 12pt, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Headings must follow APA format with bold, italics, and indentation as appropriate. Each article should be summarized in an **abstract** of 150 words (recommended) to 250 words (maximum) and should include eight **keywords** or phrases for abstracting. Avoid abbreviations, diagrams, and reference to the text in the abstract. Please consult our guidelines on keywords here. The **title page** for each manuscript should be uploaded in ScholarOne as a separate document. The title page should include the full title of the manuscript along with an author note identifying each authors name, affiliations, address and other contact information for correspondence. Please consult our guidelines on author notes here.

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Abstract

Childhood sexual abuse (CSA) is a devastating, universal social epidemic with long-term negative outcomes for female adult survivors. This study employs qualitative secondary analysis of transcriptions collected during two groups of a Survivor to Thriver (S2T) collaborative strengths-based intervention for female adult survivors of CSA. Thematic analysis was conducted using a coding framework on the data of two S2T groups of women, comprising 15 group intervention sessions with 12 participants ranging from the ages of 18 to 52 years, spanning over a three-year period. Emerging themes which corresponded with the analysis conducted in phase 1 of the study were a loss of safety, deprivation of fundamental psychological needs and a loss of sexual capacity. An additional, unique theme also emerged, namely a loss of true self. These themes of stigmatised loss can be seen as unique markers in the recovery portfolio of female adult survivors of CSA and the findings will be further used to inform the S2T collaborative strengths-based group intervention programme so as to contribute to the recovery process of these female CSA survivors.

Keywords: childhood sexual abuse, female adult, survivors, qualitative, South Africa, stigmatised loss

3.1 Introduction

Childhood sexual abuse (CSA) is seen as a complex ordeal and a global phenomenon which causes an enormous bout of trauma in the lives of female survivors of CSA. CSA is a prevalent problem in South Africa and has been well-documented in literature (Kendall-Tackett, Williams, & Finkelhor, 1993; Ullman, Peter-Hagene, & Relyea, 2014; Webster, 2001). The CSA phenomenon presents daunting challenges for helping professionals who work in the field, due to the complex and negative symptomology that arises in adulthood.

As such, CSA survivors are likely to suffer psychological distress and physical and emotional trauma. Research indicates that CSA produces lasting effects on inter- and intra-personal relatedness, identity and affect regulation (Davis & Petretic-Jackson, 2000; Dolan & Whitworth, 2013; Kendall-Tackett et al., 1993; Kerlin, 2013; Mathews, Abrahams, & Jewkes, 2013; Singh, Parsekar, & Nair, 2014; Ullman et al., 2014). Also, the negative impact on the survivors' sexual functioning is well-documented, which includes increased sexual anxiety and decreased sexual satisfaction (Bigras, Godbout, & Briere, 2015; Hodges & Myers, 2010; Penning & Collings, 2014; Walsh, Latzman, & Latzman, 2014). Furthermore, CSA has been linked to a variety of psychological disorders including anxiety, depression and post-traumatic stress disorder.

In addition to experiencing psychological difficulties, CSA survivors also have to deal with secondary losses, as a result of the traumatic sexual abuse ordeal, such as the loss of innocence, a loss of a sense of safety, loss of secure attachment relationships, a loss of childhood, a loss of the capacity to trust and the loss of emotional and psychological well-being (Alaggia, 2005; Bloom 2007; Murthi & Espelage, 2005). Bloom (2007) emphasises CSA to be kept secret by the victims and, as such, the secondary losses become stigmatised as the victims grieve in secret as a result of

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the attached guilt (Bloom, 2007; Bonanno & Field, 2001). The term “stigmatised loss” was coined by Bloom (2007) and can be defined as unacknowledged loss whereby grief is complicated when these losses or their causes are hidden because of the social stigma attached (Brosnan, 2013; Doka, 1997). Stigmatised loss is devastating as it denies victims the opportunity of grieving spontaneously or naturally and so results in delayed grief (Bloom, 1994; Bloom & Vargas, 2007; Sofka, 1999). Delayed grief is experienced when survivors are unable to deal with the secondary losses of the CSA due to the fact that the CSA is not recognised and becomes stigmatised and may later manifest as a distorted self-concept, poor affective capacity, and a defective cognitive and emotional orientation to the world (Bloom, 2003, 2007; Bonanno & Field, 2001; Putnam, 2003; Ullman et al., 2014; Webster, 2001).

Due to the above long-term effects of stigmatised loss and the resulting delayed grief, therapeutic intervention becomes imperative to effectively assist survivors of CSA with these losses. As such, these therapeutic interventions need to be based on empirical findings. To date, most therapeutic interventions focus on treating symptoms and little attention is given to addressing the trauma-causing factors involved in CSA such as stigmatised loss (Walker-Williams & Fouché, 2017).

In manuscript one a scoping literature review was conducted to provide a summary of studies about stigmatised loss. The scoping review found that to date few studies have explored stigmatised loss in survivors of CSA. Studies in the United States of America (Blizard & Bluhm, 1994; Classen, Field, Atkinson, & Spiegel, 1998; Classen, Koopman, Nevillmanning, & Spiegel, 2001; Colarusso, 2009; Combs, Jordan, & Smith, 2014; Del Castillo & O’Dougherty Wright, 2009; Liem, O’Toole, & James, 1992; Noll, Trickett, & Putnam, 2003; Nusbaum, 2000; Schwerdtfeger & Wampler, 2009; Talbot, 1996; Thomas & Hall, 2008; Turner, 1993), Israel (Chopra, 2006), Australia (Goldman & Bode, 2012), Canada (McEvoy & Daniluk, 1995) and New Zealand (Romans,

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Gendall, Martin, & Mullen, 2001) found the following losses: a loss of boundaries, a loss of trust in others, a loss of a sense of identity, a loss of trust in the self, a loss of emotional control, a loss of a sense of agency or control, a loss of childhood innocence, a loss of sexual control and the loss of normal sexual responses. However, little research has been done on stigmatised loss in the South African context. No empirical studies exploring stigmatised loss in survivors of CSA were identified in the scoping literature review (see Manuscript 1). As such a need for such a study arose to ultimately contribute to the global knowledge base and inform treatment practice.

Due to the secrecy as well as the underreporting of CSA, gaining access to this vulnerable population can be challenging and ethically restricting. Thus, one option is to make use of existing data sets. Therefore this study employed qualitative secondary analysis (QSA) on data sets of two Survivor to Thrive (S2T) collaborative strengths-based group intervention programmes for female adult survivors of CSA in South Africa. The aim was to explore emerging reports of stigmatised losses in these female survivors of CSA attending the S2T collaborative strengths-based group intervention.

Next a literature review, then an overview of the coding framework that guided this study, followed by the methodology used in answering the research questions of this study will be explicated. Then the findings will be discussed, followed by the limitations and recommendations of this study.

3.2 Literature review

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CSA is widespread in societies across the world with the prevalence of CSA found to be high globally (Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh, Van IJzendoorn, Euser, & Bakemans-Kranenburg, 2011). Research indicates that the prevalence rate might be higher in Africa (Jewkes, Dunkle, Nduna, Jama, & Puren, 2010). As such, a recent study in the Eastern Cape Province of South Africa reported the prevalence to be 39.1% for women and 16.7% for men (Jewkes et al., 2010). Furthermore, Jewkes and Abrahams (2002) evidenced that 44.4% of children experienced rape and 52% experienced indecent assault during 2007/08 in South Africa. Furthermore, the first national representative South African study by Artz et al. (2016) indicated that boys reported higher lifetime prevalence rates of sexual abuse (36.8%) than did girls (33.9%). This study focuses on women, yet the alarming impact on men is not disputed.

The impact of CSA does not disappear and can have long-term effects into adulthood. Researchers over decades reported that CSA is often associated with poor mental and psychological health outcomes such as depression, anxiety, destructive behaviours, eating disorders, posttraumatic stress disorder, marital dissatisfaction, sexual revictimisation and risk-taking behaviours, disrupted and unhealthy attachments and general relationship problems (Boden, Horwood, & Fergusson, 2007; Colangelo & Keefe-Cooperman, 2012; Cutajar et al., 2010; Frazier, West-Olatunji, Juste, & Goodman, 2009; Griffing et al., 2006; Kendall-Tackett et al., 1993; Phillips & Daniluk, 2004; Rellini, Elinson, Janssen, & Meston, 2011; Schloretdt & Heiman, 2003; Senn & Carey, 2010; Senn, Carey, & Coury-Doniger, 2011; Senn, Carey, & Venable, 2008; Sweet & Welles, 2012). In addition, a body of research found that CSA survivors are more likely to display poor self-esteems, negative body images, eating disorders, relationship difficulties, drug and alcohol problems and problematic sex lives (Amado, Arce, & Herraiz, 2015; Dolan & Whitworth, 2013; Kendall-Tackett et al., 1993; Mathews et al., 2013; Walker-Williams & Fouché, 2017).

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However, few studies mention the experiences of loss associated with CSA and the importance of addressing such stigmatised loss when assisting in the recovery portfolio of female survivors of CSA. It is therefore important to understand loss within the context of CSA. From literature it appears that losses experienced by CSA survivors are not socially recognised nor accepted; hence CSA survivors often find it difficult to cope with and adjust to the long-term impact of the CSA (Bloom, 2007; Bonanno, 2008). Thus the impact of stigmatised loss is often interpreted as a character fault and thus not acknowledged in adulthood as legitimate grief and thus the survivor is denied the right to be a legitimate supported mourner (Bloom, 2007). These losses may go on to become part of the survivor's everyday life and could have a negative effect on their overall well-being and quality of life (Bloom, 2000b). It is therefore important to understand the experiences of loss associated with CSA, in the culturally diverse South African context, so as to provide helping professionals with a better knowledge base to assist helping professionals in successfully engaging in the recovery process of CSA survivors. By identifying the losses associated with CSA, effective tailor-made intervention services can further enable survivors to recover from the devastating effects of CSA (Bonanno, 2008; Miller, Cardona, & Hardin, 2006).

3.3 Coding framework

A coding framework was developed from the key findings of the scoping literature review reported in manuscript one. These findings were used to deductively explore emerging stigmatised losses in the data of two S2T collaborative strengths-based group intervention programmes. The three losses from the scoping literature review were: 1) a loss of safety; 2) deprivation of fundamental psychological needs; and 3) a loss of sexual capacity. These three losses and their included core factors were then refined into a coding framework. A brief discussion to contextualise these losses and core factors will follow.

3.3.1 Loss of safety.

Individuals develop a sense of safety during childhood when they engage in a secure relationship, which then allows them to develop and understand healthy personal boundaries (Mcevoy & Daniluk, 1995; Oz, 2005; Schwerdtfeger & Wampler, 2009). Loss of safety indicates an invasion of personal space and the feeling of being vulnerable and threatened (Bloom, 2007; Gidycz, Coble, Latham, & Layman, 1993; Miller et al., 2006). The core factors in a loss of safety involve the violation and disrespect of personal boundaries, and a loss of trust in others. As such, CSA survivors experience being out of control and due to their physical, mental, and emotional boundaries not being respected, they become confused, vulnerable, insecure, and distrusting. Furthermore, their trust is broken at an early age by the people who were supposed to care for them. Also, due to the secrecy surrounding the abuse, survivors learn to put others' needs first and tend to withdraw and to mistrust others (Chopra, 2006; Hightower, Smith, & Hightower, 2006; Schwerdtfeger & Wampler, 2009; Thomas & Hall, 2008;). Thus, such trauma has significant negative effects on their relationships with others and the development of secure personal boundaries. As such, survivors often feel they deserve to be hurt, abused or manipulated by others. Survivors often blame themselves for being trusting and begin to question their judgment, and this may further imbed their lack of trust in people and in secure relationships (Colarusso, 2009; Liem et al., 1992).

3.3.2 Deprivation of fundamental psychological needs.

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Deprivation of fundamental psychological needs includes core factors such as a loss of a sense of agency or control, a loss of trust in the self, a loss of a sense of identity, a loss of emotional control and a loss of childhood innocence.

Significant relationships are important for the development of one's sense of self; this allows for self-mastery and autonomy. As mentioned above, when a child feels safe and secure they explore their sense of self in relationships and the world, which in turn increases their self-esteem and sense of competence or mastery. CSA then threatens this security and attachment and they thus lose their trust in themselves and in others. Due to this boundary violation, CSA survivors often feel powerless and do not trust their own judgment, or feel that they may have missed the signs that might have warned them of the assault or in some way were responsible for the abuse (Benight & Bandura, 2004; Combs et al., 2014; Finkelhor & Browne, 1985; Goldman & Bode, 2012; Lamoureux et al., 2011; Mcevoy & Daniluk, 1995; Nusbaum, 2000; Oz, 2005; Romans et al., 2001; Talbot, 1996). CSA survivors often experience victimisation, shame and disgust and this can impact their self-esteem and self-efficacy. Self-esteem affects an individual's ability to competently regulate emotions, thoughts, and behaviours and also to engage in positive social relationships. When CSA occurs, victims often feel helpless and powerless and are unable to achieve any level of mastery in the abusive situation. The impact of this loss later rehashes feelings of shame, relationship difficulties, and loneliness. As such, an individual who has experienced CSA may also experience a loss of their self-identity. Survivors see themselves as worthless and weak and so often seek a source of attention and approval at any cost (Blizard & Bluhm, 1994; Chopra, 2006; Classen et al., 1998; Mcevoy & Daniluk, 1995; Noll et al., 2003; Schwerdtfeger & Wampler, 2009; Talbot, 1996). Due to this sense of powerlessness, survivors also lack emotional control, especially when disclosing the CSA (Del Castillo & O'Dougherty Wright, 2009). The

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survivor's childhood is often disrupted due to the CSA and they often suppress memories of their childhood and feel deprived of a safe, fun and ideal family life, especially when the perpetrator was known (Classen et al., 2001; Mcevoy & Daniluk, 1995; Oz, 2005; Turner, 1993).

3.3.3 Loss of sexual capacity.

Due to the emotionally devastating impact of CSA, survivors often experience a loss of sexual capacity. This includes core factors such as a loss of normal sexual responses and a loss of sexual control. Survivors experience a loss of interest in sex, a loss of sexual bodily control, a loss of pleasure and a loss of control over their sexuality (Combs et al., 2014; Talbot, 1996). Loss of sexuality and sexual control can be described as the loss of womanhood or accepting the "little girl inside" (Roth & Newman, 1992, p. 227). Survivors often feel that they do not like their sexual parts and the CSA changes the meaning they attach to sex and sexuality which in turn leads to them having distorted beliefs about sex. They often have the perception that sexuality is something that may be used as a weapon and feel as if they do not want to be touched or are not good at sex (Colarusso, 2009; Schwerdtfeger & Wampler, 2009). These losses have a harmful effect on female adult survivors by making them feel victimised, objectified and unworthy. These unhealthy perceptions often result in sexual behaviour extremes such as promiscuity or aversion to sex (Colarusso, 2009; Noll et al., 2003; Schwerdtfeger & Wampler, 2009). As mentioned earlier CSA survivors often struggle with trusting people and want to be in control (Colarusso, 2009; Liem et al., 1992; Mcevoy & Daniluk, 1995; Oz, 2005; Schwerdtfeger & Wampler, 2009). Due to the loss of control experienced during the CSA trauma, survivors try to exert control in other aspects of their lives including their relational and sexual experiences (Colarusso, 2009; Roth & Newman, 1992). This control often makes sexual experiences challenging. Bass and Davis (2008) contends that adequate sexual encounters involve both being in control and being able to relinquish control.

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This presents a challenge to female CSA survivors whose need for control often obstructs their sexual experience. Additionally, female adult survivors of CSA may experience dissociation as a defence mechanism during or after sex. They regularly remove themselves from the sexual experience physically and emotionally. Due to this, survivors lack the capacity to fully experience any pleasure and often experience recollections of the abuse during sex which leads to sexual retraumatisation (Bass & Davis, 2008; Haines, 2007).

3.4 Aim of the current study

The aim of this study was to perform qualitative secondary analysis (QSA) of data from two S2T collaborative strengths-based group intervention programmes conducted over a three-year period. The study aimed at answering the following research questions: “What stigmatised loss due to CSA emerged in a group of adult female survivors of CSA participating in two S2T collaborative strengths-based group intervention programmes?” and “What findings relating to stigmatised loss due to CSA could further inform S2T treatment practice for adult female survivors of CSA?”

3.5 Methodology

QSA was employed using data from treatment sessions of two groups of S2T collaborative strengths-based group intervention programmes for South African women who experienced CSA. Secondary analysis is the reuse of preexisting qualitative data collected for previous studies and the data contains semistructured interviews, responses to open-ended questions in questionnaires, field notes and research diaries. These data had already been produced to develop new questions (Heaton, 2008; Irwin & Winterton, 2011). The two main purposes of QSA are to study new or additional research questions; or to confirm the findings of previous research (Heaton, 2008).

3.5.1 Sampling and data collection.

As QSA was employed, participant sampling was not required, since existing data sets were used. The researcher had to sample transcripts of the audio recordings from the two S2T collaborative strength-based group intervention programmes for female survivors of CSA and then decided to make use of all the transcripts ($N = 15$). Formal data sharing was applied as a method, whereby previous data was collected independently, which also fulfilled the ethical requirements of obtaining consent for the reuse of data for secondary analysis (Heaton, 2008).

3.5.2 Data analysis.

The aim of this study is to explore stigmatised losses as reported by female adult survivors of CSA from the data of two groups of females who attended the S2T collaborative strengths-based intervention programme; therefore the unit of analysis will be female adult survivors of CSA, as they shared the same experience (Creswell, 2007). Participant quotes were used as evidence to indicate the relationship between the theory and the scoping literature review findings. Supra analysis (whereby the aim and focus of the secondary study exceeds those of the original research) was used in the study as it exceeds the original research that examined the efficacy of the S2T intervention programme, by looking into stigmatised losses in female survivors of CSA (Heaton, 2008; Leech & Onwuegbuzie, 2008).

The QSA was conducted in two phases. Initially, deductive thematic analysis was performed to analyse the existing data from the two groups of S2T treatment sessions within a new context (Elo & Kyngäs, 2008). A coding framework was then developed from the categories that emerged in the scoping review where the data from the transcripts were coded to then determine whether it corresponded with the identified categories (Elo & Kyngäs, 2008). Following the deductive

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analysis, any aspects that did not fit the categories were then coded into their own concepts applying inductive analysis principles (Elo & Kyngäs, 2008). The thematic analysis of the transcripts was an iterative process whereby the researcher frequently moved back and forth between the data and the coding framework to discern whether the data supported or differed from the theoretical framework (Nieuwenhuis, 2011a). The data sets were also coded by an independent coder who has a master's degree in psychology. The final themes and core factors were contextualised within Bloom's (2007) model of loss.

3.5.3 Trustworthiness.

The primary S2T researchers obtained written consent from participants in which permission was given to the researcher in this study to make use of the data of the S2T intervention programme. The researcher consulted with helping professionals in qualitative data analysis (NWU Research Personnel) with regard to the qualitative data to verify the results of the study (Nieuwenhuis, 2011a). Consensus discussions were also held with an independent coder to further verify results. Also, peer debriefing sessions with helping professionals in the field of CSA (supervisors) were held to assert that data interpretations were clear and credible (Marshall & Rossman, 2016).

3.5.4 Background to the data set.

The primary study from which the data sets were sourced, aimed at evaluating the benefit of the Survivor to Thrive (S2T) collaborative strengths-based group intervention programme which was aimed at facilitating posttraumatic growth in women who experienced CSA (Walker-Williams &

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Fouché, 2017). The S2T intervention programme follows a collaborative strengths-based and supportive approach which focuses on female adult survivors' strengths so as to facilitate posttraumatic growth following their traumatic childhood experiences (Walker-Williams & Fouché, 2017). This intervention covers four treatment outcomes (Walker-Williams & Fouché, 2017, p. 196):

(1) providing a supportive space for sharing the trauma story, experiencing heightened emotional awareness, and validating the group members' experiences (drawing on cognitive-behavioural therapy and principles of cognitive processing therapy); (2) normalising symptoms (emerging from the psychodynamic approach) and reframing trauma messages (cognitive-behavioural therapy and posttraumatic growth model); (3) active adaptive coping drawing on psychological inner strengths (psychodynamic and posttraumatic growth model); and (4) transforming from meaning-making to personal growth by resharing the trauma story “for a change” from a new perspective (posttraumatic growth model).

Participants were females who experienced CSA residing in the Vaal Triangle and surrounding areas within the larger Gauteng Province in South Africa. A quasi-experimental design was employed during a pilot study conducted in 2013/2014 (Walker-Williams & Fouché, 2017). To further test the benefit of this strengths-based intervention, the researchers recommended longitudinal research over a three-year period. A second group commenced in 2014/2015. The data sets from these two groups of women were analysed for the study. Inclusion criteria for the groups were: a minimum age of 18 years; disclosure of the CSA; that the women had received some form of crisis intervention (as child/adult); could understand and respond to English/Afrikaans; and were willing to participate voluntarily and partake in the S2T intervention

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sessions at a central community location. Initially, 18 participants commenced (aged 18-52 years) with the group sessions, after which six withdrew across the two groups. The participants experienced contact sexual abuse and the perpetrator was known to them. Overall, 15 group intervention sessions were held, spanning over a three-year period, with delayed follow up sessions. The following table indicates the biographical information of the groups and research procedure of the S2T collaborative strengths-based intervention programme of Walker-Williams and Fouché (2017).

Table 4

Biographical information of S2T group members

Participants	Total			Race	Average age
	Initial	Post-test	Delayed post-test		
Group 1 (pilot study, 2013/2014)	10	7	5	5 Black; 5 White	36 years
Group 2 (2014/2015)	8	5	5	5 Black; 3 White	25 years
Research procedure					
Ethics number	NWU 00041-08-A1 (Group 1, pilot study, 2013/2014)				
	NWU 00041-08-A1 (Group 2, 2014/2015)				
Ethics	Informed consent (Group 1, pilot study, 2013/2014)				
	Informed consent (Group 2, 2014/2015)				

3.6 Ethical considerations

An ethical application was submitted to the Humanities Health Research Ethics Committee (HHREC) of the North-West University Vanderbijlpark Campus to obtain permission and ethical clearance for this current study. Ethical clearance for the QSA in phase 2 was obtained (NWU-HS-2016-0047) (Addendum F). The researchers of the primary S2T study obtained informed

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consent from the participants of groups 1 and 2 of the S2T collaborative strength-based group intervention programmes who indicated their voluntary participation in the research, and informed consent that the data obtained could be used for QSA by the researcher. The researcher obtained written consent from the researchers in the primary study for the use of the existing data sets from the two groups (Addendum I). Anonymity and confidentiality were ensured in the primary study of S2T by not mentioning the names of participants in the transcripts, and the audio recordings were and continue to be kept in a secure location as stipulated in the Health Professions Act 56 of 1974 (Department of Health, 2006).

3.7 Results

The deductive analysis of the two sets of data identified three factors corresponding to those documented in literature, namely: (1) loss of safety; (2) deprivation of fundamental psychological needs; and (3) loss of sexual capacity. In addition, a loss of true self was found and this was not seen in the literature. The findings from this study are discussed below and are further illustrated by quotes from the data to confirm the evidence of the losses that emerged in these female adult survivors who participated in the S2T collaborative strength-based intervention programmes.

3.7.1 Loss of safety.

Two core factors represent a loss of safety: (1) personal boundaries being violated and disrespected and (2) a loss of trust in others.

The effect on female adult survivors concerning their personal boundaries being violated and them being disrespected due to the sexual abuse was evident in the following statement: “*So no entry*

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zone... It is like a, I want you in my life but I don't want you there... It is like don't come too close... As soon as you enter into getting to know me, I just want to like get the person away from me... I was violated" (Participant 1, age 30, group 2).

Participants also reported that they experienced a loss of trust in others which could be explained as: a loss of important relationships, a loss of connection with people, a loss of trust in men, a loss of trust in God and a loss of trust in the world. Participants reported that relationships with important figures in their life were damaged due to the CSA: *"We don't have a relationship at all...it is difficult to accept my father... so if anyone tries to get close to you, you immediately think they can see through you, so you push them away... you always think somebody has an ulterior motive"* (Participant 2, age 36, group 2). A loss of connection with people was expressed: *"I was sexually abused when I was eight... I see that had a huge impact on my communication with my family"* (Participant 7, age 39, group 1) and *"I lost how to... treat people and how to connect"* (Participant 1, age 30, group 2).

The following quote from participant 2 illustrated how her trust in men and the world was lost: *"My messages from the world and the environment is that people can't be changed... I lost my trust in mankind...I don't know how to like men... I'd love to have a relationship but I don't know how to... any male in my life I was treating like dirt"* (Participant 2, age 36, group 2) and *"I feel that people are, they are kind of dangerous, and they have their motives...you can't understand what they're up to... I feel like it's a trap...like there's no where I can go"* (Participant 4, age 43, group 2). Furthermore participant 3 and participant 6 appeared to have lost their trust in God: *"I don't feel that relationship with God because He's a man... that father-daughter relationship which is very important sometimes so that you can connect to God. Because He is still a man, He's not a woman...so you struggle to get that intimate relationship with God because you can't trust*

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a man, how must you trust God” (Participant 3, age 34, group 1) and “I’m worthless. I brought it upon myself, maybe I made God angry... I tried praying, it seems like it’s just a cycle with no ending. I’m trying, I’m praying, but God does not care anymore. There’s times where I just wake up in the middle of the night crying. Listen to God’s promise seem to depress me even worse...maybe God doesn’t see me, maybe He’s doing this to punish me” (Participant 6, age 21, group 2).

3.7.2 Deprivation of fundamental psychological needs.

Deprivation of fundamental psychological needs were represented by the following core factors:

(1) a loss of a sense of agency or control; (2) a loss of trust in self; (3) a loss of a sense of identity; (4) a loss of emotional control; and (5) a loss of childhood innocence.

A loss of a sense of agency or control was described by participant 2 as: *“It ruins my life and it still controls me...it feels like control has been taken away from me with the things that happened to me in my life...I try to control every single thing...the world is a torture chamber” (Participant 2, age 36, group 2).*

Inserts from participant 7, 1 and 2 reflect a loss of trust in self : *“and I don’t trust myself” (Participant 7, age 39, group 1); “I always question my confidence” (Participant 1, age 50, group 1); “I grew up having a lot of self-confidence issues” (Participant 2, age 36, group 2).*

In the words of participants 7 and 1 a loss of identity was explained: *“I’ve been living according to this negative messages that was my identity. And to let go of, to burn something it was like there I burn my own identity” (Participant 7, age 39, group 1); “I’ve lost my identity, kind of, and the withdrawal, I was hating myself” (Participant 1, age 30, group 2).*

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In a statement made by participant 5 emotional dysregulation is apparent which points to the loss of emotional control: *“And honestly if I could change something, I would choose not to disclose anything to anybody, because ever since the disclosure I can see that they look at me differently, the same pity party, and I feel that was moving on. Because throughout my childhood, there was fuss, this like, oh you’re an orphan type of thing in my family. And now that I was grown, it went away and it came back, after the disclosure it came back”* (Participant 5, age 20, group 2).

A loss of childhood innocence was expressed by several participants in the following inserts: *“When I look back, I am only twenty one, I feel forty inside because of the things that happened to me... I felt like an innocent child... I couldn’t go around playing with any girls... I just wanted to play with boys”* (Participant 5, age 26, group 1); *“I couldn’t have a normal childhood like other children had”* (Participant 5, age 20, group 2); *“And in an adult world you think like an adult, you walk and talk, you do everything like an adult, but you still, even though you’re in the body of an adult, you’re still a child. You haven’t – you lost your childhood and you lost your growing up years, that was taken, because it was, you were robbed of it...I want to be an adult. But I want to grow up because I wasn’t allowed to grow up, so now I want to grow up... I don’t know whether it’s pain caused by the pain of the loss, when we lost our childhood, so if somebody loses a family member, you know, it’s still the same loss, we’ve lost our childhood”* (Participant 2, age 36, group 2). Participant 2 further went on to state that *“The inner child got destructed and destructed me... I think it’s a more of a big problem for me accepting the fact that there is the inner child, because I know that my childhood was stopped, taken away and a lot of what children do was taken away at that age... I feel like I also lost my childhood, I was always protecting myself more than playing, more than trying – more than growing up. Part of me grew up before it was supposed to, and I couldn’t – my emotion tensions was not at the right level to cope with that, to cope with that adult*

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moment. So now I feel like I lost my childhood...It's like your innocence is taken away, in a very rude manner" (Participant 2, age 36, group 2).

3.7.3 Loss of sexual capacity.

Evidence of a loss of sexual capacity was reflected in the core factor of a loss of normal sexual responses in the following statements: *"We had sex and that was never a pleasure for me...I don't enjoy it because I think of what happened"* (Participant 7, age 39, group 1); *"Maybe I would have had sex which I enjoyed now. Because since then I've never had any sexual encounters"* (Participant 6, age 21, group 2). An interesting finding regarding the loss of sexual capacity by female survivors which was not evident in the literature was a loss of womanhood. This was evident in the following statement: *"I don't feel, I won't feel anytime soon, or learn how to feel good enough as a woman, being sexual, because I don't like it"* (Participant 7, age 39, group 1). A loss of sexual control was not identified in the analysed transcripts.

3.7.4 Loss of true self.

During the inductive analysis phase, an additional theme was identified, which was not evident in the literature, namely: a loss of true self. This was defined by the following five core factors: (1) a loss of hope; (2) a loss of normal developmental experiences; (3) a loss of happiness and freedom; (4) a loss of true character; and (5) a loss of the person I was supposed to be. A loss of hope was reflected in a statement made by participant 5: *"and then when I tried to find myself when I thought it changed it happened again. I lost hope"* (Participant 5, age 26, group 1). Also a loss of

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experiences was clearly stated in the following quote: *“It robbed me of me, of experiences. There are certain things that I could have experienced differently than what I experienced, certain things I could have done, certain ways I could have done things, and the victim was always the one taking decisions, always. She was, I think she was trying to protect herself, but in a manner she was also hurting me in the process. So I think if I had the opportunity to go back there are certain things I might have done differently, certain things I would have done that I didn’t do”* (Participant 6, age 21, group 2).

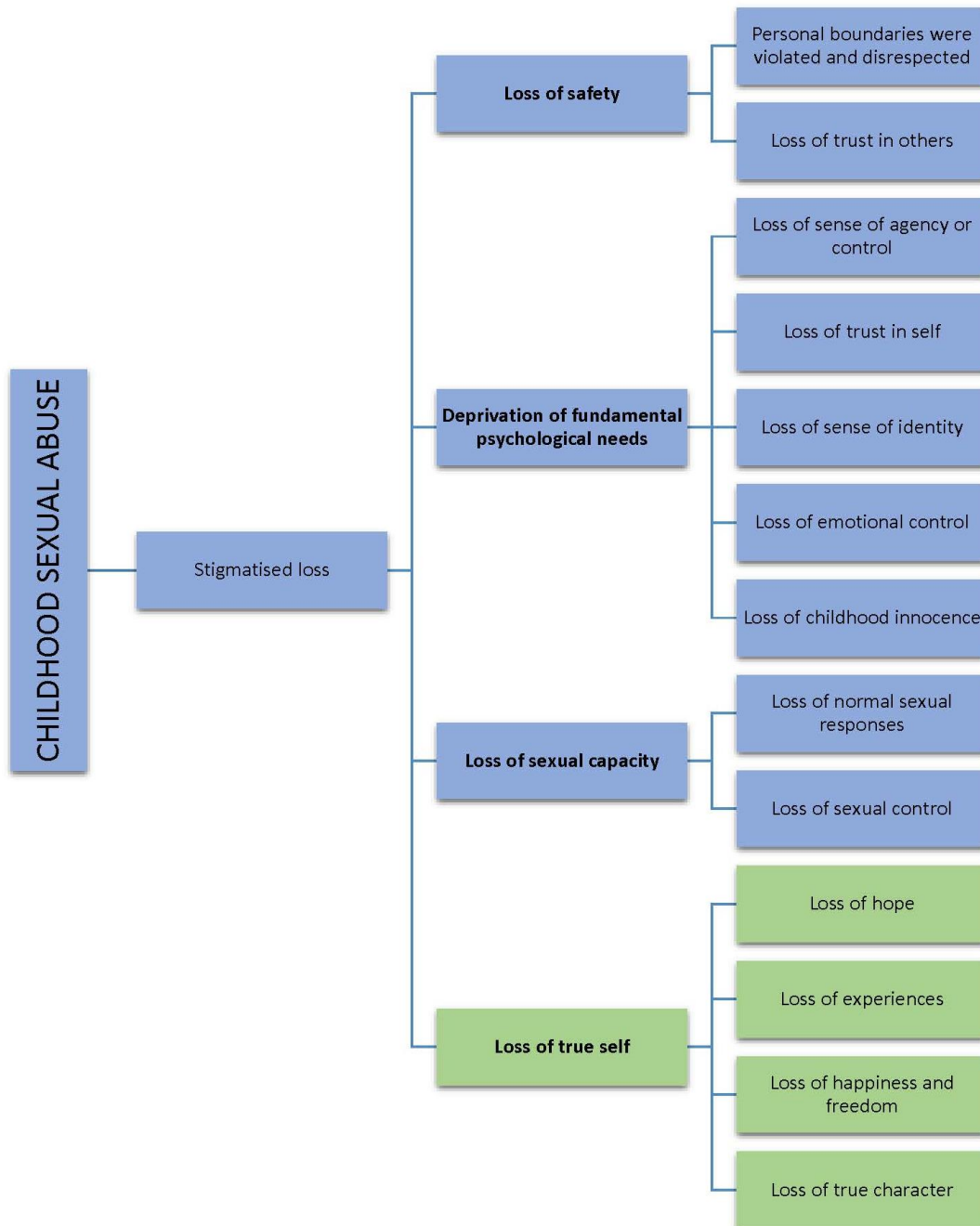
Reports of a loss of happiness and freedom were mentioned by participant 2: *“I lost a lot of happiness... a lot of freedom”* (Participant 2, age 36, group 2), while a loss of true character was reflected in the following quote: *“I’d say that I lost my true character. That instead of being this person, I was always this sad case, this pity party, everybody had to feel pity for me”* (Participant 5, age 20, group 2). Participant 6 also experienced a loss of the person she was supposed to be by stating the following: *“I would say I lost the sense of the person that I was supposed to be. Because at times I reacted in a manner that the victim wanted me to react in, not the manner I should have reacted in”* (Participant 6, age 21, group 2).

3.8 Discussion

The objective of the deductive analysis was to explore the stigmatised losses that emerged in the data of two groups of female adult survivors who participated in the S2T collaborative strengths-based group intervention programme. The findings as stated above indicate three themes: a loss of safety; deprivation of fundamental psychological themes; and a loss of sexual capacity. These themes correspond with the literature found in the scoping literature review (see Manuscript 1) with the exception of the theme: a loss of true self. Taken together, the findings of this study shed

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light on the stigmatised losses apparent in the global epidemic of CSA as experienced by female adult survivors as well as the impact these stigmatised losses have had on these CSA survivors' lives. A conceptual framework (Figure 2) was developed for this study to provide a clear interpretation of these stigmatised losses due to CSA and to answer the fourth research question.



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Figure 2. Conceptual framework: Stigmatised losses in female adult survivors of CSA

The current study agrees with previous research on CSA survivors' stigmatised losses in terms of a loss of safety. Loss of safety reported by participants in this study corresponds with findings of other studies (Chopra, 2006; Schwerdtfeger & Wampler, 2009; Thomas & Hall, 2008) and represents feeling unsafe and in danger, as well as having their personal space violated (Bloom, 2007; Liem et al., 1992; Miller et al., 2006). Similar to what has been reported in literature, participants explained feeling vulnerable in the abusers presence, feeling dependent on the abuser and having a lack of security in their own home environment (Chopra, 2006; Gidycz et al., 1993; Hightower et al., 2006; Schwerdtfeger & Wampler, 2009; Thomas & Hall, 2008). A loss of trust in others was also reported by the participants, which corresponded to a body of researches over decades on CSA studies (Colarusso, 2009; Liem et al., 1992; McEvoy & Daniluk, 1995; Oz, 2005; Schwerdtfeger & Wampler, 2009). Participants reported losing their sense of trust in others by referring to a loss of important relationships in their lives including that in God and in men in general. Several researchers confirm that these relationships assisted in confirming their identity as a victim and contributed to their destructive coping mechanisms, feelings of abandonment and mental health difficulties (Colarusso, 2009; Durà-Vilà, Littlewood, & Leavey, 2013; Liem et al., 1992). Furthermore, participants also reported having no connection with people and a loss of trust in the world around them due to the fact that the perpetrator was known. This finding was also confirmed in literature (Chopra, 2006; Hightower et al., 2006; McEvoy & Daniluk, 1995; Oz, 2005; Schwerdtfeger & Wampler, 2009).

These findings may contribute to practice implications for therapists working with survivors of CSA due to the fact that issues pertaining to distrust and the violation of personal boundaries could

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potentially become a stumbling block in the therapeutic relationship as these are two fundamentally important contributing factors in such a relationship of trust.

Evidence of deprivation of psychological needs in this study corresponds to literature, indicating that the experience of CSA impacted survivors' loss of a sense of agency or control, a loss of trust in self, a loss of sense of identity, a loss of sense of emotional control and a loss of childhood innocence. As reported in literature, participants experienced disturbances in their emotional, cognitive and interpersonal development which affected their individual and societal well-being (Combs et al., 2014; McEvoy & Daniluk, 1995; Nusbaum, 2000; Oz, 2005; Romans et al., 2001; Talbout, 1996). Furthermore, their lack of control and power in their daily lives was emphasised in the transcripts. Another body of literature confirms a loss of self-confidence due to the abuse, impacting on their sense of identity resulting in the internalisation of negative messages about themselves and feelings of worthlessness (Blizard & Bluhm, 1994; Classen et al., 1998; Combs et al., 2014; Goldman & Bode, 2012; McEvoy & Daniluk, 1995). Similar to the findings of Del Castillo and O'Dougherty Wright (2009), a loss of emotional control was also evident in the participants' statements about the stigma attached to disclosing where they experienced anxiety and felt judged. Another finding which was prominent in the transcripts of the survivors was the loss of childhood innocence which was also indicated in the literature (Classen et al., 2001; McEvoy & Daniluk, 1995; Oz, 2005; Turner, 1993).

The losses mentioned above appear to indicate developmental arrest where the survivor experiences an interruption of normal childhood development and appears to remain stuck in the childhood developmental phase in which the trauma occurred as reported in literature by Briere and Runtz (1993) and Orbke and Smith (2013). Therapists in practice should be encouraged to be

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cognisant of the effect of this developmental arrest on the CSA survivors and to include inner-child work as a therapeutic outcome in the recovery process.

As noted in previous studies (Colarusso, 2009; Combs et al., 2014; Roth & Newman, 1992; Schwerdtfeger & Wampler, 2009; Talbot, 1996) a loss of sexual capacity has an impact on survivors feeling objectified, and due to the abuse it could lead to sexual revictimisation. Similarly, participants reported experiencing a loss of normal sexual responses by referring to a loss of sexual pleasure. However, a surprising finding was that the reports of a loss of womanhood by members in the group were not evident in the literature. The above findings suggest that CSA treatment interventions could benefit from the inclusion of a sexuality component assisting survivors in becoming aware of their sensuality and womanhood.

Another theme not evident in literature was the loss of true self. This was reported in core factors such as: a loss of hope, loss of experiences, a loss of happiness and freedom and a loss of true character. Participants expressed their need for hope by trying to make sense of the abuse, looking for ways to self-nurture and by making a distinct effort to maintain close relationships. Female adult survivors of CSA further require a supportive environment to develop a positive self-image and master daily achievements. Survivors of CSA can experience meaning-making by forming secure attachments with individuals who provide a caring and safe space to express their emotional state. Goldner-Vukov & Moore (2011) explain that these attachments may allow for survivors to make sense of the abuse and develop a sense of hope and self-love. Participants also expressed a loss of happiness and freedom which suggests that CSA may threaten a survivor's sense of hope and healthy functioning. Furthermore, survivors experience a loss of true character when they lack intimacy, generativity and spirituality. By experiencing these losses survivors may feel that due to the CSA they lost the opportunity of being who they were supposed to be (Goldner-Vukov &

Moore, 2011). The above-mentioned findings highlight the need for therapeutic intervention to explore the survivors' meaning-making process and trajectory towards hope and living a healthy life.

3.9 Limitations of this current study

The small sample size available in the two S2T intervention groups creates a limitation to this study, since such findings cannot be generalised. The researcher was not directly involved in collecting the data, and was thus not instrumental in terms of questions posed and observations made. Another limitation of QSA is that the data sets were not gathered to answer the research question for this current study and therefore there could have been other losses prevalent in these groups not accounted for in this study. In addition, the data sets were of two group intervention programmes and thus women may not have been entirely open due to trust issues perhaps experienced in the group context.

3.10 Conclusion

A coding framework was used to deductively analyse data from two collaborative strengths-based group intervention programmes for female survivors of CSA. Four stigmatised losses were identified. Three corresponded to those found in literature, namely: a loss of safety; deprivation of fundamental psychological themes; and a loss of sexual capacity, with the exception of one theme: a loss of true self. This factor was identified using inductive analysis. Lastly, a conceptual

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framework was developed for this study to provide a clear interpretation of these stigmatised losses due to CSA.

3.11 Recommendations

It is recommended that a larger study be conducted to develop and expand the information on stigmatised losses due to CSA in female survivors of CSA in the South African context and it would be worthwhile to examine how these losses could be incorporated in treatment outcomes to improve strength-based interventions that are tailored to survivors of CSA.

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SECTION C

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

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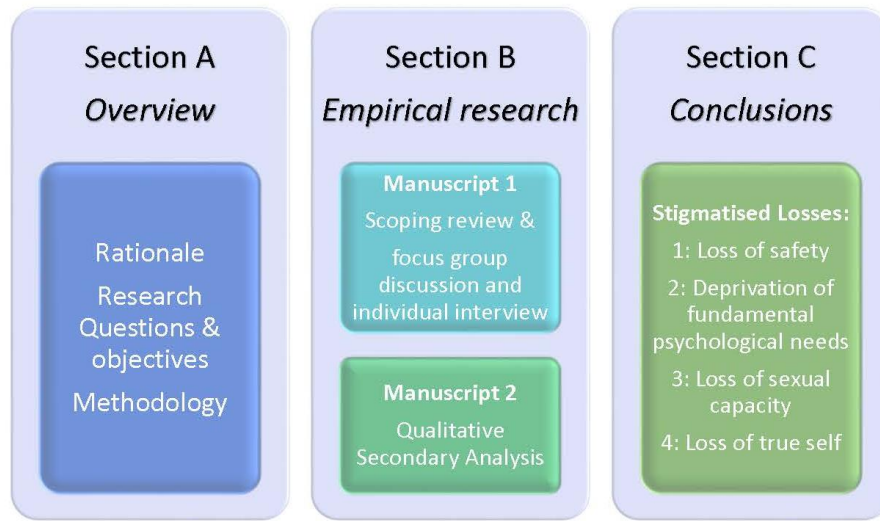


Figure 3. Unfolding of the study

4.1 Introduction

The main aim of this exploratory qualitative research study was to explore what is known from literature and practice about stigmatised losses experienced in adult female survivors. This was reached by achieving four objectives: (1) to conduct a scoping literature review for identifying available literature and providing a summary of evidence from a variety of studies on stigmatised loss in adult female survivors of CSA; (2) to present the findings of the scoping literature review to a panel of helping professionals working within the scope of CSA in practice and exploring whether they agree or identify any additional emerging issues regarding stigmatised loss in female survivors of CSA; (3) to perform QSA of data sets from two groups of women attending the S2T collaborative strengths-based group intervention programme, stretching over a three year period, aimed at exploring emerging reports of stigmatised loss in this population; (4) to contextualise the findings on stigmatised losses in order to inform future S2T treatment practice.

To achieve the four above-mentioned objectives, the study was divided into two phases. Phase I of this current study consisted of a scoping literature review, a focus group discussion as well as an individual interview – with all participants being helping professionals who work within the field of CSA to fulfil objectives one and two in Manuscript 1. To fulfil objective three in Manuscript 2, a coding framework was developed (as an outcome of objective one’s findings) and used in phase II to employ QSA on data sets from two S2T collaborative strengths-based group intervention programmes. Finally, the findings were formulated in a conceptual framework developed for this study in an attempt to fulfil objective four – which was successful.

An overview of the conclusions, limitations and recommendations from the study will be discussed below. Firstly, the research questions will be reconsidered; secondly, the conclusions emanating

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from this study will be discussed followed by a personal reflection, limitations, contributions of this study and future recommendations.

4.2 Research questions reconsidered

This study was guided by a primary research question and four secondary research questions.

Below is a schematic representation (Figure 4) of how the research questions were explored.

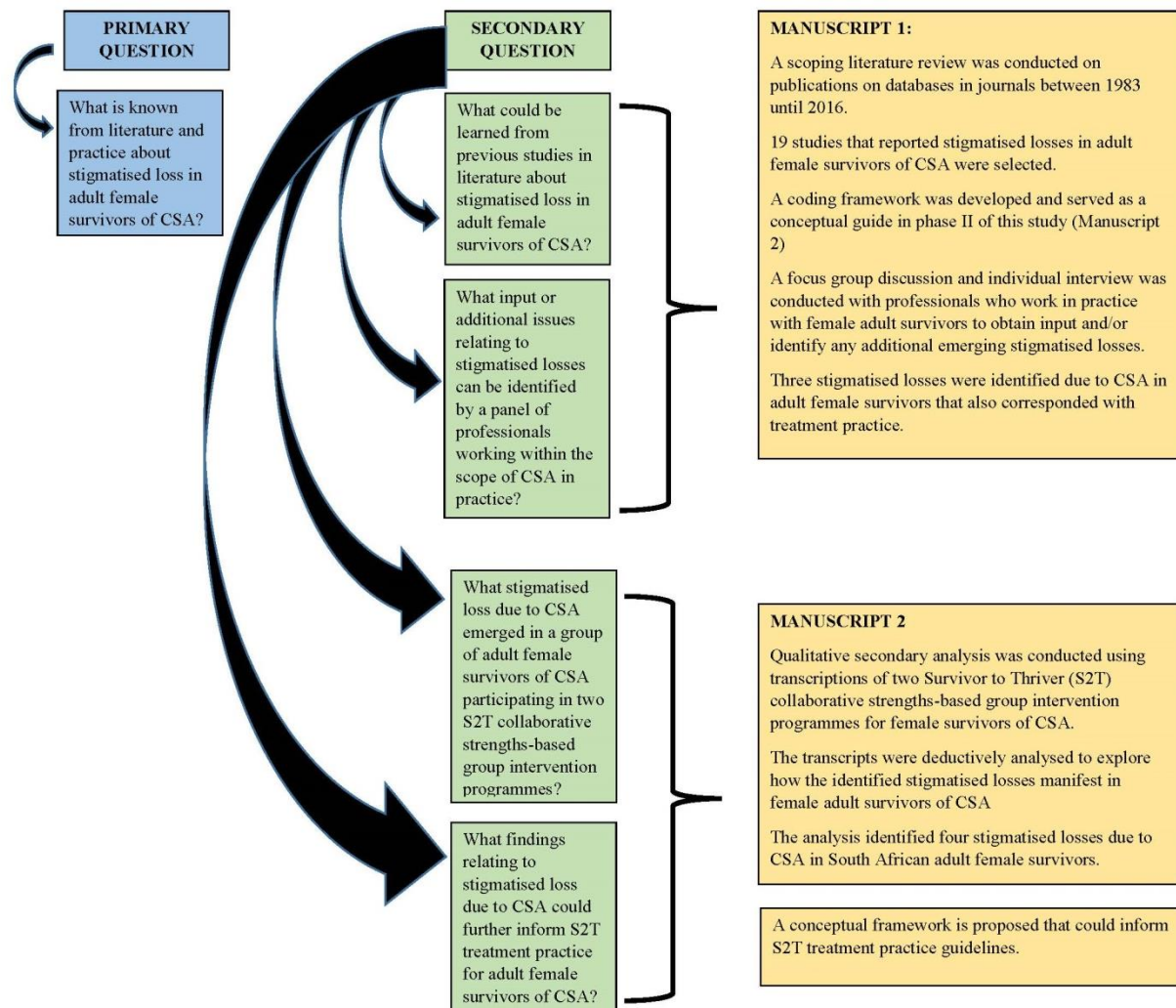


Figure 4. A schematic representation of how the research questions were explored

4.3 Conclusions emanating from the study

4.3.1 Manuscript 1.

The results of the scoping literature review identified and summarised 19 studies on stigmatised losses in female survivors of CSA (see Addendum D). It is acknowledged that the search strategy utilised in this study may have overlooked some studies. However, the findings suggest a dearth of empirical studies on stigmatised loss.

A total of seven studies indicated a loss of safety, which reflected a loss of trust in others and that personal boundaries were violated. Fifteen studies indicated a deprivation of fundamental psychological needs where losses indicated a lack of well-being. Five studies specified a loss of sexual capacity due to CSA and emphasised how the impact of the abuse could lead to sexual revictimisation.

The findings thus support and extend Bloom's (2007) model of stigmatised loss. Only one theme was apparent as described by Bloom (2007) (loss of safety). The remaining two losses identified by Bloom's (2007), namely loss of attachment relationships and a loss of childhood, were included as core factors in a newly emerging theme: deprivation of fundamental psychological needs. Another, additionally emerging theme not included in the original model of Bloom (2007), was the loss of sexual capacity. The professional perspectives suggesting three additional losses not identified in the scoping literature review remains an interesting finding. However, due to the small sample size it should be seen as anecdotal and more research in this regard is needed.

A coding framework (Addendum E) was then developed from the findings from the scoping literature review and was used as a guideline to conduct QSA in Manuscript 2. Due to the

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limitations of the focus group findings mentioned earlier, the losses identified in the focus group were not included in this coding framework.

4.3.2 Manuscript 2.

A coding framework was used to deductively analyse data from two collaborative strengths-based group intervention programmes for female survivors of CSA. Four stigmatised losses were identified. Three corresponded to those found in literature, namely: a loss of safety; deprivation of fundamental psychological themes; and a loss of sexual capacity, with the exception of one theme: a loss of true self. This factor was identified using inductive analysis. Lastly, a conceptual framework was developed for this study to provide a clear interpretation of these stigmatised losses due to CSA.

4.3.3 Overall conclusion.

The main aim of this dissertation was achieved by exploring what is known from literature and practice about stigmatised losses in female adult survivors of CSA. The overall conclusion drawn from this study is that there is a dearth of studies on this topic and more specifically in South Africa. Stigmatised losses pose a long-term negative impact on the lives of these CSA survivors; hence treatment interventions should address these losses.

4.4 Personal reflection

As I reflect on the current study, I acknowledge that every piece of the study was a unique but challenging experience. Before starting this research project I was oblivious of the hidden suffering and the high prevalence of CSA in South Africa among women. Conducting the scoping literature review was a challenging task due to the extensive number of articles to review. Through trial and

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error and the help of an independent coder, I managed to overcome this challenge. When reading through the transcripts I saw how deeply the hurt runs for these women and the effects it has on their daily functioning, especially their conscious effort to get through each day. From the evidence it is clear that due to these losses being unacknowledged, survivors often feel alone and depressed. It is often said that when one speaks about a traumatic event, one heals. Thus these women should be encouraged to attend intervention programmes where they are provided with a platform to tell their story and be heard and to form a supportive bond with other women experiencing the same trauma. Although the entire process seemed frustrating at times, I was always encouraged by fellow colleagues, family and supervisors to persevere. Overall, I feel that this experience was a valuable and learning one which gave me confidence in my academic abilities and research skills.

4.5 Limitations of the current study

The limitations presented by each manuscript are as follows:

4.5.1 Manuscript 1.

Due to the small number of helping professionals that contributed to the focus group discussion and individual interview, the data acquired could be limited as other helping professionals could have included other additional losses. Due to the unavailability of a helping professional, one individual interview was conducted. The insight of this helping professional could have provided a richer data if they were included in the focus group. Also, only studies published in English were used for the scoping review and this could have excluded any other important research done and findings reported in other languages.

4.5.2 Manuscript 2.

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The foremost limitation to the study is the small sample size of participants in the two S2T group intervention programmes, seeing that such findings cannot be generalised. Also, the researcher was not directly involved in collecting the data, and was thus not instrumental in terms of questions posed and observations made. Another limitation of QSA is that the data sets were not gathered to answer the research question for this current study; therefore there could have been other losses prevalent in these groups not accounted for in this study. In addition, the data set was of a group intervention and thus women may not have been entirely open due to trust issues perhaps experienced in the group context.

4.6 Contributions of the study

This study contributes to the global knowledge base of stigmatised losses in female survivors of CSA as it supported and extended on Bloom's (2007) model of loss. This study emphasises the importance of updating treatment outcomes in interventions to improve the well-being of survivors of CSA, especially the S2T collaborative strengths-based intervention.

4.7 Recommendations for future research

A larger study is recommended to be conducted to develop and expand the data on stigmatised losses due to CSA in the female survivors in the South African context, and it would be worthwhile to examine how these losses could be incorporated with treatment outcomes to improve strength-based interventions that are tailored to survivors of CSA. Furthermore, a primary study should be conducted to explore the stigmatised losses in adult female survivors of CSA. In addition it would be beneficial if this study could be replicated with adult male survivors of CSA.

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ADDENDUM A

Scoping review process and protocol

1) Review title - Adapted from the five-stage framework of Arksey and O'Malley (2005)

What are the stigmatised losses reported by adult female survivors of CSA in South Africa?

2) Reviewers:

Baaqira Kays Ebrahim

3) Center conducting the review:

North-West University – Vanderbijlpark Campus

4) Review question / objective:

- What could be learned from previous studies in literature about stigmatised loss in adult female survivors of CSA?
- What input or additional issues related to stigmatised losses can be identified by a panel of helping professionals working within the scope of CSA in practice?

5) Inclusion criteria:

a. Participants:

- i. studies that include adult women survivors of childhood sexual abuse

b. Phenomenon of interest:

- i. studies that include child/childhood sexual abuse
- ii. studies that include stigmatised loss

c. Type of outcome:

- i. studies that indicate stigmatised loss in adult women survivors of child sexual abuse

d. Type of studies:

- i. Empirical
- ii. Case studies
- iii. Qualitative
- iv. Quantitative
- v. Mixed method
- vi. Dissertations

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

- vii. Meta synthesis
- viii. Research synthesis
- ix. Systematic reviews
- x. Scoping reviews
- e. **Publication dates of studies:** 1983 –2016
- f. **Language of studies:** English
- g. **Key terms:**
 - i. (*child sexual abuse* OR *childhood sexual abuse*) AND (stigmatised loss OR stigmatised loss)
 - ii. (*child sexual assault* OR *childhood sexual assault*) AND (stigmatised loss OR stigmatised loss)
 - iii. (*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors* OR *adult female survivors)
 - iv. (*women who experience child sexual abuse* AND (*sexual abuse as children*))
 - v. (*child sexual abuse* OR *childhood sexual abuse*) AND (*stigmatized loss* OR *stigmatised loss) AND (*adult women survivors* OR *adult female survivors*))
- h. **Sources**
 - Data base search
 - 1. EbscoHost
 - a. Academic Search Premiere
 - b. Africa-Wide Information
 - c. E-Journals
 - d. PsycARTICLES
 - e. PsycINFO
 - f. SocINDEX
 - g. ERIC
 - 2. SAePublications
 - 3. Science Direct (Social Sciences and Psychology)
 - 4. Cross Ref

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

Academic journals search

5. *Child Abuse & Neglect*
6. *Child Abuse Research in South Africa*
7. *Child Abuse Review*
8. *Journal of Child Sexual Abuse*
9. *Sexual Abuse: A Journal of Research and Treatment*
10. *Trauma, Violence and Abuse: A Review Journal*

****Reference lists after duplicate studies have been removed**

6) **Exclusion criteria**

a. **Participants:**

- i. studies that include adult male survivors of CSA, studies that include children

b. **Type of studies :**

- i. Literature reviews
- ii. book reviews
- iii. policy documents
- iv. government documents
- v. grey literature
- vi. training manuals

c. **Publications:** studies that were not peer reviewed

d. **Sources:**

- i. training manuals
- ii. reference to blogs
- iii. reference to books
- iv. newspaper articles
- v. magazine articles

7) **Study selection process**

- a. Identify publications through data base searches using key terms
- b. Identify publications through academic journal searches using key terms
 - i. Remove duplicates
- c. Identify additional citations from reference lists of publications found through searches

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

- i. Application of exclusion criteria
- d. Screen titles and abstracts for eligibility criteria
- e. Access and assess full text studies for eligibility criteria
 - i. Exclude studies that do not meet inclusion criteria
 - ii. Exclude studies that do not answer the research question
- f. Reviewers apply inclusion and exclusion criteria to full text studies to validate eligibility
- g. Indicate studies for inclusion in scoping review

8) Search strategy

- a. Analysis of text words contained in the title and abstract
- b. Index terms used to describe article
- c. Identified keywords and index terms
- d. Reference list of all identified reports and articles

9) Charting the data

Extraction and mapping of data from the selected studies in the data charting form.

10) Consultation with helping professionals

Focus group discussion with helping professionals working in the field of child/childhood sexual abuse

ADDENDUM B

Identified database and journal studies

DATA BASE	Key terms	After exclusion criteria
Ebscohost Academic Search Premier	*child sexual abuse* OR *childhood sexual abuse* AND *stigmatised loss* OR *stigmatized loss*	3
	child sexual assault OR *childhood sexual assault* AND *stigmatised loss* OR *stigmatized loss*	1
	child sexual abuse OR *childhood sexual abuse* AND *adult women survivors* OR *adult female survivors*	213
	women AND *sexually abused as children*	139
	adult women AND *sexually abused as children*	453
	child sexual abuse OR *childhood sexual abuse* AND *stigmatised loss* OR *stigmatized loss* AND *adult women survivors* OR *adult female survivors*	331
	TOTAL	1140
	ENDNOTE TOTAL	1140

DATA BASE	Key terms	After exclusion criteria
Ebscohost Africa-Wide Information	*child sexual abuse* OR *childhood sexual abuse* AND *stigmatised loss* OR *stigmatized loss*	154
	child sexual assault OR *childhood sexual assault* AND *stigmatised loss* OR *stigmatized loss*	5
	child sexual abuse OR *childhood sexual abuse* AND *adult women survivors* OR *adult female survivors*	154
	women AND *sexually abused as children*	11
	adult women AND *sexually abused as children*	0
	child sexual abuse OR *childhood sexual abuse* AND *stigmatised loss* OR *stigmatized loss* AND *adult women survivors* OR *adult female survivors*	154
	TOTAL	478
	ENDNOTE TOTAL	478

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

DATA BASE	Key terms	After exclusion criteria
Ebscohost PsycARTICLES	*child sexual abuse* OR *childhood sexual abuse* AND *stigmatised loss* OR *stigmatized loss*	2
	child sexual assault OR *childhood sexual assault* AND *stigmatised loss* OR *stigmatized loss*	0
	child sexual abuse OR *childhood sexual abuse* AND *adult women survivors* OR *adult female survivors*	87
	women AND *sexually abused as children*	339
	adult women AND *sexually abused as children*	147
	child sexual abuse OR *childhood sexual abuse* AND *stigmatised loss* OR *stigmatized loss* AND *adult women survivors* OR *adult female survivors*	38
	TOTAL	613
	ENDNOTE TOTAL	613

DATA BASE	Key terms	After exclusion criteria
Ebscohost PsycINFO	*child sexual abuse* OR *childhood sexual abuse* AND *stigmatised loss* OR *stigmatized loss*	17
	child sexual assault OR *childhood sexual assault* AND *stigmatised loss* OR *stigmatized loss*	8
	child sexual abuse OR *childhood sexual abuse* AND *adult women survivors* OR *adult female survivors*	140
	women AND *sexually abused as children*	87
	adult women AND *sexually abused as children*	17
	child sexual abuse OR *childhood sexual abuse* AND *stigmatised loss* OR *stigmatized loss* AND *adult women survivors* OR *adult female survivors*	54
	TOTAL	323
	ENDNOTE TOTAL	323

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

DATA BASE	Key terms	After exclusion criteria
Ebscohost SocINDEX	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	2
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	0
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	169
	(*women*) AND (*sexually abused as children*)	140
	(adult women) AND (sexually abused as children)	21
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	13
	TOTAL	345
	ENDNOTE TOTAL	345

DATA BASE	Key terms	After exclusion criteria
Ebscohost ERIC	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	1172
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	34
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	24
	(*women*) AND (*sexually abused as children*)	25
	(adult women) AND (sexually abused as children)	6
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	3
	TOTAL	1264
	ENDNOTE TOTAL	1231

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

DATA BASE	Key terms	After exclusion criteria
Ebscohost E-Journals	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	4
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	6
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	1
	(*women*) AND (*sexually abused as children*)	72
	(adult women) AND (sexually abused as children)	14
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	37
	TOTAL	134
	ENDNOTE TOTAL	134

DATA BASE	Key terms	After exclusion criteria
Science Direct	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	10
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	0
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	3
	(*women*) AND (*sexually abused as children*)	21
	(adult women) AND (sexually abused as children)	11
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	0
	TOTAL	45
	ENDNOTE TOTAL	45

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

DATA BASE	Key terms	After exclusion criteria
SA ePublications	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	3
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	0
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	23
	(*women*) AND (*sexually abused as children*)	34
	(adult women) AND (sexually abused as children)	12
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	3
	TOTAL	75
	ENDNOTE TOTAL	75

DATA BASE	Key terms	After exclusion criteria
CrossRef (filters) -APA PsycNET	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	4
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	1
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	33
	(*women*) AND (*sexually abused as children*)	4
	(adult women) AND (sexually abused as children)	2
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	1
	TOTAL	45
	ENDNOTE TOTAL	45

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

JOURNAL	Key terms	After exclusion criteria
Child Abuse & Neglect	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	5
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	2
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	64
	(*women*) AND (*sexually abused as children*)	150
	(adult women) AND (sexually abused as children)	111
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	2
	TOTAL	334
	ENDNOTE TOTAL	334

JOURNAL	Key terms	After exclusion criteria
Child Abuse Research in South Africa	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	1
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	0
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	10
	(*women*) AND (*sexually abused as children*)	9
	(adult women) AND (sexually abused as children)	7
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	2
	TOTAL	29
	ENDNOTE TOTAL	29

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

JOURNAL	Key terms	After exclusion criteria
Child Abuse Review	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	7
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	1
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	9
	(*women*) AND (*sexually abused as children*)	17
	(adult women) AND (sexually abused as children)	13
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	0
	TOTAL	47
	ENDNOTE TOTAL	47

JOURNAL	Key terms	After exclusion criteria
Journal of Child Sexual Abuse	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	1
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	1
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	50
	(*women*) AND (*sexually abused as children*)	47
	(adult women) AND (sexually abused as children)	49
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	0
	TOTAL	148
	ENDNOTE TOTAL	148

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

JOURNAL	Key terms	After exclusion criteria
Sexual Abuse: A Journal of Research and Treatment	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	3
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	0
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	65
	(*women*) AND (*sexually abused as children*)	16
	(adult women) AND (sexually abused as children)	7
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	0
	TOTAL	91
	ENDNOTE TOTAL	91

JOURNAL	Key terms	After exclusion criteria
Trauma, Violence and Abuse: A Review Journal	(*child sexual abuse* OR *childhood sexual abuse*) AND stigmatised loss OR stigmatized loss	0
	(*child sexual assault*) OR *childhood sexual assault*) AND (stigmatised loss) OR (stigmatized loss)	0
	(*child sexual abuse* OR *childhood sexual abuse*) AND (*adult women survivors*) OR (*adult female survivors)	3
	(*women*) AND (*sexually abused as children*)	2
	(adult women) AND (sexually abused as children)	1
	(*child sexual abuse*) OR (*childhood sexual abuse*) AND (*stigmatised loss* OR (*stigmatized loss*)) AND (adult women survivors) OR (adult female survivors)	0
	TOTAL	6
	ENDNOTE TOTAL	6

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

TOTALS	ENDNOTE DATABASE & JOURNAL SEARCHES	18 144
	ADDITIONAL ARTICLES CITED IN REFERENCE LISTS	65
	<i>TOTAL</i>	18 209
	AFTER DUPLICATES REMOVED	3126
	TITLE AND ABSTRACT SCREENING (after application of exclusion criteria; duplicates removed)	570
	STUDIES EXCLUDED	186
	FULL TEXT ASSESSED	384
	ELIGIBLE STUDIES	19
	STUDIES INCLUDED IN SCOPING REVIEW	19

ADDENDUM C

Focus group schedule and interview questions



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FOCUS GROUP INTERVIEW QUESTIONS

“Exploring stigmatised loss in a group of adult women who experienced childhood sexual abuse”

RESEARCHER: Baaqira Ebrahim

RESEARCH STUDY OBJECTIVE:

To present the findings of the scoping review to a panel of professionals in order to obtain feedback on the findings and identify and discuss any additional emerging issues relating to stigmatised loss in CSA.

RESEARCH QUESTION:

What feedback or additional issues relating to stigmatised loss can be provided by a panel of professionals working within the field of CSA?

INTERVIEW QUESTIONS:

Please take some time and reflect on the findings of the scoping review presented to you.

1. Given the themes emerging in literature what are your views pertaining to stigmatised loss and CSA?
2. Is there any additional emerging issues relating to stigmatised loss and CSA that you observed in practice while working with survivors of CSA?

Thank you for participating.
Your expertise will be a valuable asset to this study.

Baaqira Ebrahim
Contact numbers: 016-910 3424 / 072 889 8711
Email: Baaqira.ebrahim@nwu.ac.za

ADDENDUM D

Data charting form

Nr.	Author; Publication year; title	Country	Research Approach; method; participants	Contextual factors of sample background	Themes	Subthemes (Axial coding)	Open ended coding
1.	Blizard, R. A. & Bluhm, A. M. (1994) <i>Attachment to the abuser: integrating object-relations and trauma theories in treatment of abuse survivors</i>	USA	Qualitative; Case illustrations; Female (N=2); Age: not specified	Known perpetrator	Deprivation of fundamental psychological needs	Loss of sense of identity	Loss of the internal representation of the self
2.	Castillo, D. D. & Wright, M. O. (2009) <i>The perils and possibilities in disclosing childhood sexual abuse to a romantic partner</i>	USA	Qualitative; Females (N=7); Age (18-50 years)	Not specified	Deprivation of fundamental psychological needs	Loss of emotional control	Loss of control in disclosing Stigmatization in disclosure
3.	Chopra, M. (2006)	Israel	Qualitative; Female (N=1); Age (Late 20s)	Known perpetrator	Loss of safety	Loss of boundaries Loss of sense of identity	Loss of boundaries Loss of self Loss of sense of agency

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

	<i>Delusional themes of penetration and loss of boundaries and their relation to early sexual trauma in psychotic disorder</i>				Deprivation of fundamental psychological needs	Loss of sense of agency/control	
4.	Classen, C., Field, N. P., Atkinson, A. & Spiegel, D. (1998) <i>Representations of self in women sexually abused in childhood</i>	USA	Quantitative; Females (N=27) Age (M=44.5)	Not specified	Deprivation of fundamental psychological needs	Loss of sense of identity	Loss of core sense of self
5.	Classen, C., Koopman, C., Nevill-Manning, K. & Spiegel, D. (2001) <i>A preliminary report comparing trauma-focused and present-focused group therapy against a wait-listed condition among childhood sexual abuse survivors with PTSD</i>	USA	Quantitative; Females (N=55) Age (M=38.4)	Not specified	Deprivation of fundamental psychological needs	Loss of childhood innocence	Loss of innocence

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

6.	Colarusso, C. A. (2009) <i>The relentless past</i>	USA	Qualitative; Females ($N = 4$) Age = ($M = 59.5$)	Not specified	Loss of safety Loss of sexual capacity	Loss of trust in others Loss of sexual control	Loss of faith Loss of sexual control
7.	Combs, J. L., Jordan, C. E. & Smith, G. T. (2014) <i>Individual differences in personality predict externalizing versus internalizing outcomes following sexual assault</i>	USA	Quantitative; Females ($N = 750$); Age: Not specified	Not specified	Deprivation of fundamental psychological needs Loss of sexual capacity	Loss of sense of agency/control Loss of normal sexual responses Loss of trust in self	Loss of control Loss of interest in sex Loss of confidence Loss of pleasure
8.	Goldman, J. D. G. & Bode, A. (2012) <i>Female survivors' perceptions of lifelong impact on their education of child abuse suffered in orphanages</i>	Australia	Qualitative; Females ($N=10$) Age = (44 – 72)	Not specified	Deprivation of fundamental psychological needs	Loss of trust in self	Loss of trust Loss of self-esteem
9..	Liem, J. H., O'Toole, J. G. & James, J. B. (1992) <i>The need for power in women who were sexually abused: an exploratory study</i>	USA	Qualitative; Female ($N=10$) Control ($N=10$) Age = (19 – 42)	Known perpetrator;	Loss of safety	Loss of trust in others	Loss of highly valued relationships through which identity is achieved Loss of relationship

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

10.	Mcevoy, M. & Daniluk, J. (1995) <i>Wounds to the soul: the experience of aboriginal women survivors of sexual abuse</i>	Canada	Qualitative; Female (N=6) Age = (29-53)	Known perpetrator;	Loss of safety Deprivation of fundamental psychological needs	Loss of sense of identity Loss of childhood innocence Loss of sense of agency/control Loss of trust in self Loss of trust in others	Loss of self Loss of innocence Loss of power Loss of efficacy Loss of dignity Loss of control Loss of belief in people and themselves Loss of belief in safe, nurturing intimate relationships
11.	Noll, J. G., Trickett, P. K. & Putnam, F. W. (2013) <i>A prospective investigation of the impact of childhood sexual abuse on the development of sexuality</i>	USA	Quantitative; Females (N = 77) Age (M = 20.41)	Known perpetrator	Deprivation of fundamental psychological needs	Loss of sense of identity	Loss of respect for self
12.	Nusbaum, G. A. (2000) <i>A case illustration of combined treatment using a psychodynamic group for women sexual abuse survivors to address and modify</i>	USA	Qualitative; Female (N = 1) Age = (mid-30s)	Known perpetrator	Deprivation of fundamental psychological needs	Loss of sense of agency/control	Loss of control

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

	<i>self-punitive superego trends</i>						
13.	Oz, S. (2005) <i>The “Wall of Fear”: the bridge between the traumatic even and trauma resolution therapy for childhood sexual abuse</i>	Not specified	Qualitative; Female; Age: Not specified	Not specified	Loss of safety Deprivation of fundamental psychological needs	Loss of sense of agency Loss of childhood innocence Loss of trust in others	Loss of control Loss of innocence Loss of ideal family Loss of ability to have fun Loss of intimate relationships
14.	Romans, S.E., Gendall, K. A., Martin, J. L. & Mullen, P. E. (2000) <i>Child sexual abuse and later disordered eating: a New Zealand epidemiological study</i>	New Zealand	Mixed method; Female (N=3000)	Not specified	Deprivation of fundamental psychological needs	Loss of sense of agency / control	Loss of control
15.	Roth, S. & Newman, E. (1992) <i>The role of helplessness in the recovery process for sexual trauma survivors</i>	Not specified	Qualitative; Female (N = 2) Age: Not specified	Not specified	Loss of sexual capacity	Loss of sexual control	Loss of control of her sexuality

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

16.	Schwerdtfeger, K. L. & Wampler, K.S. (2009) <i>Sexual trauma and pregnancy: a qualitative exploration of women's dual life experience</i>	USA	Qualitative; Female ($N = 12$); Age = (18-34)	Not specified	Loss of safety Deprivation of fundamental psychological needs Loss of sexual capacity	Loss of boundaries Loss of trust in others Loss of sexual control Loss of sense of identity	Loss of a sense of safety Loss of trust in others Loss of sense of sexuality Loss of self-regard
17.	Talbot, N. (1996) <i>Women sexually abused as children: the centrality of shame issues and treatment implications</i>	USA	Qualitative; Female ($N = 1$) Age = 30	Not specified	Deprivation of fundamental psychological needs Loss of sexual capacity	Loss of sense of identity Loss of normal sexual responses Loss of sense of agency/control	Loss of idealized self Loss of bodily control Loss of control
18.	Thomas, S. P. & Hall, J. M. (2008) <i>Life trajectories of female child abuse survivors thriving in adulthood</i>	USA	Qualitative; Female ($N = 27$) Age ($M = 48.9$)	Known perpetrator	Loss of safety	Loss of boundaries	Deprived of the safety and security
19.	Turner, S. (1993) <i>Talking about sexual abuse: the value of short-term groups for women survivors</i>	USA	Qualitative; Female; Age: Not specified	Unknown	Deprivation of fundamental psychological needs	Loss of childhood innocence	Loss of their childhood

ADDENDUM E

Coding framework

CODE	DESCRIPTION
Loss of safety	
Personal boundaries were violated and disrespected	Any referral to: <ul style="list-style-type: none"> • Personal dignity being insulted • Dependence on abuser
Loss of trust in other	Any referral to: <ul style="list-style-type: none"> • Negative relationships • Loss of trust in higher being / God • Loss of faith / religion • Distorted worldview • Fear of rejection
Deprivation of fundamental psychological needs	
Loss of a sense of agency or control	Any referral to: <ul style="list-style-type: none"> • Powerlessness • No control of life
Loss of trust in self	Any referral to: <ul style="list-style-type: none"> • Loss of self-esteem • Loss of belief in self • Loss of self-efficacy • Loss of trust in self • Loss of confidence in self
Loss of a sense of identity	Any referral to: <ul style="list-style-type: none"> • Loss of internal representation of self • Worthlessness • Loss of dignity • Loss of respect for self • Loss of core sense of self • Difficulty in accepting self • Feeling of not being good enough
Loss of emotional control	Any referral to: <ul style="list-style-type: none"> • Loss of control in disclosing • Stigma attached to abuse
Loss of childhood innocence	Any referral to: <ul style="list-style-type: none"> • Loss of childhood • Loss of innocence • Loss of fun • Loss of ideal family unit

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

Loss of sexual capacity	
Loss of normal sexual responses	Any referral to: <ul style="list-style-type: none">• Loss of interest in sex• Loss of bodily control in sex• Loss of sexual pleasure• Being objectified in sexual interactions
Loss of sexual control	Any referral to: <ul style="list-style-type: none">• Loss of sexuality• Loss of being in control in sexual encounters• Repulsion to sex• Promiscuity• Unhealthy attitude or behaviour toward sex• Dissociation during sexual activity

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

ADDENDUM F

Ethics approval certificate



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Ethics Committee

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ETHICS APPROVAL OF PROJECT

The North-West University Ethics Committee (NWU-EC) hereby approves your project as indicated below. This implies that the NWU-EC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: The Efficacy of a Survivor to Thrive Strengths-based Intervention Programme facilitating Posttraumatic Growth in Women who experienced Childhood Sexual Abuse															
Project Leader: Dr H Walker-Williams															
Ethics number:	N	W	U	-	0	0	0	4	1	-	0	8	-	A	1
	Institution			Project Number						Year		Status			
<small>Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation</small>															
Approval date: 2014-10-01								Expiry date: 2019-09-30							

Special conditions of the approval (if any): None

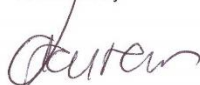
General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-EC:
 - annually (or as otherwise requested) on the progress of the project,
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-EC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-EC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-EC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the NWU-EC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely



Prof Amanda Lourens

(chair NWU Research Ethics Regulatory Committee (RERC))

ADDENDUM G

Confidentiality agreement

H. Walker-Williams
Dr Hayley Walker-Williams

H. Walker-Williams 30/01/2016
(signature) (date)

Ansie Fouche
Prof Ansie Fouché

Ansie Fouche 30/01/2016
(signature) (date)

If you have any questions or concerns about this study, please contact:
Dr Hayley Walker-Williams
Psychology Subject Group
School of Behavioural Sciences
North-West University, Vanderbijlpark Campus
Building 7- 119
Hayley.williams@nwu.ac.za
016-910 3416

Prof Ansie Fouché
Social Work Subject Group
School of Behavioural Sciences
North-West University, Vanderbijlpark Campus
Building 9A- G19.5
Ansie.fouche@nwu.ac.za
016-910 3428

3. Return all research information in any form or format to Dr Hayley Walker-Williams and Prof Ansie Fouché when I have completed the research tasks.

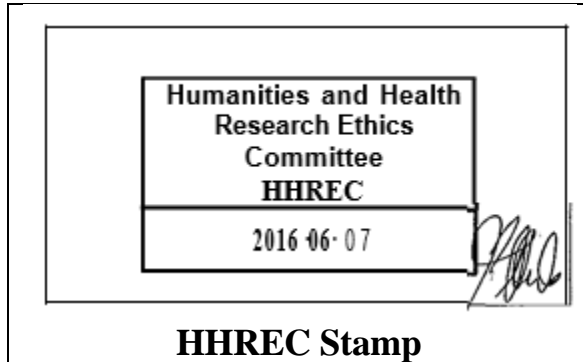
MA student:

B. EBRAHIM
Ms Baaqira Ebrahim

B. Ebrahim 30/01/2016
(signature) (date)

ADDENDUM H

Focus group informed consent



PO Box 1174, Vanderbijlpark
South Africa, 1900

Web: <http://www.nwu.ac.za>

DATE

**PARTICIPANT INFORMATION LEAFLET AND CONSENT
FORM FOR FOCUS GROUP**

TITLE OF THE RESEARCH PROJECT: Exploring stigmatised loss in adult women who experienced childhood sexual abuse

REFERENCE NUMBERS:

RESEARCHER: Baaqira Ebrahim

ADDRESS: North-West University, P.O. Box 1174, Vanderbijlpark, 1900

CONTACT NUMBER: 016-910 3424 / 072 889 8711

SUPERVISOR: Dr Hayley Walker-Williams

CO-SUPERVISOR: Prof Ansie Fouché

This study forms part of a larger research project a newly developed strengths-based group intervention (group therapy programme), for female adult survivors of childhood sexual abuse (CSA) called Survivor to Thrive (S2T).

You are invited to participate in a focus group pertaining to the findings of a research study exploring stigmatised loss in adult women who experienced CSA.

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

This letter is to inform you about the purpose of the study and what the expectations would be should you agree to participate. If you have any questions, please feel free to direct them to the researcher. It is important that you understand what this research is about and what your involvement would entail prior to giving your informed consent.

Your participation in this study is voluntary and you are free to withdraw from the study at any time.

This study has been approved by the Humanities and Health Research Ethics Committee (HHREC) of the Faculty of Humanities of the North-West University (NWU_____) and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council.

It might be necessary for the research ethics committee members or relevant authorities to inspect the research records to make sure that the researcher is conducting the research in an ethical manner.

What is this research study all about?

The main aim of this study is to explore the stigmatised loss reported by a group of South African women, who experience CSA, and particularly in a group intervention programme for woman survivors of CSA, in order to inform further S2T treatment outcomes.

This study has five objectives:

- To conduct a systematic scoping review (literature study) to identify literature and provide a summary of evidence from a variety of studies on stigmatised loss in women who experienced CSA.
- To present findings of the scoping review to a panel of helping professionals working within the field of CSA to clarify and identify emerging issues relating to stigmatised loss in women who experienced CSA.
- To perform QSA of a collective set of data from S2T treatment programmes conducted with two groups of women over a 2 year period, aiming at exploring/emerging reports of stigmatised loss in this population.
- To conduct thematic analysis of transcripts from a focus group with helping professionals working within the field of CSA and two S2T treatment programmes
- To contextualise findings on stigmatised losses in order to inform future S2T treatment outcomes.

Why have you been invited to participate?

You were nominated to participate in this study by Dr Hayley Walker-Williams and Prof. Ansie Fouché. You are invited because you have a minimum of three to five years practice experience in working with CSA survivors, are a qualified clinical psychologist or registered social worker working in private practice, and can communicate in English.

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

What will your participation entail?

The focus group discussion will be held in and around August 2016. Only one focus group discussion of approximately two hours will be held at a secure location and at a convenient time.

The focus group will be conducted in English. You will be presented with the finding of a scoping review (literature study) and asked for your feedback and opinion on whether the literature correlates with your practice experience. You will also be requested to consent to the discussion being digitally recorded.

You will be requested not to divulge any personal details of your clients. Confidentiality will be encouraged during the sharing of information in the focus group and you will be asked to indicate your agreement to this in writing.

Will you benefit from taking part in this research?

You will be provided with a summary of the findings upon completion of the study. These findings may contribute towards your knowledge base on stigmatised loss in CSA survivors.

Are there risks involved in your taking part in this research and how will these be managed?

There are no known risks to your involvement in this research study, however should you feel the need to debrief after the focus group, kindly indicate this to the researcher in person or via email and one session will be arranged at no cost to you with a qualified psychologist.

Who will have access to the data?

Only the researcher and her supervisors will have access to the audio recordings and transcriptions which will be stored in a locked filing cabinet. All data will be stored electronically in an encrypted file. The findings of the research may be published but your name will not appear in the publication.

What will happen to the data?

All data and identifying information will be kept confidential, as required by the Health Professions Act 56 of 1974 (Department of Health, 2006). Your participation and identity will be kept confidential. Your name and any identifying information will be removed from the transcript of the focus group and your contributions will be identified by a numbered code assigned to you.

Will you be paid/compensated to take part in this study and are there any costs involved?

You will receive reimbursement of travel costs according to Automobile Association (AA) rates. You will also receive a book for helping professionals working with CSA in the South African context, entitled: 'Sexual abuse – Dynamics, assessment & healing'. Refreshments and snacks will be provided on the day of the focus group discussion.

How will you know about the findings?

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

You will receive a written summary of the results of the research upon its completion. Kindly provide a mailing address at the bottom of this form.

Is there anything else that you should know or do?

- If you have any questions or would like more information, you may contact me at 016-910 3424 / 072 889 8711 or via email at Baaqira.ebrahim@nwu.ac.za
- You can contact the chair of the Humanities and Health Research Ethics Committee (Prof Linda Theron) at 016 910 3076 or Linda.theron@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher. You can also contact, the co-chair, Prof Tumi Khumalo (016 910 3397 or Tumi.khumalo@nwu.ac.za). You can leave a message for either Linda or Tumi with Ms Daleen Claasens (016 910 30441)
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I agree to take part in a research study entitled:

I declare that:

- I have read and understood this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher (if this is a different person), and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I hereby consent that the focus group discussion may be digitally recorded.
- I understand that what I contribute (what I report/say) could be reproduced publically and/or quoted, but without reference to my personal identity.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I understand the importance of not divulging any personal information of my clients during the focus group.
- I endorse the importance of confidentiality during my participation in the focus group discussion.

Signed at (*place*) on (*date*) 20....

.....
Signature of participant

.....
Signature of witness

STIGMATISED LOSS IN CHILDHOOD SEXUAL ABUSE

- You may contact me again Yes No
- I would like a summary of the findings of this research Yes No

The best way to reach me is:

Name & Surname: _____
 Postal Address: _____
 Email: _____
 Phone Number: _____
 Cell Phone Number: _____

In case the above details change, please contact the following person who knows me well and who does not live with me and who will help you to contact me:

Name & Surname

Phone/ Cell Phone Number /Email

Declaration by person obtaining consent

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) on (*date*) 20....

.....
Signature of person obtaining consent

.....
Signature of witness

ADDENDUM I

Consent to use the S2T data



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
VAAL TRIANGLE CAMPUS

PO Box 1174, Vanderbijlpark
South Africa, 1900

School of Behavioural Science
Psychology Department
Tel: (016) 016 910 3416
Cell: 082 496 4105
Email Hayley.williams@nwu.ac.za
Date: 30 January 2016

Dear Ms Baaqira Ebrahim

CONSENT TO USE TRANSCRIPTIONS OF S2T TREATMENT SESSIONS (GROUP ONE & TWO):

RESEARCH PROJECT: The Benefit of a Survivor to Thrive (S2T) Strengths-Based Group Intervention Programme for Women Who Experienced Childhood Sexual Abuse

NWU ETHICAL CLEARANCE NUMBER: NWU 00041-08-A1

PRINCIPAL INVESTIGATOR: Dr Hayley Walker-Williams

CO-INVESTIGATOR: Prof Ansie Fouché

ADDRESS: North-West University, School of Behavioural Sciences, Hendrik Van Eck Blvd, Vanderbijlpark, 1900

CONTACT NUMBER: 016 9103416 / 0169103428

We hereby grant permission to Ms Baaqira Ebrahim (identity number: 8807210078085) a prospective MA student in the above research project and consent to the following:

- To have access to the transcriptions of the recorded S2T group treatment sessions for groups one and two for which group participants have provided their written consent. Access will be made available once her proposal has been approved by the Optentia's committee for advanced degrees and ethical clearance has been obtained.