

**Risk and Resilience: Exploring the Ecological Factors that Impact the Recovery of
Sexual Assault Survivors at Two Centres in the Western Cape**



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MNNLUC002

SUBMITTED TO THE UNIVERSITY OF CAPE TOWN
In (dissertation only) fulfilment of the requirements for the degree
Master of Philosophy (Public Mental Health)

9 February 2023

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PLAGIARISM DECLARATION

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DEDICATION

This dissertation is dedicated to my Dad, P.T Munnik, for always encouraging me to think deeply, passionately and with intention. And in the times when I wanted to give up on my very unquiet mind, thank you for always reminding me of my different way of thinking.

ACKNOWLEDGEMENTS

This MPhil dissertation would be incomplete if it were not for the following people:

- My inspiring supervisors, **Dr Thandi Davies**, and **Dr Petal Petersen Williams**: thank you for your patience, understanding and guidance throughout this daunting, and rather lonely process. You both made me feel less alone.
- **Dr Claire van der Westhuizen**: thank you for encouraging me to apply to the Public Mental Health programme, for your insightful guidance as the course convener and for helping me feel I am capable of completing this dissertation – which now I have!
- The **counselling coordinator staff** at the two rape centres at which I conducted this research: thank you for your patience and dedication in helping me recruit participants.
- **Mom**: you have raised me to be the strong woman I am today, and I hope you are proud. If so, this pride is purely a reflection of you.
- My siblings, **Reidie and Sammy**: Despite living in different places around the world, thank you for your encouragement, love, and belief that your little sister can achieve just about anything.
- And finally, my dear husband, **Joshua**: thank you for helping me see the light each day – this light being your unwavering love and support for me.

This work is based on the research supported wholly by the National Research Foundation of South Africa (**Grant Number: 141140**).



ABSTRACT

Background: Sexual assault is highly prevalent in South Africa and many women who are sexually assaulted are at high risk of developing poor health outcomes, ranging from HIV to mental disorders. The high prevalence of sexual assault and the burden of poor health outcomes highlights a serious need for interventions for these women. However, it is common that survivors face many challenges when being assisted. In legal settings, there is a lack of prosecution of perpetrators and survivors often face secondary victimisation. In psychosocial settings, they have little access to counselling services with treatment being short-term and involving no follow-up procedure. These problematic legal and psychosocial barriers demonstrate a need to explore survivors' perspectives to understand what factors should be promoted to increase resilience and improve rape recovery.

Aims and Objectives: This research aimed to explore how factors on Campbell et al.'s (2009) ecological model contribute to mental ill-health, resilience, and recovery in female sexual assault survivors. The ecological model explains the link between sexual assault and mental health amongst survivors. It uses factors on seven interrelated levels to examine which factors worsen or improve survivors' recovery and mental well-being. The research objectives included: 1) to explore female survivors' subjective experiences of mental health related to their sexual assault incident, 2) to explore how factors on the seven levels of the ecological model improve or worsen female survivors' mental health, and 3) to explore how factors on the 'self-blame' level of the ecological model interact with other levels to impact female survivors' mental health.

Methods: The study involved an exploratory qualitative research design using purposive sampling as the sampling method. There were 19 participants involved in the study. The data collection methods included 11 in-depth interviews with sexual assault survivors, specifically survivors of rape, and two focus group discussions with four HCWs per group. Data collection took place at two different sexual assault centres in Cape Town, Western Cape, and a framework analysis approach was used to analyse data.

Results: Results were coded into themes and categorised according to the seven levels of the ecological model. The first category, the individual level, focused on the survivors' mental health experiences and coping mechanisms following sexual assault experiences. Survivors experienced a range of mental health problems, such as depression and panic attacks, and used various unhealthy and healthy coping mechanisms to cope with their mental ill-health, such as creative expression or substance use. There were also many biopsychosocial factors that either improve or worsen survivors' recovery. Biological factors include disturbed eating, sleeping and sexuality patterns, psychological factors include affected emotions, memory, and behaviour, and sociological factors included social

support, socio-economic status, and social interactions. The second category, the assault level, found that the weapon used and triggering memories of weapons worsened reactions to trauma, and therefore recovery. Category three, the microsystem level, highlighted that negative social reactions and lack of support worsened recovery while positive family social reactions improved well-being. Category four, the mesosystem level, demonstrated that negative interactions with legal and healthcare professionals as well as poor case management impacted the way in which survivors perceived and accessed treatment. This differed to the beneficial factors which involved therapy accessed through NGOs and hearing stories from other survivors. The fifth theme, the macrosystem level, highlighted that rape misconceptions, ignorance about rape in families, and maternal history of rape played a role in hindering chances of recovery and increasing risk to mental ill-health. In contrast, raising awareness through education can help recovery progression and potentially increase support for victims. Category six, the chronosystem level, demonstrated that repetitive experiences of sexual assault have a negative impact on survivors' sense of self-worth and recovery while also worsening symptoms of mental ill-health. The final category, the self-blame level, emphasised that because survivors engaged in unhealthy coping mechanisms and internalised external blame and stigma, this led to creating and worsening feelings of guilt and shame. In contrast, attending counselling, seeking justice, talking about the rape incident, and accepting the occurrence of the assault, facilitated empowerment, well-being, and healing.

Conclusion: This study aimed to explore factors that contribute to mental ill-health, resilience, and recovery in female sexual assault survivors. Findings highlighted that many different factors such as unhealthy coping mechanisms, myths about rape, and weapon use, played a role in increasing risk to mental ill-health. Conversely, factors such as therapy, social support, and empowerment increased resilience and improved recovery. Findings also revealed that self-blame was linked to all levels on the ecological model, and this hindered recovery due to survivors often blaming themselves for their rape and feeling ashamed. This research enabled survivors to share their perspectives of what factors strengthened and worsened their mental health, recovery, and resilience. By understanding which factors support or worsen rape recovery, recommendations on how to incorporate positive factors are suggested, such as educational programmes, psychosocial interventions, and further research.

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LIST OF ABBREVIATIONS

CMD – Common mental disorders
FGD – Focus group discussions
GAD – Generalised anxiety disorder
HCW – Healthcare worker
HICs – High-income countries
IDI – In-depth interviews
IPV – Intimate partner violence
K-10 – Kessler Psychological Distress Scale
LMICs – Low-and middle-income countries
MDD – Major depressive disorder
NPSV – non-partner sexual violence
PTSD – Post-traumatic stress disorder
RTS – Rape trauma syndrome
SAPS – South African Police Service
SMI – Serious mental illness
TCC – Thuthuzela Care Centre
VEP – Victim Empowerment Programme
WHO – World Health Organization

CHAPTER ONE: INTRODUCTION

1.1 Problem Statement

Sexual assault is highly prevalent in South Africa. During the 2019/20 reporting year, the South African Police Service (SAPS) recorded over 50 000 counts of sexual offences, with rape contributing to 93.9% of the total sexual offences reported (South African Police Service, 2020). When examining this high prevalence of rape and its impact on the well-being of victims, research suggests that the impact of rape is compounded by various negative health consequences, ranging from HIV to mental disorders (Jina & Thomas, 2013). Despite these impacts, essential services needed to assist victims are not always present in South Africa (Harris & Freccero, 2011; Abrahams & Gevers, 2017; Sepeng & Makhado, 2019). In legal settings, there are many challenges that victims experience, including the lack of prosecution of perpetrators and the dismissal of sexual assault events (Steyn & Steyn, 2008; Holton et al., 2018). These challenges extend into the mental health settings where often there is poor mental health assistance and counselling services provided by trained practitioners. Furthermore, mental health care that is available is often short-term and lacks follow-up (Christofides et al., 2006; Harris & Freccero, 2011; Abrahams & Gevers, 2017; Sepeng et al., 2019).

In addition to these challenges, secondary victimisation is also an issue in both legal and medical settings where victims often experience judgement from both police officers and healthcare workers (HCWs) (Steyn & Steyn, 2008; Holton et al., 2018). Although statutory policies in South Africa, such as the Victim Empowerment Programme (VEP) policy, have attempted to prevent secondary victimisation through written guidelines that instruct professionals on how to manage victims, there are still incidences of secondary victimisation in various settings (Department of Social Development, 2009). The challenges demonstrated within legal and medical settings as well as the failure to implement necessary guidelines suggest a need to explore the perspectives of survivors of sexual assault. This is important because it may enable understanding of what aspects of services should be developed in order to improve survivor well-being and increase chances of recovery.

The various secondary impacts of sexual assault can be explored using an ecological model adapted for sexual assault that unpacks how sexual assault affects women's mental health and hinders or strengthens their recovery process (Campbell et al., 2009). The ecological model is based on the premise that human development occurs through evolving interactions between an individual and their environment (Campbell et al., 2009). The model is divided into seven levels: individual; assault characteristics; microsystem; mesosystem; macrosystem; chronosystem; and self-blame (meta-construct). This study used Campbell et al.'s (2009) ecological model as a theoretical framework to explore how factors on each level of this model increase risk to mental ill-health or improve resilience and recovery.

1.2 Aims and Objectives of Study

This research aims to explore how factors on the ecological model contribute to ill-mental health, resilience, and recovery in female sexual assault survivors. The three objectives of the research are as follows:

1. To explore female survivors' subjective experiences of mental health related to their sexual assault incident.
2. To explore how factors on the seven levels of the ecological model improve or worsen female survivors' mental health.
3. To explore how factors on the self-blame level of the ecological model interact with other levels to impact female survivors' mental health.

1.3 Clarification of Concepts

1.3.1 Sexual Assault and Sexual Violence

Sexual assault and sexual violence are terms that are used interchangeably in literature and there appears to be no clear distinction between the two. Krug et al. (2002) defines sexual violence as any non-consensual sexual acts that aim to control, manipulate, humiliate, or degrade. It may involve other violent acts, such as physical force, psychological intimidation, coercion, and blackmail, all of which result in physical and psychological harm to the victim (Krug et al., 2002). It can be perpetuated by anyone, including intimate partners, in cases of intimate partner violence (IPV) or non-partners, in cases of non-partner sexual violence (NPSV) (World Health Organization, 2021).

In this dissertation both 'sexual assault' and 'sexual violence' are used, but sexual assault is predominantly used to align with the ecological model put forward by Campbell et al. (2009).

1.3.2 Rape

Rape is one form of sexual assault or sexual violence. As described in the Republic of South Africa Criminal Law (Sexual Offences and Related Matters) Amendment Act of 2007 (Act No. 32 of 2007), 'rape' refers to the forced action of sexual penetration. While rape is a form of sexual assault, not all sexual assault is rape. This is because sexual assault can also include other sexual acts, such as unwanted touch, forcing victims to preform sexual acts or sexual commentary towards victims (Dworkin et al., 2021). In this dissertation, 'sexual assault survivor' and 'sexual assault victim' refers to individuals who have experienced sexual assault, including rape.

1.3.3 Sexual Assault Survivors or Victims

It is important to distinguish between the terms, 'victim' and 'survivor'. 'Victim' refers to someone who has recently been sexually assaulted and is in the period prior to receiving assistance, such as governmental assistance or social support. 'Survivor' refers to someone who has received assistance

or is in the process of recovery. These terms are used deliberately to highlight the exact moment when women who have been sexually assaulted receive assistance (National Sexual Assault Kit Initiative, 2015). Due to this research's focus on exploring how the ecological model contributes to mental distress and resilience in *survivors*, it is important to use the two terms according to the context of their rape recovery.

Is it important to note that although sexual assault can also be directed towards men, it disproportionately affects women (World Health Organization, 2010). Hence, the focus of this research is on female survivors of sexual assault.

1.3.4 Healthcare Workers

'Healthcare worker' is defined as a person engaging in actions that focus on improving the health of others (World Health Organization, 2006). In this study, focus groups were conducted with lay counsellors who were regarded as HCWs providing services to sexual assault survivors. According to van Rensburg (2008), lay counsellors work mostly in the non-governmental sector to not only educate clients on health but also provide emotional support. In this dissertation, 'HCW' and 'lay counsellor' are used interchangeably.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This literature review will begin with examining the global and national prevalence of sexual violence. Thereafter, it will define trauma and its relation to sexual assault while also exploring the impact that sexual assault has on the survivor from a biopsychosocial perspective. In addition, the review will examine the Ecological Model of the Impact of Sexual Assault on Women's Mental Health (Campbell et al., 2009) as a theoretical framework. It will explore how the ecological model relates to the factors that increase risk to poor mental health outcomes and improve resilience and the recovery process. Finally, the review will present literature around the recovery process of survivors and the issues they experience with legal and psychosocial services.

2.2 Impact of Trauma

With such high rates of sexual assault, including rape, on both a national and global scale, it is expected that women will experience high levels of trauma. Psychological trauma is defined as the emotional response resulting from a stressful event or crisis (Eaton & Fallin, 2019). For individuals who are more vulnerable, crises can exacerbate the factors that influence mental health problems and prevent the individual's ability to cope with daily life (Eaton & Fallin, 2019). Traumatic events, especially that which is repetitive, cause a detrimental impact on the brain that often results in emotional and cognitive changes. However, not every crisis will impact the individual in a way that influences the development of a serious mental illness (SMI), such as psychotic and substance use disorders (Oram et al., 2017). This largely depends on predisposed vulnerability and the reaction to the crisis itself as well as the extent to which an individual develops resilience (Eaton & Fallin, 2019).

As noted by Eaton and Fallin (2019), often the first emotional and instinctual response when reacting to trauma is fear and disbelief, which can last up to 72 hours after the event. Other strong emotions may appear from 24 hours and can last until several weeks, depending on whether the person has sought assistance and learned appropriate coping strategies. Thereafter, individuals experience exhaustion, fear, confusion which may be accompanied by guilt, avoidance and denial (Eaton & Fallin, 2019). Often, individuals recover from traumatic experiences. However, individuals that continue to experience psychological difficulties on a chronic basis are less likely to return to a normal level of functioning, in which case, symptoms reoccur every time they are confronted with the traumatic experience. This increases the risk of these individuals to develop a SMI (Eaton & Fallin, 2019).

2.3 Prevalence of Sexual Violence

2.3.1 Global Prevalence of Sexual Violence

In a World Health Organization (2021) review of available global prevalence data focused on 12-month and lifetime global prevalence of sexual violence, it was discovered that 13% of women between the ages of 15 and 49 have experienced physical or sexual violence from a partner in the previous 12 months. The percentage is higher for lifetime prevalence, where 27% of women and girls have experienced violence by a partner or someone they know, in their lifetime (World Health Organization, 2021). In addition, one in four females aged 15 to 19 is estimated to have already experienced sexual violence by an intimate partner at least once in their lifetime, indicating that sexual violence can occur early in a female's life (World Health Organization, 2021).

Regarding non-partner sexual violence 6% of women 15 years and older have experienced this type of violence in their lifetime (World Health Organization, 2021). However, the WHO suggests that this estimate may be under-estimated due to NPSV being a stigmatised form of violence that often remains unreported. In total, the WHO reported that 30% of women aged 15 years and older having experienced either IPV or NPSV on a global scale (World Health Organization, 2021).

In low and middle-income countries (LMICs), particularly in the Sub-Saharan African regions, women are at a higher risk to sexual violence than higher-income countries (HICs). In Southern and Central Africa, adjusted prevalence rates of NPSV are estimated at 21.0% and 17.4%, respectively (Abrahams et al., 2014).

2.3.2 Prevalence of Sexual Violence in South Africa

In the 2019/20 reporting year, 42 289 cases of rape were reported alongside 7 749 cases of sexual assault in South Africa (South African Police Service, 2020). The Western Cape was rated the fourth-highest province for sexual offences with a total number of 7 303 cases for the 2019/20 reporting year (Western Cape Government, 2020). Despite this high occurrence, sexual assault is often underreported with as little as one in 23 women reporting sexual offences to police officers (Department of Women Youth and Persons with Disabilities, 2020).

A study conducted in Gauteng found that one in four women reported a NPSV event in their lifetime while nearly one in five women reported experiencing sexual IPV (Department of Women Children and People with Disabilities, 2013). Another study conducted in Gauteng among 774 men and 794 women found that 31% of men disclosed to having raped a woman who was a non-intimate partner, and 12.2% of women reported that they had been raped by a non-intimate partner (Gender Links, 2011). In 2020, SAPS also reported out of a national sample of 31 690 rape cases, 32.1% of cases

were NPSV while 54.3% of cases were perpetrated by a familiar person (South African Police Service, 2020).

2.4 Impact of Sexual Assault

Sexual assault is suggested to be an event that may have a traumatic outcome and this can have many different health impacts on survivors, including mental health problems and illnesses (Department of Women Youth and Persons with Disabilities, 2020). Sexual assault can impact the biological, psychological, and sociological domains of a survivors' health and well-being in various ways.

2.4.1 Biological Impact

There are various biological outcomes that may be experienced by female survivors of sexual assault, including sexually transmitted infections (STIs), human immunodeficiency virus (HIV), and unwanted pregnancy (Jina & Thomas, 2013). Alongside experiencing barriers to treating STIs and HIV, having an unwanted pregnancy weakens the likelihood of seeking pre-and-postnatal care and strengthens susceptibility to abusing substances amongst survivors (Harris & Freccero, 2011; Jina & Thomas, 2013).

Short-term consequences can include bloating, vomiting, shock and confusion while long-term consequences involve development of chronic conditions, including pain, insomnia and fatigue (Jina & Thomas, 2013). In a South African study exploring symptoms resulting from sexual IPV, it was found that somatic symptoms included lethargy, headaches, and coughing as well as physical injuries and pain from forced penetration (Mkhonto et al., 2014; Sebaeng et al., 2016).

2.4.2 Psychological Impact

Female sexual assault survivors are prone to poor mental health outcomes, including mental disorders, substance use and self-blame (Jina & Thomas, 2013; Mgoqi-Mbalo et al., 2017; Sepeng & Makhado, 2019). In addition, insomnia, fear of the event reoccurring and suicidality are common amongst South African female survivors, specifically those who have experienced rape (Sebaeng et al., 2016). Psychological symptoms, such as shame, anger, tension and crying, may occur two to three months post-assault and these can develop into psychiatric illnesses, such as anxiety, depressive and substance use disorders, several years after the assault (Campbell, 2001).

Literature suggests that generalised anxiety disorder (GAD), major depressive disorder (MDD), and post-traumatic stress disorder (PTSD) are more likely to develop after a traumatic event and sometimes may develop months after the event occurred (Sepeng et al., 2019). Research conducted in two South African provinces demonstrated that 62.8% of female survivors displayed evidence of depression and suicidality while other qualitative research conducted in Gauteng highlighted a high

likelihood of anxiety disorders amongst their female IPV survivor participants (Abrahams et al., 2013; Mkhonto et al., 2014). Substance abuse, another common problem amongst female sexual assault survivors, often occurs as a comorbidity with GAD, MDD, and PTSD (Sepeng et al., 2019).

Often, the psychiatric symptoms that survivors experience manifest into PTSD, qualifying it as the most common disorder associated with sexual assault (Campbell et al., 1999; Sepeng et al., 2019). PTSD symptoms involve flashbacks and nightmares; uncontrollable thoughts; severe anxiety; social isolation; hostility and irritability (American Psychiatric Association, 2013). Female survivors living with PTSD most commonly experience paranoia, panic attacks and flashbacks (Cerulli et al., 2012).

2.4.3 Sociological Impact

Reactions from friends, family and community have a large impact on the survivor and can determine whether they develop poor mental health outcomes. Sexual assault can result in stigma placed on survivors by society, health and legal providers as well as family and friends (Jewkes et al., 2021). There are two types of stigma experienced by survivors: internal and external. External stigma refers to misconceptions that are expressed by others, while internal stigma refers to misconceptions that is personally internalised by an individual (Jewkes et al., 2021). Stigma plays a large role in driving depression and PTSD, while also hindering recovery and enhancing self-blame and shame (Jewkes et al., 2021).

Internal and external stigma are interrelated, whereby survivors who experience self-blame (internal stigma) expect others to also blame them (external stigma) and this plays a role in how they interpret other people's attitudes and behaviours towards them (Jewkes et al., 2021). As a result of both internal and external stigma, survivors may receive little to no support from family and friends, which may lead to withdrawal and enhancing feelings of isolation and vulnerability (Jina & Thomas, 2013). In contrast to this, it has been found that survivors who experience social withdrawal may be protected from exposure to negative social reactions, and this may play a role in strengthening resilience and recovery (Ullman, 1999). Sexual assault perpetrated against women has also been found to increase distrust and anger towards men (Sebaeng et al., 2016), which can impact future relationships of heterosexual female survivors with men. It also may lead to avoidance of activities with men which may impair social functioning (Sebaeng et al., 2016).

2.5 Theoretical Framework: Ecological Model

Campbell et al developed a model of the Impact of Sexual Assault on Women's Mental Health, which provides a thorough understanding of the factors that influence the mental health and recovery of survivors of assault. Originally based on Bronfenbrenner (1994)'s ecological model for human development, Neville and Heppner (1999) adapted the model to explain how sexual assault effects the

recovery and mental health outcomes of female sexual survivors. Campbell et al. (2009) then used this model to develop a version that includes various levels, demonstrating interaction of factors across a broad ecological framework. This model acts as a tool that can decipher the impact of these factors on the risk and resilience to mental health outcomes post-sexual assault (Campbell et al., 2009; Carter-Snell & Jakubec, 2013).

Although there is research that has illustrated the issues preventing women from receiving treatment and that has explored the poor mental health outcomes of sexual assault, there have been few studies illustrating the factors that act as barriers or facilitators to the well-being and recovery of survivors. In addition, there is a paucity of research that explores the various ways in which women cope with the impact of sexual assault, particularly in the South African context and using the ecological model.

This version of the ecological model is suggested as particularly appropriate in its application to understanding the impact of factors on sexual assault, recovery, and resilience. By first understanding these factors and their impact, conclusions can be drawn about their interactions with each other, which can inform recommendations for recovery as well as guide prevention strategies against adverse mental health effects (Carter-Snell & Jakubec, 2013).

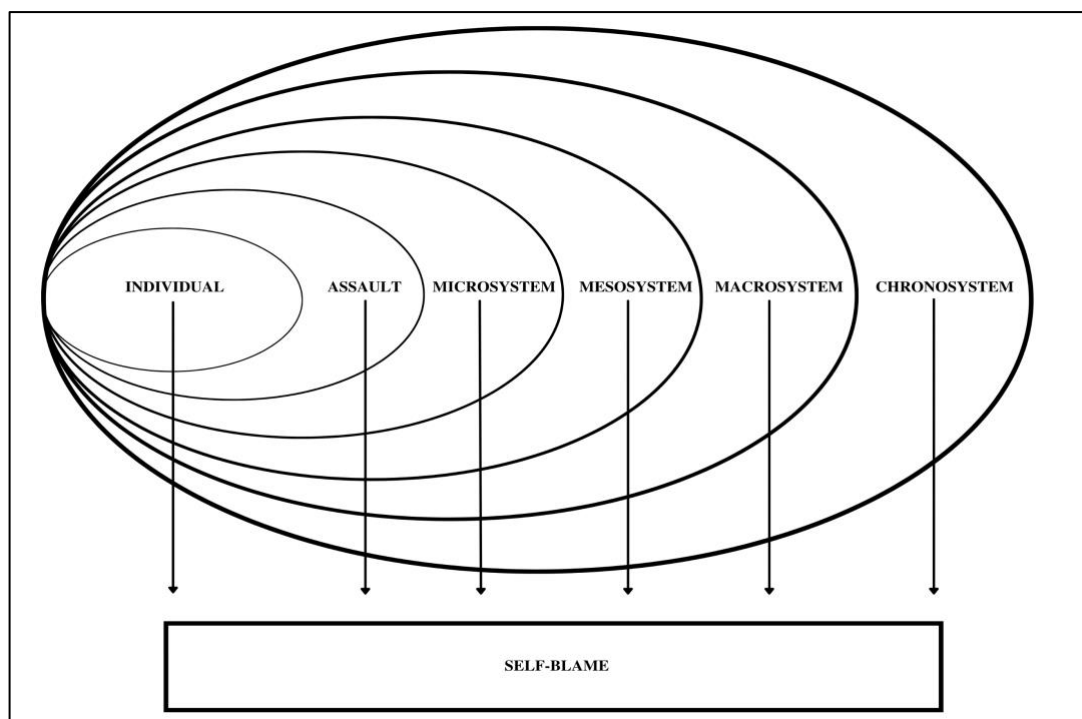


Figure 1: The Ecological Model of the Impact of Sexual Assault on Women's Mental Health (Campbell et al., 2009)

The first level of the model, namely the individual level, consists of biopsychosocial characteristics. This includes sociodemographic variables, personality factors, pre-existing mental health conditions,

genetic and biological factors, and coping responses (Campbell et al., 2009). The second level, assault, includes the characteristics of the sexual assault itself and the way in which it happened. This can impact the severity of the mental health symptoms, and therefore the well-being of the survivor. Aspects such as the relationship of perpetrator to the victim, substance use by both victim or perpetrator as well as weapon use and severity of force by perpetrator are considered at this level (Campbell et al., 2009).

The third level, the microsystem, refers to the impact of disclosure to sources of support. These sources are considered informal, such as family, friends or peers (Campbell et al., 2009). The fourth level, the mesosystem level, refers to the associations between community environments and how linkages and connections occur within these environments. This includes the various formal systems consisting of legal and medical systems, including mental health (Campbell et al., 2009). The fifth or macrosystem level examines the societal factors that contribute to cultural identity and its role in rape recovery, including rape myths, victim-blaming and use of stereotypes (Campbell et al., 2009).

The sixth level consists of the chronosystem which defines prior victimisation that the individual may have experienced during their childhood or more recently. This is an important element because multiple experiences of sexual assault can influence recovery outcomes (Campbell et al., 2009). Last, because the act of victim-blaming contributes to internalised guilt and shame, which in turn influences recovery, self-blame is placed as a meta-construct that spans across all the levels (Campbell et al., 2009).

Although the ecological model is often used to identify the overall risk factors to poor mental health amongst sexual assault survivors (Centers for Disease Control and Prevention, 2004), professionals can do little with this information other than to identify whether a woman is at risk to poor mental health (Carter-Snell & Jakubec, 2013). Therefore, it may be beneficial to use the ecological model to explore the factors that promote resilience and increase risk to mental ill-health because this may be more informative to healthcare professionals when assisting survivors while also potentially improving the services offered.

The ecological model, consisting of these interrelated levels, enables a deeper understanding of the factors that influence the recovery of an individual. In addition, it acts as a tool that can help to decipher the impact of these factors on the risk and resilience to mental health outcomes post-sexual assault (Carter-Snell & Jakubec, 2013). By first understanding these factors and their impact, conclusions can be drawn about their interactions with each other, which will inform recommendations for recovery as well as guide prevention strategies against adverse mental health effects (Carter-Snell & Jakubec, 2013).

2.6 Factors Increasing Risk and Resilience

Risk and resilience are two interplaying concepts, because survivors often develop resilience after experiencing an event that involves risk. ‘Risk’ is defined as factors that contribute to the development – or potential development – of mental health conditions, while ‘resilience’ is defined as an individual’s ability to demonstrate positive psychological outcomes after experiencing high exposure to stressful events (Agaibi & Wilson, 2005; Eaton & Fallin, 2019). This section will now detail the risk and protective factors on the different levels of the ecological model in order to highlight how factors decrease risk and increase resilience.

2.6.1 Individual

While GAD, MDD, and PTSD are common mental disorders (CMD) among victims of sexual assault, various individual factors such as sociodemographic variables and coping strategies impact whether and to what degree these outcomes are experienced (Mgoqi-Mbalo et al., 2017). For example, a South African study discovered that marital status and employment play a significant role in the development of depression and PTSD in which lack of partner support and financial barriers to seeking help increases the risk of developing mental health problems (Mgoqi-Mbalo et al., 2017).

The way in which survivors use strategies to cope with the assault also strengthens or worsens their chances of developing poor mental health outcomes. The use of avoidant mechanisms, such as denial, substance use and isolation, were found to be associated with emotional distress while positive mechanisms, such as social support and acceptance, were found to be associated with diminished self-blame and lessened likelihood of developing depression (Lekganya, 2015; Mgoqi-Mbalo et al., 2017).

2.6.2 Assault

The characteristics of sexual assault are also linked to psychological well-being of the survivor in particular. In South Africa, severity of the sexual assault was found to be associated with worsened symptoms of depression (Mgoqi-Mbalo et al., 2017). Victims who face sexual assault by known perpetrators are more likely to experience depression symptoms than those who are assaulted by strangers (Abrahams et al., 2013). Survivors who were threatened with a weapon and whose experience involved the perpetrator using the weapon demonstrated a higher likelihood of depression (Mgoqi-Mbalo et al., 2017). Similarly, sexual abuse experiences that are more severe demonstrate a greater impact on survivors’ levels of emotional distress where increased anxiety and depression symptoms are illustrated alongside low likelihood of resilience (Lekganya, 2015).

2.6.3 Microsystem

As mentioned above, the microsystem level refers to the social support received after disclosure (Campbell et al., 2009). A study exploring the experiences of South African rape survivors discovered that lack of social support worsened the traumatic experience of violence and the negative impact on rape survivors. This differed to positive support from family and friends that created a sense of healing and recovery (Sebaeng et al., 2016). Moreover, supportive reactions are associated with less psychological distress while negative social reactions are linked to increased anxiety, depression and PTSD (Campbell et al., 2009). Hurtful or negative reactions from family and friends have a greater detrimental impact on survivors' mental health than supportive reactions have for fostering well-being (Campbell et al., 2009).

2.6.4 Mesosystem

In order to address the medical and legal needs of women who have experienced sexual assault, specific protocols need to be followed. If services do not address negative outcomes on the individual level, then the victim will experience secondary victimisation which magnifies feelings of shame and guilt, thereby preventing them from initiating recovery (Campbell et al., 2009).

Assistance from formal legal support systems is vital in ensuring perpetrator accountability. However, in South Africa, this is not always the case and often secondary victimisation occurs. When victims report their cases to the police, officers are often unempathetic and unhelpful, which results in victims experiencing feelings of guilt, shame and self-blame (Steyn & Steyn, 2008). In addition, officers also interrogate the victim which can seem as if they are lessening the severity of the assault (Holton et al., 2018).

Similar interactions were also found to occur within medical systems where HCWs, such as nurses, may demonstrate negative attitudes towards survivors when interacting with them (Randa & Mokoena, 2019). Fearful of nurses' reactions, victims may not disclose their sexual abuse experiences and subsequently may not receive care or assistance. Sepeng and Makhado (2019) found that in times where victims did report their sexual assault, they often did not initiate a follow-up session. The authors suggested that this may have been because the questions asked by HCWs that were directed towards the clothing they wore or their history of sexual activity (Sepeng & Makhado, 2019).

2.6.5 Macrosystem

The macrosystem refers to the societal factors that involve culture and larger society (Campbell et al., 2009). Jewkes et al. (2011) found that violent sexual assault against women is viewed as an acceptable interaction among perpetrators, suggesting a normalised attitude towards violent rape in South Africa. In addition, there are existing problematic rape myths that victims internalise which can enhance

feelings of self-blame, shame, and self-stigma. Rape myths are defined as stereotypes or untrue beliefs about rape victims that specifically shift blame onto them. Internalising rape myths creates a negative impact because rape myth acceptance decreases the chances that victims will seek help and disclose the violence due to fear of judgement (Campbell et al., 2009). It can also lead to issues of low self-esteem and guilt, which impacts well-being and exacerbates risk to developing anxiety and depression (Steyn & Steyn, 2008).

2.6.6 Chronosystem

The chronosystem level involves the concept of revictimisation, which refers to sexual assault events that occur repeatedly during both childhood and adulthood (Campbell et al., 2009). Multiple sexual assaults throughout a survivor's lifespan have a cumulative effect on well-being and potential to recover. This is because many of the symptoms that developed after the most recent assault may have already existed as a result of prior assault during childhood (Dollman, 2019). This means that post-assault symptoms will increase in severity with each new assault, thereby weakening resilience, lowering chances of recovery, and increasing vulnerability to negative and chronic psychological outcomes (Campbell et al., 2009; Dollman, 2019).

2.6.7 Self-Blame

Self-blame cuts across all levels on the ecological framework. The individual level involves internalised self-blame, consisting of either blaming one's own character or blaming one's actions as the cause of the assault. This links to the microsystem and mesosystems as these levels include blame from informal (family, friends and peers) and formal (legal and medical institutions) systems, which is then internalised by the survivor (Campbell et al., 2009). On the macrosystem level, the cultural acceptance of gender attitudes, rape myths and victim-blaming triggers and exacerbates the survivor's internalised self-blame (Campbell et al., 2009). Moreover, patriarchal notions of masculinity can also drive this by excusing aggression in men, while simultaneously encouraging the belief that men are sexually entitled to women's bodies (Seedat et al., 2009; Department of Women Children and People with Disabilities, 2013). Finally, on the chronosystem level, repeated sexual assault leads to self-blame, blame from society, and an increase in the intensity of symptoms, especially if the survivor does not receive assistance (Campbell et al., 2009).

2.7 The Recovery Process

While 'resilience' refers to the ability to overcome stress by managing the causes of stress and sustaining well-being, 'recovery' refers to the journey of healing that enables improvement of poor mental health outcomes and promotes resilience (Walker-Williams et al., 2013; Eaton & Fallin, 2019). Instead of focusing solely on improving symptoms, mental health recovery also aims to ensure sustained – and sustainable – improvement of mental health (Eaton & Fallin, 2019). It is important to

ensure that female survivors access the services needed to achieve a state of recovery and subsequently, develop resilience and improved well-being (Walker-Williams et al., 2013).

Harvey (1996) developed an eight-dimension model that enables a deeper understanding of the recovery and resilience process following a traumatic event. This model can be used to explain the dimensions of functioning and recovery that have been impacted by trauma. The dimensions of recovery consist of: authority over memory; integration of memory and affect; affect tolerance; symptom mastery; self-esteem; self-cohesion; safe attachment; and meaning making (Harvey, 1996). These are unpacked below.

2.7.1 Memory

Dimensions one and two in the recovery process involve the survivor's memory. 'Authority over memory' refers to the survivor's ability to recall the memory, often accounting for intrusive flashbacks, while 'integration of memory and affect' refers to how the memory ignites the survivors' feelings. As suggested by Harvey (1996), recovery is evident in survivors when they are less uncomfortable with intrusive flashbacks and can tolerate their feelings when recalling their sexual assault (Harvey, 1996).

2.7.2 Feelings and Symptoms

Dimensions three and four involve the survivor's feelings and possible symptoms of PTSD. 'Affect tolerance' refers to the survivor's ability to cope with intense feelings that arise after the incident. The way in which survivors cope can be facilitated through unhealthy or healthy coping mechanisms. 'Symptom mastery' refers to when survivors manage their PTSD symptoms effectively enough to gain self-control. Recovery is evident when survivors' range of emotions are not affected and when they can manage difficult symptoms through self-care (Harvey, 1996).

2.7.3 The Self

Dimensions five and six involve the survivor's sense of self. 'Self-esteem' comprises the extent to which survivors value themselves, which can be challenging due to the natural response of self-blame. 'Self-cohesion' refers to the survivors' ability to experience themselves as a whole person who is able to grow and progress. During recovery, survivors are able to replace self-blame with a more accurate belief of themselves and acknowledge the positive progression demonstrated within their sense of self (Harvey, 1996).

2.7.4 Engagement

Dimensions seven and eight involve the survivor's engagement with others and society. 'Safe attachment' refers to the ability to create and maintain relationships with others in which their physical

and emotional well-being is respected. 'Meaning making' refers to the survivors' ability to understand that despite its complexities, the world is worth engaging with. Recovery is evident when survivors are able to trust others as well as protect themselves within their relationships. Additionally, recovery is also present when survivors have reshaped their lives in society while also connecting with their communities (Harvey, 1996).

2.8 Challenges Influencing Recovery

Factors that promote recovery improve the quality of life of female survivors. Therefore, in order to improve the well-being of survivors, challenges influencing recovery, specifically those that exist within legal and healthcare services, should be addressed.

Although it is vital that female survivors receive services that facilitate improvement of their quality of life and ensure all aspects of their sexual assault is assisted, this is not always evident in South Africa (Harris & Freccero, 2011; Abrahams & Gevers, 2017; Sepeng & Makhado, 2019). There are challenges in settings that provide legal and psychosocial services designed to assist women who experience sexual assault, which may negatively affect recovery.

2.8.1 Challenges in Legal Settings

In legal settings, such as police services and judicial systems, there are various challenges. One of these is the issue of secondary victimisation by police officers, where authorities are found to portray apathetic attitudes, refuse to believe victims, and remain uncommunicative about the feedback process of reporting (Steyn & Steyn, 2008). Furthermore, the sexual assault incidents that victims experience are often dismissed by police officers (Steyn & Steyn, 2008; Holton et al., 2018). This behaviour is suggested to play a large role in victims developing a distrust for authorities as well as triggering depression and self-doubt (Steyn & Steyn, 2008).

Another issue is the lack of prosecution of perpetrators, with many cases remaining stagnant and unattended to (Holton et al., 2018). Jewkes et al. (2012) discovered that in South Africa, of the single perpetrator rapes that were reported, 54.1% were arrested, while only 38.7% were arrested when involved in multiple perpetrator rape cases (Jewkes et al., 2012). In addition, 15% of perpetrators arrested were not charged, suggesting that there is lacking prosecution of perpetrators who are guilty (Jewkes et al., 2012).

A final issue involves the progression of cases to court. In many instances, cases are often closed by police, for reasons such as untraceable perpetrators or that perpetrators could not be identified (Vetten et al., 2008). In study conducted in South Africa by Vetten et al. (2008), only 54.3% of cases progressed beyond police investigation, with 17.3% of cases actually being trialled in court.

2.8.2 Challenges in Healthcare Settings

There are few services that treat the mental health symptoms of female survivors, despite them displaying emotional difficulties when screened by HCWs (Christofides et al., 2005; Phaswana-Mafuya & Ramalepe, 2008). When healthcare services are provided, often physical symptoms are treated and managed alone and not alongside mental health symptoms (Harris & Freccero, 2011; Abrahams & Gevers, 2017; Sepeng & Makhado, 2019). Several studies have explored the mental health needs of survivors, with many women presenting symptoms of anxiety, depression, PTSD, and substance abuse (Christofides et al., 2006; Harris & Freccero, 2011; Abrahams & Gevers, 2017; Sepeng et al., 2019).

Despite the presentation of symptoms, there is little mental health assistance, with counselling services provided by trained practitioners lacking. When mental health care is provided it is often short-term and without follow-up procedures (Abrahams & Gevers, 2017; Holton et al., 2018; Sepeng et al., 2019). In addition to the problematic features within healthcare settings, HCWs are often unaware of the mental health implications of sexual assault and tend to initiate secondary victimisation as well as victim-blaming, similar to the reactions of police officers (Randa & Mokoena, 2019).

Another challenge in healthcare settings is the potential for HCWs to experience trauma and how this impacts their ability to work. It has been well documented that HCWs, specifically mental health workers, are impacted when treating survivors, with many of them experiencing their own symptoms, such as fear, depression, insomnia and other physical health problems (Campbell, 2001). This concept is understood as secondary trauma or vicarious trauma and suggests that individuals are often traumatised without being physically harmed or threatened. Rather, they are traumatised by listening to the stories told by those who have been harmed or threatened (Campbell, 2001). When exploring the experiences of South African psychologists who worked with trauma survivors, Sui and Padmanabhanunni (2016) discovered that by engaging in therapeutic interventions with survivors, HCWs experience various ‘side effects’ of trauma. These include disruptions in safety; recurrent nightmares; negative emotions and somatic symptoms, such as headaches and muscle tension (Sui & Padmanabhanunni, 2016).

Due to HCWs being at risk to secondary trauma, it is vital that they receive prevention and treatment measures in healthcare settings. This is because by not assisting HCWs needs, it directly impacts their ability to assist survivors (Campbell, 2001). Petrak and Hedge (2002) identify the various methods healthcare settings can use to prevent vicarious trauma, including, stress management training, coping skills exercises, social support networks, modification of the work environment and finally, psychological workplace support.

2.9 Conclusion

In this literature review, an overview of the prevalence of sexual violence on a global and national scale was presented, and the impact of trauma was also defined alongside its relation to sexual assault. Thereafter, the review discussed the impact that sexual assault has on the survivor from a biopsychosocial perspective. Additionally, survivors' experiences of mental health and sexual assault were described, aligning to Campbell et al.'s (2009) ecological model, and touched on the ecological factors that increase risk, resilience, and recovery. Finally, the review highlighted survivors' recovery process and the issues that work against recovery demonstrated within legal and psychosocial services.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This section describes the methodology used to conduct the research. A detailed overview of the research design, setting and population will be discussed. Thereafter, the study procedure and data analysis used during the research process will be explained. Finally, the ethical considerations will be detailed.

3.2 Design and Sampling

The study used an exploratory qualitative research design. This is a type of research design that focuses on discovery and developing theory rather than testing hypotheses (Jupp, 2006). Using this design was useful because it allowed for interpretations of personal experience through in-depth interviews (IDIs) and focus group discussions (FGDs). The sampling procedure involved purposive sampling.

3.3 Research Setting

The research was conducted at two rape centres in Cape Town, South Africa. This city is situated in the Western Cape province. According to the Western Cape Government (2021), there are seven Thuthuzela Care Centres* (TCC), 22 stay shelters, and seven other centres in the province that are available for victims of sexual assault. All these centres provide counselling, legal services and health services (Western Cape Government, 2021).

The centres at which the research was conducted offered all these services, including mental health counselling. Four non-profit organisations that run rape crisis centres in Cape Town were contacted via email to seek permission to conduct research with female survivors and HCWs at their centre. A request letter was attached to the email (Appendix A). The researcher selected the only two centres that accepted the invitation and approved the research. These two centres belonged to the same organisation, which was a non-profit organisation that focussed on providing counselling, legal and reporting services to survivors who have been sexually assaulted.

3.4 Research Procedures

3.4.1 Recruitment and Enrolment

3.4.1.1 Survivors of Sexual Assault Participants

11 survivors of sexual assault were recruited at two centres. The centre counsellors suggested survivors to the researcher who then approached the survivor at the centre, handed them an information sheet (Appendix B) and asked if they wanted to partake in the study. Survivors were

*TCCs are South African care facilities that provide medical and forensic services for victims of sexual assault.

excluded if they were too emotionally distraught to partake in the study. This was determined in two ways. Firstly, by using the expertise of the HCWs employed at the centre. The staff working with these women have experience in identifying signs of distress and the researcher worked closely with the counselling coordinators to confirm any suspicion regarding emotional distress that was present. Secondly, by using a score on the Kessler Psychological Distress Scale (K10) screening tool.

The K10 is a 10-item self-administrated questionnaire that identifies the likelihood of emotional distress, with scores ranging from 10 to 50 (Kessler et al., 2003). It has been validated in South Africa (Spies et al., 2009). Following informed consent (Appendix C), women who fitted the initial inclusion criteria (Table 1) were screened using the K10 (Appendix D). The results of the K10 were calculated and the women who scored below 29 were invited to participate in the interview of the study. Women who scored above 29 were thanked for their time and were not invited to participate in an interview. This was done following recommendations by Kessler et al. (2003), who stated that a score of above 29 indicates likelihood of extreme distress. These women were instead referred to their lay counsellor at the organisation itself and also given a list of mental health organisations in Cape Town from which they could seek additional help.

Table 1: Survivors of Sexual Assault: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Female and 18 years or older.	Male or younger than 18.
Has experienced sexual assault.	Has not experienced sexual assault.
Is receiving assistance and was not sexually assaulted in the last three weeks.	Is not yet receiving assistance and was sexually assaulted in the last three weeks.
Able to speak and understand English.	Unable to speak and understand English.
Score below 29 on the K10 screening tool	Score above 29 on the K10 screening tool
Appears able to provide informed consent.	Appears too distraught to provide informed consent.

3.4.1.2 Healthcare Worker Participants

The researcher requested to attend staff meetings at the centres to talk about the study and hand out information flyers to the HCWs (Appendix E). The counselling coordinators at both centres assisted the researcher in recruiting the HCWs who were employed as lay counsellors at the two centres. The researcher decided to recruit only four HCWs per focus group because a smaller group would allow for a more intimate environment to discuss sensitive issues surrounding sexual assault.

Table 2: Healthcare Workers: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
More than six months of experience working as a female HCW at a centre for sexual assault.	Less than six months of experience working as a male HCW at a centre for sexual assault.
Provides informed consent to participate.	Does not provide informed consent to participate.

3.5 Data Collection Methods

Data collection involved using IDIs and FGDs. During the interviews and focus groups, data were collected using an audio recorder. All information, such as audio recordings, were securely stored electronically in a password-protected folder. All methods were conducted in English and facilitated only by the researcher.

IDIs were used to explore the survivors' experiences of mental illness symptoms and how the various ecological factors have positively or negatively influenced their well-being and recovery. Using in-depth interviews was useful because it enabled the complex issues experienced by the survivors to be probed. It also allowed for a more in-depth understanding of personal experiences by interpreting the meaning of what was said (Bowling, 2014). FGDs with lay counsellors were used to gain insight into the ecological factors that hinder the well-being of survivors, as well as to what factors benefit their recovery. Using focus groups was helpful because it enabled a group dynamic and sharing of collective experiences.

3.6 Research Process

3.6.1 Screening and Interviews

For the initial screening, the survivor participants were given an initial information sheet (Appendix B) and consent form (Appendix C) to read and if they agreed to be screened, they signed the consent form prior to completing the K-10 screening tool. The participants who scored below 29 were invited for an interview and received a second consent form to sign if they agreed to be interviewed (Appendix F). To ensure that the participants understood the information sheet and consent form and what was required of them, the researcher asked the participants to briefly summarise the purpose of the research and what they expected during the interviews.

Interviews took place in a private room at the designated centres during working hours and the majority of interviews lasted under one hour. The interviews were conducted using a semi-structured interview guide (Appendix G). The guide has four main sections: individual factors; microsystem factors; mesosystem factors; and macrosystem factors. It also included elements of the chronosystem and assault factors throughout the guide. All phases drew from the ecological model as adapted and theorised by Campbell et al. (2009) and aimed to explore survivors' experience of factors on each

ecological level and how these factors improve or worsen their recovery and well-being. In addition, the guide included an introduction that provided details of the study to the participants and aimed to retrieve their demographic background, as well as a debriefing that involved a check up on how the participant felt after the interview.

Debriefing of the interview process between the researcher and participant occurred at the end of the interviews. A debriefing phase was included to ensure that the participants had no issues with the researcher's questions or topics and were also not emotionally distressed or harmed during the interview process. The debriefing proved to be helpful after the interview as it enabled the participants to reflect on what was said. All participants said that they felt comfortable after the interview ended.

3.6.2 Focus Group Discussions

Similar to the IDIs, a consent form (Appendix H) was signed by all the HCW participants prior to the start of the FGDs and a debriefing session occurred after the focus group was held. The guide used for the FGDs concentrated on HCWs' views of the hinderances and facilitators to the well-being of survivors (Appendix I). It began by exploring the HCWs' perspectives of the ecological factors that impact the well-being of survivors. Thereafter, it touched on how assault characteristics impact survivors and contribute to self-blame.

3.6.3 Reimbursement

No direct cash payment was made to any of the participants for partaking in the interviews or FGDs discussions. However, the survivors and HCWs were provided with a supermarket voucher worth R100 to thank them for their time and participation.

3.7 Data Analysis

Audio recordings were transcribed verbatim, and transcripts were imported into NVivo 12 for analysis. A framework analysis method was used to analyse the data. There are five stages involved in framework analysis. Firstly, familiarisation, where the researcher engaged with the data set to become more familiar with it. Familiarisation involved reading transcriptions and fieldnotes as well as listening to the audio recordings. Secondly, thematic analysis or coding was conducted, where applicable data was coded into various 'sub-themes'. The researcher used the seven ecological framework levels as a-priori categories to guide the analysis, while also allowing space for new themes to emerge. Thirdly, indexing, where the data that materialised was used to create a thematic matrix that was labelled and numbered. Fourthly, charting, where the researcher entered the summarised data into the thematic matrix created during the indexing stage. And finally, mapping and interpretation, where the data was interpreted and connected with other data to produce a wider understanding of the dataset (Ritchie et al., 2003; Gale et al., 2013; Green & Thorogood, 2018).

3.8 Reflexivity

Due to the relational nature of qualitative research, the researcher had to ensure not to impose her own biases onto the research process, the participants, and the analysis. Although the researcher had never experienced sexual assault, she was a South African female and has experienced mental illness, similar to the participants. However, along with the researcher's relatable experiences, there is her own bias. Therefore, during the research process, she attempted to prevent imposing her own bias through several ways.

Firstly, during the data collection methods, she never shared her own experiences but rather focused on the participants' experiences. Secondly, she took deliberate effort to prevent commentary on the participants' experiences and explanations, especially those that triggered emotional reactions. Thirdly, she listened to the participants and engaged with their experience, rather than inserting comments, questions, or interrupting the conversation. And finally, to reflect on the process of reflexivity, the researcher kept a journal and wrote notes on each participant. This was completed during the data collection process and then repeated during the data analysis process.

3.9 Ethical Considerations

This study was approved by the University of Cape Town Faculty of Health Science Human Research Ethics Committee (HREC) with the HREC reference number: 486/2021. As mentioned previously, permission was also sought from the organisation. This process entailed the counselling coordinators presenting the research to their centre and the Board granting permission for the researcher to commence the research.

3.9.1 Potential Risks and Discomforts

Discussing experiences of sexual assault and mental health could have triggered memories of trauma, and this may have caused discomfort for the survivor participants. However, participation was voluntary and if the survivors felt uncomfortable, they could withdraw from the interview at any point. In addition, the survivors who participated in the interviews all attend regular counselling sessions at the organisation itself. It was unlikely that FGDs would cause discomfort for the HCWs, but they were also informed that they could withdraw at any stage if they felt uncomfortable.

3.9.2 Risk Classification and Minimising Risk

The risks involved in the study were minimal for several reasons. First, the researcher worked closely with the staff at the centre to ensure that the survivor participants were not overly emotionally distressed or vulnerable to being impacted by questions involved in the study. This was ensured during screening and working with the staff at the centre. Second, all of the participants involved were already receiving mental health treatment and assistance, whether through a psychiatrist, psychologist,

or counsellor. Finally, although not an inclusion criterion, to ensure that they had adequate support in place, all participants had attended at least three counselling sessions at the organisation.

Due to the possibility of interviews raising traumatic topics, there was a chance of emotional harm of the survivor participants. Therefore, it was essential to ensure that no emotional harm was done during the interviewing process. Protocols were put into place to ensure that if the survivor participant demonstrated any acute emotional stress or immediate harm, the researcher would end the interview, refer the participant to the centre's lay counsellor and provide the participant with a list of organisations that also offer free counselling. However, during the interviews process, this did not occur as all the participants who participated intimated that they were comfortable speaking about their sexual assault.

3.9.3 Privacy and Confidentiality

Interviews and focus groups were conducted in a private room at the centre. Audio recordings and written transcripts were stored electronically on a password-protected hard drive that only the researcher and supervisors could access. The dataset did not contain participants' names or any identifying information. Consent forms were stored in a locked cupboard.

In addition, transcriptions and findings were de-identified and participants were given pseudonyms. Throughout the research project, there was effort to avoid collecting identifying information (for example, address or identity numbers) that could be linked to each participant. When details were mentioned by the participants, they were removed from the transcripts.

CHAPTER FOUR: RESULTS

4.1 Introduction

This chapter will present the findings of the study. The chapter begins with a presentation of the socio-demographic profile of the participants. Thereafter, it will detail the research findings according to the categories, themes and sub-themes that emerged during the data analysis process.

4.2 Sociodemographic Characteristics of Study Population

4.2.1 Survivors of Sexual Assault

The 11 survivor participants were survivors of sexual assault and often had experienced multiple sexual assault incidents in their lifetime. Most of the mental health assistance they received was through the two centres they were attending. The majority of participants resided in economically mid-range suburbs within the greater city of Cape Town. The majority had completed high school, were single with no children, and unemployed (Table 3).

Table 3: Survivor Participant Socio-Demographics

	CENTRE ONE (N = 6)	CENTRE TWO (N = 5)	TOTAL (N = 11)
AGE			
18 – 20	2	2	4 (36%)
21 – 30	1	1	2 (18%)
31 – 40	3	0	3 (27%)
41 – 50	0	2	2 (18%)
RACE			
Black	3	3	6 (54%)
Coloured	1	2	3 (27%)
Indian	0	0	0 (0%)
White	2	0	2 (18%)
GEOGRAPHIC AREA			
Blaauwberg	1	0	1 (9%)
Cape Town City Centre	1	0	1 (9%)
Northern Suburbs	1	1	2 (18%)
Southern Suburbs	3	4	7 (64%)
LEVEL OF EDUCATION			
< Grade 11	0	2	2 (18%)
Completed high school	4	1	5 (45%)
Tertiary education	2	2	4 (36%)
EMPLOYMENT STATUS			
Employed	2	3	5 (45%)
Unemployed	4	2	6 (54%)
RELATIONSHIP STATUS			
Single	4	4	8 (72%)
Married or Relationship	2	1	3 (27%)
NUMBER OF CHILDREN			
0	4	2	6 (54%)
1 – 2	2	2	4 (36%)
3 – 4	0	1	1 (9%)

4.2.2 Healthcare Workers

The eight HCWs who participated in the FGDs were employed at the two centres as lay counsellors to assist sexual assault survivors through counselling. The lay counsellors ages ranged from 26 to 63 years old and the length of employment as a lay counsellor ranged between 1 and 20 years (Table 4).

Table 4: Healthcare Workers Socio-Demographics

	CENTRE ONE (N = 4)	CENTRE TWO (N = 4)	TOTAL (N = 8)
AGE			
21 – 30	1	1	2 (25%)
31 – 40	1	1	2 (25%)
41 – 50	0	2	2 (25%)
51 – 60	1	0	1 (12.5%)
<70	1	0	1 (12.5%)
RACE			
Black	0	1	1 (12.5%)
Coloured	2	3	5 (62.5%)
Indian	0	0	0 (0%)
White	2	0	2 (25%)
GEOGRAPHIC AREA			
Atlantic Seaboard	1	0	1 (12.5%)
Southern Suburbs	3	4	7 (87.5%)
LEVEL OF EDUCATION			
< Grade 11	1	2	3 (37.5%)
Completed high school	1	1	2 (25%)
Tertiary education	2	1	3 (37.5%)
LENGTH OF EMPLOYMENT			
1 – 5 years	0	4	4 (50%)
5 – 10 years	1	0	1 (12.5%)
10 – 15 years	2	0	2 (25%)
15 – 20 years	1	0	1 (12.5%)

4.3 Presentation of Results

Using a framework analysis, data was coded into relevant sub-themes and themes, which were then categorised into the seven a-priori categories drawn from the ecological model. These themes are presented in Table 5 below. Data from both sets of participants was combined for coding.

After familiarising herself with the data set by reading transcriptions and listening to audio-recordings, the researcher conducted thematic analysis to categorise codes using the research objectives. Using a framework analysis from the ecological model, seven categories were identified from the data. Thereafter, indexing and charting occurred where a thematic matrix was developed. The matrix was then interpreted and mapped with other data to form sub-themes. These sub-themes were related to the seven levels on the ecological model and can be considered the smaller “factors’ on each level.

Table 5: Categories, Themes and Sub-Themes Arising from the Analysis

Category	Theme	Sub-Theme
Individual Level	Mental Health	Depression and anxiety
		Panic attacks and dissociation
	Coping Mechanisms	Healthy coping mechanisms
		Unhealthy coping mechanisms
	Biological	Sexual activity
		Basic needs
	Psychological	Emotions
		Behaviour
		Memory
	Sociological	Socio-economic status
		Fear of external judgement
		Fear of being a burden
Assault Level		Weapon use during rape
		Worsened reactions to trauma
Microsystem Level	Negative Social Interactions	Negative reactions to disclosure
		Change in relationships
	Positive Social Interactions	Positive reactions to recovery
Mesosystem Level	Negative System Interactions	Insensitive and victim-blaming interactions
		Incompetency and confidentiality
	Positive System Interactions	Individual therapy
		Group therapy
Macrosystem Level	Worsening Chances of Recovery	Rape misconceptions
		The influence of ignorance about rape
		Maternal history of rape
	Improving Chances of Recovery	Raising awareness
Chronosystem Level		Feelings of worthlessness
		Triggering mental illness
		Cumulative trauma
Self-Blame Level	Guilt	Internalised blame
		Internalised stigma
		Coping mechanisms, guilt and shame
	Empowerment	Counselling
		Ownership of recovery
		Seeking justice
		Acceptance

4.3.1 Individual Level

The first category pertains to the first level of the ecological model (the individual level), which consists of biopsychosocial characteristics. The findings under this level highlighted the survivors' mental health as a result of sexual assault as well as their coping responses to their poor mental health. Additionally, findings also emphasised the biopsychosocial aspects of elements that improve or hinder survivors' recovery, such as sociodemographic variables, personality factors and biological factors.

4.3.1.1 Mental Health

Although receiving mental health services from the sexual assault centre, the majority of survivor participants discussed having experienced various mental health problems from their sexual assault, including anxiety and depression, panic attacks, dissociation, and memory loss. For example, participants described panic attacks and anxiety in the following ways:

I would hyperventilate [when thinking about the rape]. So, I would start breathing really hard and fast and I would fidget a lot with my hands and stuff, or I will rub it on my leg the whole time. I would just be very restless (Jada, Survivor Participant).

I just felt too scared to leave [home]... there is so much of this time period that I just don't really remember. It's just so hazy. I wasn't here because so much happened so quickly and I was just, I can't. It's just like a brain overload (Zawadi, Survivor Participant).

While the narratives suggested the presence of mental health issues amongst most participants, it also appeared that mental health problems were related to how participants responded to and coped with their sexual assault.

4.3.1.2 Coping Mechanisms

The survivor participants were asked to discuss any coping mechanisms that they engage in that assists them in overcoming trauma. Their answers were separated into 'healthy' and 'unhealthy' coping mechanisms. Healthy coping mechanisms included creative expression, exercise, mindfulness therapy, and social support, while unhealthy coping mechanisms included substance use and avoidance of coping with emotions and the sexual assault. The following participant described a positive way of coping with the trauma:

I guess talking about it... if I don't want to talk, I'll write how I feel and that helps a lot... Sometimes, I write letters to my mom or myself. Well, mostly myself and then if I think of the rape, then I'll write it to him (Arumile, Survivor Participant).

While another participant described a negative coping style, which she related was 'a cry for help':

After the incident, I started partying and drinking and being rebellious... and then that affected my results at school, in high school and in varsity at a point where I was, okay, I must just stop drinking. It was just a cry for help (Amanda, Survivor Participant).

When asking the HCWs about the survivors' coping mechanisms, they highlighted that mental health problems may be worsened by unhealthy coping mechanisms, such as substance abuse and issues around eating. It was suggested that engaging in these coping mechanisms would only assist the survivors temporarily because it caused them to avoid appropriately responding to their emotions and trauma from the assault. One HCW explained this:

A lot of them go into drinking or drugs or they fall into deep depression. They either eat more, like they become emotional eaters and then there are some of them that simply don't eat or just don't sleep because that is part of the RTS - the 'Rape Trauma Syndrome' that they are facing.... But they find themselves smoking and they never smoked before.... I think it numbs the pain (Babsie, HCW Participant).

4.3.1.3 Biological Aspects

Many participants described how they were impacted biologically as a result of their sexual assault experience. Elements of biological impact that participants spoke about included changes in sexuality, eating, and sleeping patterns. Regarding sexuality, some participants described themselves as having a high sex drive and others, a low libido:

At the time, I thought I was being like a very cool [to have a lot of sex] ... I just thought I was grown up and this is life. This is how you cope. And this is how you know that people care about you, that you're affectionate... and now, that I'm older... I could look back and be like, wow, that's why I was doing that? (Zawadi, Survivor Participant).

The aspect of hypersexuality and hyposexuality was also highlighted by HCWs:

Like a client I had yesterday... she's got a boyfriend, but she's not interested in sex. Every time she had sex with boyfriend, she feels like it is the rape... (Didie, HCW Participant).

Regarding other basic needs, findings highlighted that issues such as irregular eating patterns as well as insomnia and nightmares impacted the survivors' ability to recover. This is demonstrated through the following quotations:

I don't eat as much as I used to... I lost a lot of weight... I also don't sleep. I have a very terrible sleeping pattern. So, I can't sleep properly (Arumile, Survivor Participant).

I couldn't sleep at night. So, I would like to wake up and then do anything or maybe cry at night... I was having nightmares like the thing happening in my mind over and over again.

Like thinking if maybe I woke up and did something maybe I wouldn't be here and all that. (Lucy, Survivor Participant).

HCWs also mentioned similar biological factors that hindered recovery and resilience with examples such as:

They struggle with sleeping, eating. The sleeping pattern is, I sleep during the day, but I don't sleep at night. I would eat during the night, but I can't eat in the day. I feel nauseous the moment I see this kind of food that look similar to sperm (Babsie, HCW Participant).

4.3.1.4 Psychological Aspects

From a psychological viewpoint, findings demonstrated three sub-themes that impacted survivors' recovery which were emotions, behaviour, and memory.

First, participants spoke about elements of repression and dysregulation of emotions. This was demonstrated by participants who emphasised the following:

You don't know why, it's just something when it happens, and you feel anxious. I'm very paranoid... I always say, I am a bit unbalanced when it comes to emotions. I would be angry one minute and I'd be happy the next minute... (Amanda, Survivor Participant).

If I go through things, I always ignore it or brush things aside. I'm not very good with coping with emotions because I am a very emotional person. I don't like feeling weak because I cry a lot so that's why I just tend to ignore it or brush things aside (Jada, Survivor Participant).

Second, regarding 'behaviour', findings showed that survivors changed their social behaviour due to a fear and distrust towards men. Narratives spoken by survivors highlighted that they became distrustful of men and men's actions towards them due to their sexual assault. This would lead to fear and aggression, especially when actions involved touch:

If I'm walking maybe in public, I would feel very anxious. If I see men, and I'm walking alone, I will walk faster, or I'll go a different direction (Jada, Survivor Participant)

I get aggressive with men. I think we were at a bar with a friend and this guy kept touching my shoulder... so I was like, "do not touch me," and he kept doing it and it was just this invasion, like, I'm saying no, you know I'm saying no. I want to feel that I can say no, and the

other person hears that and when he realised it, it doesn't matter. It's the feeling of powerlessness (Zawadi, Survivor Participant).

The HCWs suggested a strategy for assisting survivors with difficult emotions which included them normalising the feelings that survivors were experiencing during counselling sessions. HCWs felt that these strategies were beneficial for healing:

Normalise what they're feeling... you've been through trauma so it's normal for you to be experiencing these things. They will go away, and it will get better. To remind them that it's not like a permanent state of being (Rita, HCW Participant).

And I always tell my clients I am so proud of them. Even when they come every single time for their counselling session, I tell them you know what, I'm so proud of you and that you came (Babsie, HCW Participant).

It was suggested that by HCWs using this strategy, survivors are able to accept their trauma, and this leads to an improvement in their self-esteem and ability to regulate emotions.

Third, the 'memory' sub-theme related to the process of remembering the assault and the behaviour that survivors engaged in when remembering. It was suggested that often when survivors felt difficult emotions, they would remember the assault while associating these emotions to their trauma. In addition, they engaged in behaviour such as crying, when thinking about the event:

It felt that whenever I hit hard rock-bottom or I'm depressed, I'm stressed about something, I'm hurt or disappointed, I always go back to what happened then... I only realised now, whenever something hurts me or disappoints me or stresses me out, I feel, I always go back to the rape incident and everything (Amanda, Survivor Participant).

4.3.1.5 Sociological Aspects

Three sub-themes emerged under the 'sociological' category in the findings. Firstly, the findings revealed that sociological factors such as unemployment, financial stability, and socio-economic status played a large role in hindering chances of a successful recovery, through preventing access to healthcare and increasing vulnerability to rape. Furthermore, being socio-economically vulnerable increases the chances of a challenging recovery process due to issues with healthcare access and affordability.

During the FGDs, it was suggested by the HCWs that survivors' socio-economic status plays a role in increasing risk for mental ill-health and decreasing likelihood of recovery, especially when it involves financial instability alongside unemployment:

I think employment status is quite important for like a more positive outcome... because so many people were retrenched or lost jobs and things like that... and all of a sudden, they were dealing with financial stressors and self-esteem issues around the employment stuff and obviously dealing with rape too (Rita, HCW Participant).

The final sub-theme on the individual level highlighted that survivor may fear external judgement from others, and this is why they may avoid disclosing to their family and friends. They also may feel pressured to act according to what is perceived as 'normal' while in reality, they wish for the ability to speak to someone and for this person to listen:

Nobody will understand me if I must tell them how I feel. They will think I'm mad. They will think I'm stupid or I'm seeking attention... but I just want to talk. I just want to let go because it helps me a lot when I speak about it knowing there's someone that can listen to me (Aleema, Survivor Participant).

You act normal when you are with the people... you're not going to be that kind of person who speaks because you feel like you're not heard. If you must speak, no one will believe you (Vanda, Survivor Participant).

Additionally, participants mentioned that they were fearful of disclosing their rape incident in the fear that they may cause their loved ones to feel guilty or that they may become a burden on their family and friends. The narratives imply that despite bearing the impact that rape creates and needing help, survivors feel afraid to disclose because they do not want to burden others with their problems:

I was quite scared to tell them [my parents]. Not because I knew they wouldn't believe me but because my parents are very sensitive people, and they care about me a lot. I have a history of putting other people's emotional needs before my own (Lily, Survivor Participant).

It's not that I feared that she [Mother] would blame me... I just didn't know how to handle... I don't like putting a lot on people's plate when I know their plate is full. I don't think that's fair (Zawadi, Survivor Participant).

4.3.2 Assault Level

The second category addresses the second level of the ecological model, namely the assault level. The findings within this category are limited because it was not a subject deeply investigated in the interview schedule; the participants were not asked specifically about the details of how their rape occurred. As a result, there was less data under this category.

When exploring factors on this level, results were centred around characteristics of the rape, including the weapon used during the rape and the environment in which it occurred. HCW participants discussed that the use of a weapon during the assault worsened the survivor's reaction to trauma and this impacted their recovery. Two HCWs explained the use of a knife as a weapon during two different survivors' assaults, and the impact this had on the survivors:

...I had another client that was held and raped at knife point. And she said ultimately in the sessions it came out that her trauma was around the use of a weapon as opposed to the rape (Emma, HCW Participant).

I have one [client]...and he threatened her with a knife... her mother has to hide all the knives at their home because she is like, "it looks just like that one". He used a house knife and now her mother must remove all the knives (Babsie, HCW Participant).

The HCWs' narratives above emphasised that experiences of trauma may be worsened by the weapon and threat of death used during the sexual assault incidence. Additionally, HCWs related that traumatic memories may be triggered by seeing objects that are similar to the weapon used or remembering the fear experienced during the assault.

4.3.3 Microsystem Level

This category addressed factors on the third ecological level, the microsystem, which Campbell et al. (2009) describe as social support received after disclosure. The themes under this category include both negative and positive interactions with family, friends, and romantic partners, which impact recovery.

4.3.3.1 Negative Interactions

The first sub-theme under this theme involves negative interactions that survivors experienced with their family and friends. When speaking about social interactions, the majority of survivors emphasised negative reactions from their family and friends when either disclosing or talking about their rape experiences, such as not believing that they were sexual assault or forcing them to be silent about their sexual assault.

I think I expected them [parents] to be more empathetic and I felt that they blamed me for it because the time when I went over to the family friend, things at home weren't that great, and that's why, I didn't want to be at home... they basically asked me, do you see what happens if you sleep out? (Jada, Survivor Participant).

They know but they don't talk about it, and I don't think I feel comfortable because like they're in my space... my mom ignored the whole thing [rape]. I think she was shocked... I don't understand why she's not asking me about it or how I am or feeling or coping (Lucy, Survivor Participant).

During the focus group with the HCWs, it was also mentioned that families often force the survivor to not talk about their sexual assault incident and that if the perpetrator is respected by the family, then the victim is neither listened to nor believed.

I once had a client where the father actually said, no but he can come and pay lobola [isiXhosa bride price] for my child... So, it was a stranger you understand? The perpetrator will come or the family members of the perpetrator will come and give money. And then the family will take it and then plead with her, with the survivor, not to – to keep it quiet (Jane, HCW participant).

It was her dad's colleague, and he lives just opposite them... she was like now I am stopping this because I am 18 and you started when I was eight. And she was like now, no more, and he fought back, and she ended up with all the bruises and scars. And then her mother said you are trying to draw attention. She told her parents before what he's doing. But because of what he tells the dad it's like, no, your child just makes up stories man. She's just making it all up (Babsie, HCW participant).

Reactions from friends and romantic partners were also found to have a negative impact on the survivor participants. It was suggested that after survivors disclosed their assaults to their friends or romantic partners, they would feel they were avoided or would experience inappropriate comments. Additionally, a number of participants felt that disclosure often caused a change in personal relationships, where relationships with friends or romantic partners ended:

Two years ago, I had a boyfriend and then I shared everything with him and then he became distant. I think maybe the story was too heavy for him at that point and he couldn't take it (Alani, Survivor Participant).

I've had one friend that I actually told [about the rape] very recently...he wasn't very empathetic with me. The first thing he asked me was if I was drunk... with my [other] best friends, when I told him, at the beginning, he was very supportive. But now, he doesn't even talk to me at all (Jada, Survivor Participant).

4.3.3.2 Positive Interactions

Although negative interactions were more common, many survivors mentioned that they had supportive family and friends. For the survivors who reported positive interactions with family, they also emphasised notions of protection and support from their father figures, despite having previously mentioned distrusting men.

My stepfather told him [the rapist] ... I'm willing to go to prison for murder if you don't leave her alone.... and he left me alone (Aleema, Survivor Participant).

[My father] is easier to talk to... when I tell him that I don't want to talk about it or think about it at the moment, he understands... he is very supportive, and he understands that when I'm ready to talk about it, he'll be there and stuff (Arumile, Survivor Participant).

Similarly, some survivors also mentioned support from their sisters, with an emphasis placed on encouragement, understanding and support.

When I actually told my sisters [what happened], it was interesting that they went like, "Oh, now we understand" it was like a sigh. (Alani, Survivor Participant).

My sister was very supportive. She's the only person who knows about the sessions that I've been having... when we are living together with my dad, I told her everything about my sessions and all that. And she also told me I was getting better (Lucy, Survivor Participant).

4.3.4 Mesosystem Level

This category addressed the mesosystem level, which refers to the interactions between survivors and the systems that assist them. The results emphasised both negative and positive interactions with these systems. Negative interactions, also described as secondary victimisation, were demonstrated within these systems, including insensitivity and incompetency from professionals, as well as survivors experiencing stigma and blame. Contrary to this, positive interactions were also highlighted and included therapy that was accessed through the rape centre.

4.3.4.1 Negative System Interactions

The majority of participants mentioned that they had experienced negative interactions with both legal and healthcare professionals. It was highlighted in their narratives that they found these professionals to be insensitive and this negatively impacted how they perceived as well as accessed treatment, and therefore their recovery process too:

I didn't understand but maybe they did it because they did not believe me or something... that "am I sure if I am raped?" Like who wouldn't know that they are raped? You know your body and you know yourself (Lucy, Survivor Participant).

Funny enough, it's not even the sexual assault that really bothers me anymore compared to what happened... It was also just not how I thought things happened afterwards. I thought the worst thing to happen to you was your sexual assault, not the aftercare (Zawadi, Survivor Participant).

Furthermore, the HCWs expressed that survivors' interactions with other professionals often involve the notion of stigma and victim-blaming:

I have a client... when she told the story to her pastor and then her pastor was like, "maybe you were dressed inappropriately". So, he shifted the blame back at her. She thought she [was] coming for counselling (Babsie, HCW participant).

I had a prosecutor... she told two clients of mine that she has been raped and it's time that they get over it. It's like, "Get over this shit. Do some counselling and get over it," (Emma, HCW participant).

In addition to insensitive interactions with professionals, the majority of survivors' experiences of the overall legal and healthcare systems suggested incompetency and poor handling of cases and confidentiality issues:

The guy that was handling the case said he'll call me when they are at court and the trial and whatever. But he never did... so I waited on him and then I called him again and then he said he will contact me on WhatsApp so that I know what's happening and whatever. And then I was like okay, and then I waited on him... and ever since then, I got a SMS saying that my case was transferred to someone else but never anything from them...I feel betrayed. I feel like there's nothing I can do actually because they were my only hope and then my only hope is not doing anything (Lucy, Survivor Participant).

I think also when [the clinic] is in your own area it makes it more difficult because now you're afraid somebody is going to see you. And then obviously sometimes there's a lack of confidentiality even with the staff working at the health centres because they might slip something and then now. So, you see with them let them rather go to another area; to a clinic or wherever in another area than going into their own areas because of having that stigma of everybody knowing about the rape and things (Jane, HCW participant).

4.3.4.2 Positive System Interactions

In contrast to the above, positive system interactions between the NGO-based rape centres and survivors were also highlighted by survivors and HCW participants. The rape centre, as a service, was specifically emphasised as being beneficial to survivors due to the provision of individual and group-based therapy. It was beneficial several ways.

Firstly, individual therapy accessed through the rape centre was related by participants, particularly by those who felt unsupported by friends or family, as being a facilitator in their recovery:

...Ever since I started talking about it to my therapist and my counsellor, it feels like there's a bit of weight off my shoulders. Knowing that it was not my fault and I'm not the only one, sort of weighs the pressure on me or the thought about it (Amanda, Survivor Participant).

Secondly, group therapy appeared to be helpful for victims because it allowed them to hear and relate to other survivors' stories. This was demonstrated when a HCW described a survivor sharing her story during a group session:

She disclosed how when she was a child, she was a survivor of childhood sexual assault... she said that was the first time those words came out of her mouth. She said what gave her the confidence was, number one she is in a safe space. Number two, that she had witnessed other women telling their stories and had overcome them. And number three, that part of the process is not to respond; not to answer back or to give advice (Emma, HCW Participant).

Additionally, group therapy also enabled validation through therapy, which refers to survivors' feelings of vindication through having other people listening and believing them. Findings within this sub-category also included positive interactions through group therapy. It was suggested that group therapy assisted survivors' recovery process because of the support and relatability it provides:

I think social support where the people come and tell you what happened to me... if I speak, she will understand me... she's been there, and she knows what you talk. And then when you still experience the things then she comes and says to you, "it's okay, it happened to me." (Vanda, Survivor Participant).

I think group sessions.... having to listen to the other person and her experiences. Sometimes I carry somebody else like a victim, uyabona [you see]. Also, being through the experience and then now I hear, and I think that will be very good and that will be very helpful. Sometimes you telling me this doesn't really impact me in some way but somebody telling me this in this position would help (Lucy, Survivor Participant).

4.3.5 Macrosystem Level

The macrosystem level refers to the beliefs and social norms experienced by the survivors in their social environment. Results under this category included factors that improve or worsen recovery and well-being of sexual assault survivors. Results demonstrated that misconceptions of rape as well as the ignorance within families about rape while raising awareness improved well-being.

4.3.5.1 Worsening Chances of Recovery

When analysing HCW narratives, misconceptions of rape and the impact this had on survivors' recovery emerged within the dialogue. Despite rape being an act that is inherently violent, the HCW participants mentioned that there is a societal misconception that assault requires violence to be considered 'rape'. This misconception has implications for how society views victimhood amongst survivors:

We often call that [violent rape] 'ideal rape'. It has to be like somebody has seriously beaten you, held you down and raped you If you weren't raped the right way, it's like "why are you making such a big fuss?". If it doesn't look like a very violent stranger or you look like a Nobel Peace Prize winning victim, then you immediately become [not a victim] (Rita, HCW Participant).

Or they will say, "Oh no, it was just a finger. He did not penetrate you with his penis – so why are you so traumatised?" (Jane, HCW Participant).

Further narratives from HCWs suggest that rape misconceptions can hinder and even prevent the recovery process for the survivor because outsiders often do not believe rape can be perpetrated by someone known to the survivor:

I think a lot of people still think the stranger and danger model of rape is the only one. And what we see is most of our survivors know their perpetrators. I think it is also like if you know the woman's is not ripped from the vagina to anus, it doesn't count. If she didn't report it immediately or tell them immediately then there's all these, they look for the holes in the story before just giving the survivor the benefit of the doubt. (Rita, HCW participant).

In addition to the above, survivor participants also mentioned how there is ignorance in families about rape and this may influence whether rape is acknowledged. This seemed especially applicable to cases where rape occurs within the family unit:

I come from a culture where my mom's not like this, and she didn't raise me like this but outside of that, my extended family and stuff, you don't speak about these things... (Zawadi, Survivor Participant).

Elements of maternal history of rape was also emphasised amongst HCWs where it was mentioned that many of their survivor clients had mothers who were also sexually assaulted but who never dealt with it emotionally. This, in turn, impacted the chances of recovery for the survivor:

I never dealt with my rape and, now my child is raped. Now all of my emotions, my feelings are surfacing because I never dealt with mine and now, I need to deal with her. I don't know how to deal with her because she's on a different level. I'm on a different level. Everything is chaotic (Lisa, HCW Participant).

4.3.5.2 Improving Chances of Recovery

When exploring what factors assisted survivors' recovery on a societal level, the category of raising awareness through education was mentioned which played a role in lessening the effect of trauma due to increasing understanding and empathy:

It's across every society. I just say we're putting the plaster on the festering wound. We need to get to men and boys seriously... it's like saying they are in denial... They've never been taught to socialise to believe that is what rape is (Emma, HCW Participant).

We should talk about it [within] families. I know it's difficult but somewhere somehow, there should be an initiative where probably part of the subject in Life Orientation... there's a huge awareness on cancer but it feels there's so much silence when it comes to rape, close to none but thousands of people are raped each day... it would help people recover and I feel at some

extent, lessen the rape... educate everyone and I feel maybe they would also start not raping (Amanda, Survivor Participant).

Similar to the above, findings also highlighted education from a self-initiated perspective. One participant discovered that she had been repeatedly raped by her ex-husband once they separated. She felt her sexual experiences with her ex-husband were not 'right' and so this led to her researching the concept of rape using the internet:

...I started researching [rape] on my own. What is this thing? Because I don't think it's right. That's when I discovered what rape was and that I was being raped the whole time. The [information online] was more positive but actually taught me that everything that I had experienced was abusive. Everything that I experienced sexually was rape... it didn't click, and it didn't link to my experience until I read about it because when I read it, it was detailed (Alani, Survivor Participant).

4.3.6 Chronosystem Level

This category focused on the chronosystem level, which refers to prior victimisation that survivors have experienced for a specific duration of time. The results emphasised the notion of re-living experiences and how this effected recovery, self-esteem, and symptoms of mental illness. Additionally, findings also revealed the negative impact that repetitive rape has on survivors, including the triggering of mental health symptoms and worsening experiences of trauma.

The act of being raped repeatedly throughout a survivors' life seemed to have a major contribution to worthlessness:

Sometimes I feel very worthless. I feel because of what happened to me, it's never going to go away. I want it to go. I can talk positive, but my mind is never there (Aleema, Survivor Participant).

I didn't have that self-love. I felt violated. I felt that I was maybe not good enough to be in a relationship (Lucy, Survivor Participant).

You know she eventually – there was a time where she said like what does it say on my forehead? Like 'fuck me', you know what I'm saying? She said that's how I'm beginning to feel (Emma, HCW Participant).

Furthermore, when asking survivors about their experiences of repetitive rape and the impact this had on them, they described that it triggered previous mental illness symptoms, such as insomnia and suicidal ideation:

I struggled to sleep and the suicidal thoughts came back and it was difficult for me (Zelda, Survivor Participant).

The results also demonstrated that repetitive rape may have a detrimental impact on the way survivors experience trauma. Findings suggested that experiencing a rape several times is never the same experience and due to this, the survivor is forced to re-live old experiences. This results in a cumulative effect of re-experiencing trauma when having been raped multiple times across a time period.

Whether it happens once, whether it happens 10 times, it's horrible. And it makes it worse that it's different incidents and different events of the same horrific experience (Amanda, Survivor Participant).

The previous times, I got over my experiences very quickly... Now with this one, it's like everything is starting, like all my past experiences, are starting to affect me only now. It was very confusing... (Jada, Survivor Participant).

HCW participants also mentioned that when victims are raped repeatedly, the trauma created by their previous rape is re-lived, and this creates a cumulative effect where trauma is worsened. Moreover, it was also noted that there is often one specific rape that acts as catalyst to experiencing the same trauma caused by the sexual assault.

You have a survivor of multiple rapes, they will be, does it say on my forehead? Am I wearing a t-shirt or something? But as I say, sometimes it will be one incident that they will come here for and then it sort of becomes clear that it's another [incident]... something else previously that they haven't dealt with (Rita, HCW Participant).

They [survivors] choose to speak about one rape... and then it really turns out that it's not the [only] one. It's always like there's one [incident] that's the straw that breaks the camel's back. And you think out of all these things you've experienced, that would be the least concerning and it turns out to be 'that thing' that creates this trauma (Emma, HCW Participant).

4.3.7 Self-Blame Level

The final theme focuses on the level of self-blame which is a meta-construct that spans across all levels of the ecological model. The sub-themes that emerged under this theme included guilt and empowerment.

4.3.7.1 Guilt

When asked about their experiences of self-blame, the majority of participants had stated that they had internalised the blame imposed on them by family, friends, and society and that this resulted in personal feelings of shame and guilt. Due to feelings of shame and guilt, the survivors' self-esteem was impacted, and it was suggested that this resulted in survivors isolating themselves or feeling responsible for their rape.

One participant mentioned that her guilt caused her to isolate and feel ashamed:

You are not the same when you do the things and the situation where you are... if you talk with people, you feel guilt... so you isolate yourself and you don't feel okay with yourself... you always feel ashamed of yourself and you always would look down on yourself (Vanda, Survivor Participant).

While another participant described feeling responsible for her sexual assault and felt she could have prevented it:

I was having nightmares... the thing happening in my mind over and over again... thinking if maybe I woke up and did something, maybe I wouldn't be here. Like what I should have done differently...blaming myself and all that (Lucy, Survivor Participant).

Additionally, both the survivor and HCW participants emphasised that not only did the sexual assault incident trigger self-blame, but it also caused the survivors to internalise this blame due to rape myths:

At times you would ask yourself, was I too nice? Did I dress wrong? Did I give the wrong impression? Did I lure him? Did I say something? (Amanda, Survivor Participant).

She blamed herself because she shouldn't have shorts on... and she said it's my fault. I should've put on my long pants. I should have gone to the shop earlier... and then a whole lot of blame comes and then they believe [that]. It doesn't matter what you tell them. They believe it (Babsie, HCW Participant).

Finally, findings within the category of guilt also suggested that healthy coping mechanisms, such as attending church and therapy, enabled women to deal with feelings of shame and guilt. This differed to unhealthy coping mechanisms, such as risky activities, that exacerbated shame and guilt:

One thing I've wondered is how different my life would have been if I had gone [to therapy] the first time I was assaulted... how the tools I've learned now that I wished I'd known it like 17 and I'm 24 now. I'm grateful that I'm learning those tools, but I just get angry for younger me and all of those years that I didn't know the coping mechanisms... I really became in a lot of aspects of my life, just smaller (Zawadi, Survivor Participant).

It's like, I wanted to punish myself and punish him for what happened by having more sex... I just felt that it would remove some of the shame that I had, which at the end of the day, didn't... I stopped....and.... I started going to church... that's what actually helped me more (Alani, Survivor Participant)

4.3.7.2 Empowerment

While many participants internalised shame and guilt, there were others who subsequently experienced empowerment and healing, following the processing of their trauma. This was suggested to be facilitated through four factors, which were: counselling, taking ownership of recovery, seeking justice, and acceptance that the sexual assault incidence occurred.

Firstly, it was found that counselling enabled a safe space, helped survivors restructure their life and normalised the feelings they experienced. In doing so, survivors were able to forgive themselves which led a reprieve from self-blame:

Sometimes I don't remember some things about myself. I don't have that much self-love... I had a very low self-esteem before... but with the sessions, I think I am regaining self-esteem and begin to see myself as this queen and all that (Lucy, Survivor Participant).

I think the one thing that I still appreciate is that I was allowed to be myself without being judged. And I was told "that this is for you" and I could feel that they're genuine when they're saying, "this is for you now. You're doing this for you. And we're here for you to carry you." (Alani, Survivor Participant).

So, talking [in individual therapy] about it does help in a way... it was like, there's weight removed on my shoulders, and you feel hopeful. You feel, at the end, there's hope and you feel

you will eventually heal. I also feel there will come a time where I will talk about it, and I won't be crying about it (Amanda, Survivor Participant).

Alongside the positive impact that counselling has on the recovery of the survivor, other factors that play a large role in facilitating healing and improving well-being are taking ownership of recovery and choosing to practice healthy coping mechanisms, as demonstrated by the quotes below:

I realised I am running away from the thought. I must focus on other things... I must just not entertain the thought of it... I would drink now and then what happens the next morning. You have a headache... it doesn't wash away or drink away the rape (Amanda, Survivor Participant)

I don't want to smoke because I know it's unhealthy.... Or with alcohol, I would just feel like, I need to drink now... I don't want to rely on something that's unhealthy for me (Jada, Survivor Participant)

Thirdly, survivors expressed that seeking justice and talking about their experiences assisted their chances of recovery because they were not only taking ownership of their experience, but because they were also facilitating a sense of healing and empowerment in doing so.

It's been hard, but this process of going to the police and poisoning his reputation and all of these sorts of things have helped. They've been hard but they've been very empowering and felt like he has deserved what he's received (Lily, Survivor Participant).

I don't know how my family would react towards me or him, but I feel it's something that needs to be said... I feel it will be something for me to heal. It will look like a chapter closed. Even if I'll be opening something, like a can of worms in a sense.... I want to heal. I want to get over it (Amanda, Survivor Participant).

Finally, survivors accepting that their sexual assault occurred enabled their healing because this prevented denial and engaging in unhealthy coping mechanisms:

And now, I feel like I'm in a yield space where I not only feel comfortable talking about it, but it makes me feel better and makes me feel more empowered in my experience (Lily, Survivor Participant).

I'm okay if you judge or not because at the end of the day, this is my story and if you feel like you should judge it, well, if you feel like you'll learn something from it, all well. I'm at that point whether they judge me or not, this is still my story and I'm sharing my truth (Alani, Survivor Participant).

CHAPTER FIVE: DISCUSSION

The findings detailed in Chapter four will now be discussed according to the study's objectives, namely, experiences of mental ill-health related to sexual assault, improving or worsening factors of mental health and well-being and finally, interactions with self-blame on the ecological model.

5.1 Experiences of Mental Ill-Health Related to Sexual Assault

When exploring the survivor participants' experiences of mental health, it was evident there was a link between their mental ill-health and their sexual assault incident that they experienced, in particular, their emotional and mental response to the assault.

Many of the women described symptoms of anxiety, depression, and PTSD in their interviews and these symptoms developed after their assault. Other symptoms, of which were most related to PTSD, included panic attacks, dissociation, and memory loss. Findings also suggested that mental ill-health were related to the way in which participants had responded to the trauma of their sexual assault. For example, some women denied confronting their emotions as a coping mechanism, which may have worsened their mental health and resulted in developing symptoms of a mental disorder. Other South African studies have demonstrated similar findings. Mkhonto et al. (2014) found that 62.8% of female South African survivors displayed symptoms of anxiety and depression which is similar to the majority of survivor participants in this study. Further to this, Sepeng et al. (2019) discovered that psychiatric symptoms experienced by survivors often manifest into PTSD, and Cerulli et al. (2012) highlighted these symptoms as being panic attacks, flashbacks, paranoia, similar to what was expressed by survivor participants in the interviews.

One contribution that worsened the symptoms of mental ill health experienced by study participants involved unhealthy coping mechanisms. The negative coping mechanisms that were common amongst participants included substance use and repression of emotions. The narratives highlighted that participants' mental health was worsened when using these coping strategies due to enabling avoidance and temporarily avoiding emotional pain. As indicated in the results, the coping mechanisms that were considered 'healthy' by participants included creative expression, exercise, mindfulness therapy, and social interaction. The narratives from the participants suggest that healthy coping mechanisms assist recovery because they enable survivors to address the incident in a productive way; one that heals symptoms of trauma rather than enables avoidance of emotions.

The findings of unhealthy and healthy coping mechanisms match existing South African literature. Regarding unhealthy ways of coping, previous studies conducted by Lekganya (2015) and Hyman and Williams (2001) have demonstrated that emotional distress is associated with denial, isolation and

substance abuse. In contrast, using healthier coping mechanisms such as social support, through confiding in friends or talking to family about feelings, leads to improved self-acceptance and a lower likelihood of depression amongst survivors (Lekganya, 2015; Mgoqi-Mbalo et al., 2017).

5.2 Improving and Worsening Factors of Risk and Resilience

The second theme explores how factors on the ecological model increase risk to mental ill-health or improve resilience and recovery. This will be unpacked relative to each level of the ecological model.

5.2.1 Individual Level

On the individual level, a variety of biological, psychological, and sociological factors were found to increased risk to poor mental health outcomes. Biologically, it was discovered that having a high or low libido impacts the chances of recovery because it prevents survivors from practising healthy sexual activity, which impacts on their current or future relationships with men. This finding is reflected in a study conducted by O’Callaghan et al. (2020) who found that survivors who had unpleasant sexual experiences with their partners attributed it to their lack of sexual drive and therefore, this prevented them from having positive relationships with men.

Regarding worsening psychological factors, when participants detailed their experiences, repressing emotions and difficulties with emotional regulation were emphasised. Coping with emotions was difficult for the participants and this often led to repressing them, thereby making them unable to emotionally cope with the trauma of rape in an appropriate manner. Findings also highlighted the notion of survivors’ fear and distrust towards men and how this impacted their relationships with men by leading to fearful reactions and aggression. This finding is supported by Sebaeng et al. (2016) who found in their South African study that distrust and anger towards men can impair social functioning of female survivors with men. Finally, findings on the psychological level revealed that remembering the event affected the way survivors behaved. Through remembering what had happened to them, survivors would experience emotional distress, and this is suggested to prolong the process of recovery.

Regarding worsening sociological factors, socio-economic background, isolation, fear of judgement and distrust were found to play a role in worsening the chances of recovery. Participants related that disclosing to family or friends was often avoided due to the fear of external judgement from other people. This non-disclosure and fear of rejection also led victims not to seek assistance. There is various literature that supports the notion of positive and negative social interactions. Jewkes et al. (2021) suggests that reactions from friends, family and community can impact recovery due to the potential judgement and stigma placed on survivors, thereby worsening recovery, and enhancing elements of self-blame and shame. Furthermore, Campbell et al. (2009) found that if survivors

received negative reactions from outsiders when disclosing for the first time, they were less likely to disclose again, thereby impacting their recovery due to not seeking assistance.

The findings also included beneficial biological, psychological, and sociological factors. Biologically, exercise and mindfulness therapy were found to improve the recovery process because they were positive coping mechanisms that enabled increased well-being. On a psychological level, HCWs mentioned that normalising the feelings of survivors was a facilitator in the recovery process and helped improve survivors' self-esteem and improve their emotional regulation. Additionally, and represented as a sociological factor, receiving social support was also helpful for recovery. The notion of social acceptance being associated with positive mental health outcomes is supported by research conducted by Lekganya (2015) and Mgoqi-Mbalo et al. (2017). Both authors note that social support and acceptance is associated with diminished self-blame and lessened likelihood of developing depression and PTSD.

The graphic below presents a summary of the biopsychosocial factors that worsened and benefitted survivors' recovery process. This graphic was developed by the researcher to reflect the findings under the individual level. Each biological, psychological, and sociological section of the graphic demonstrates the factors that worsen and improve survivors' well-being as well as which factors strengthen or weaken their chances of recovery. It also includes coping mechanisms highlighted on individual level.

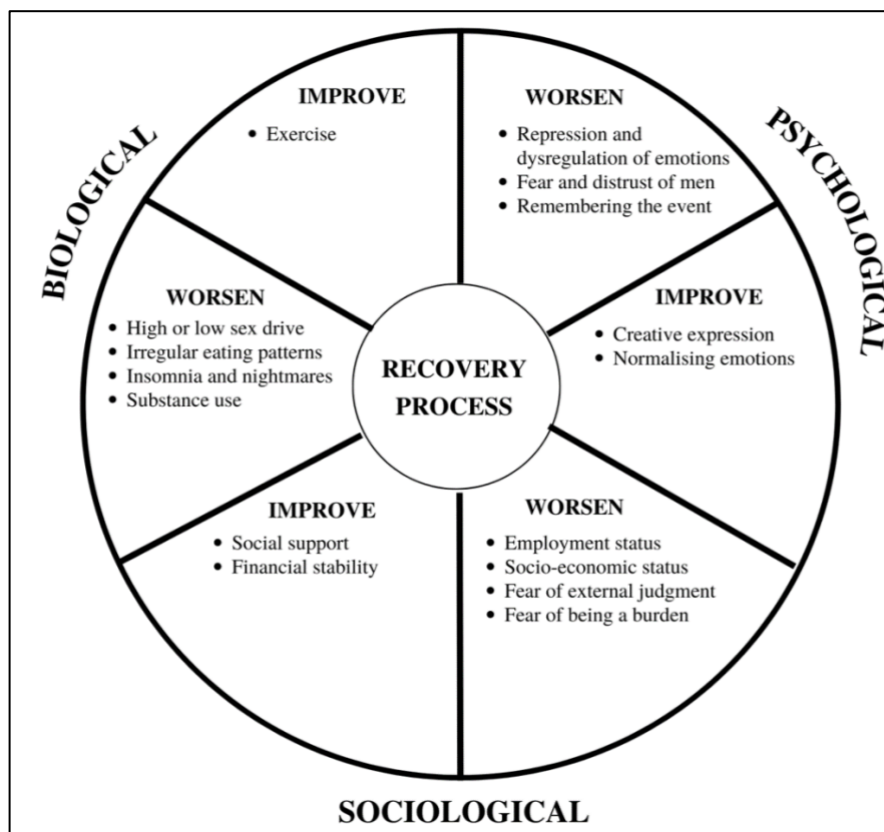


Figure 2: Individual Level Factors Impacting Recovery

5.2.2 Assault Level

While there were no positive factors on this level that were found to facilitate well-being, various factors, specifically the weapon used during the assault, was found to worsen well-being. The weapon used during the assault was said to impact the survivor's recovery by worsening their traumatic response to the event, leading to a more likely development of mental health problems. Moreover, traumatic memories may be triggered by seeing objects similar to the weapon used during the event and this may slow down recovery. This notion of witnessing objects that trigger memories of weapons used during the assault is also cited by Campbell et al. (2009). The authors identified that post-assault murder threats predicted anxiety and depression and decreased resilience. In the same review, the authors identified that victims who had a weapon involved during their assault were more likely to develop PTSD.

While Campbell et al. (2009) discovered the link between weapon use and PTSD development, other authors conducted a review on the various evidence-based psychotherapy interventions used to treat PTSD. After reviewing the methodology of PTSD guidelines, Watkins et al. (2018) found that cognitive processing therapy (CPT) clinically reduced anxiety, depression and PTSD among sexual assault and veteran samples. Similarly, trauma-focused cognitive behavioural therapy (CBT) was also effective in treating PTSD due to its cognitive and behavioural techniques, such as cognitive restructuring and cognitive exposure. The review detailed results where 61% to 82.4% of participants treated with CBT lost their PTSD diagnosis. (Watkins et al., 2018).

5.2.3 Microsystem Level

When exploring factors on the microsystem level of the ecological model, various reactions from friends and family were found to worsen recovery. The narratives of survivors emphasised toxic interactive spaces that hindered their ability to disclose and confide in their family and friends. When survivors did disclose their rape, it was noted by HCWs that their families would either force the survivor to be quiet about the rape or they would not believe the survivor. The detrimental impact of negative social reactions from family and friends is noted by authors such as Campbell et al. (2009) and Sebaeng et al. (2016). Lack of social support can worsen the traumatic experience of rape and subsequently prevent recovery. Campbell et al. (2009) found that negative social reactions to disclosure, such as enforcing silence or disbelieving the survivor, can be more damaging to the survivor's mental health than positive social reactions can be for fostering resilience. The authors suggest this is because sympathetic reactions are expected from family members and when these are not received, it can worsen the overall experience of disclosure.

In this study, it was discovered that friends and romantic partners made inappropriate remarks after the survivor disclosed their rape. Moreover, survivors found that friendships and romantic relationships

changed after exposure, suggesting that negative reactions have an impact on women's mental health. Conversely, studies have demonstrated that positive reactions from friends improve recovery. After conducting research on how individuals were coping with their friend's rape disclosure, Ahrens and Campbell (2000) and Banyard et al. (2010) discovered that friends who survivors disclosed to often reacted positively and experienced positive changes in the relationship that strengthened recovery.

Some survivor participants also highlighted that positive interactions from family, such as fathers and sisters, strengthened their recovery process. These interactions helped them to feel protected, understood, and supported. Research conducted by Campbell et al. (2009) also discovered that supportive reactions have a positive impact on survivors and their recovery. The authors noted that positive social reactions from friends and family are related to experiencing less psychological distress.

5.2.4 Mesosystem Level

Findings on the mesosystem level suggested that experiences with legal and healthcare professionals were largely negative. Many participants noted that insensitive actions had a large impact on how they perceived and accessed treatment.

Regarding legal professionals, many police and prosecutors were described as insensitive, and many participants related that many of these interactions were anxiety-provoking or victim-blaming. These findings are similar to those discovered by Steyn and Steyn (2008) in South Africa, where legal professionals, such as police officers, were often unempathetic and unhelpful during sexual assault reporting and this led to survivors experiencing guilt, blame and shame. Additionally, officers often interrogated the victim, which made them feel that the assault was less severe than they experienced it as (Steyn & Steyn, 2008).

In addition to professionals' negative interactions with survivors, this research discovered that survivors experienced poor case management from legal professionals, while HCWs noted confidentiality issues from healthcare professionals and secondary victimisation of their clients. Other research in South Africa found that survivors experienced lack of privacy and loss of confidentiality when attending primary care clinics and this led to survivors not attending follow-up sessions (Holton et al. (2018). Secondary victimisation by police officers was also noted in research conducted by Steyn and Steyn (2008) and this led to survivors distrusting the system. Negative attitudes, case management issues and confidentiality issues impact the recovery of the survivors because it prevents them from receiving effective treatment.

While the above were factors that worsened recovery, individual and group therapy accessed through the NGO-based rape centre were emphasised as factors that improved recovery. Findings suggested that individual therapy enabled survivors to relieve the pressure of remaining silent about their rape by disclosing to their counsellor. Similarly, group therapy enabled survivors to feel less lonely through relating to other survivors participating in therapy as well as feeling validated through being listened to and believed. Recovery was attributed to survivors finding it helpful to hear and relate to other stories of women who had survived rape. This finding is supported by research conducted by Brown et al. (2013). In their study that explored the effectiveness of group therapy amongst survivors of incestuous rape, the authors discovered that survivors felt supported by survivors in the group therapy sessions, particularly with those who shared similar thoughts and feelings.

5.2.5 Macrosystem Level

On the macrosystem level, it was found that rape misconceptions, influence of family on their knowledge of rape, and maternal history of rape were factors that increased risk to mental ill-health and decreased resilience and recovery.

Findings suggested that because of the misconception that rape is inherently violent, many survivors are not seen as victims of rape. This hinders recovery and it may prevent them from seeking assistance. Findings also revealed that within some families, rape is not spoken about, and this impacts the survivor due to being unable to seek help from their family. Additionally, it was also found that survivors' mothers who were also raped often did not know how to cope with their daughter's rape. This impacts the chances of recovery for the survivor, especially younger survivors, because they do not receive guidance from their mothers or parental figures. This finding is supported by research, conducted by Langevin et al. (2022), that explored the maternal history of childhood sexual abuse and the outcomes in sexually abused children. The findings demonstrated that when the children of sexual assault survivors were sexually assaulted themselves, this triggered difficult memories and previous mental health symptoms in the sexual assault survivors. Moreover, mothers who had higher levels of emotional distress were less supportive of their children who were sexually abused.

Differing to this, factors that were found to improve recovery included education and sharing of survivors' stories. Findings demonstrated that spreading the awareness of sexual assault through education is vital when strengthening chances of recovery. This is for two main reasons. Firstly, education may prevent cases of rape due to people being educated on key concepts such as consent. Furthermore, it may facilitate more support for survivors due to improved understanding of how to assist them. Secondly, by understanding the concept of sexual assault, victims may be more aware that they were sexually assaulted, and this would encourage them to seek assistance, therefore assisting recovery. Beres (2020) conducted a study that explored educator and activists' views on the usefulness

of teaching consent concepts to prevent sexual assault. Results revealed that consent education was viewed as a useful solution, but only for people who lacked knowledge about consent.

5.2.6 Chronosystem Level

There were no factors on the chronosystem level that demonstrated an improvement of well-being for survivors in this study. Instead, findings demonstrated that repetitive experiences of sexual assault have a negative impact on the survivor's sense of self-worth and recovery. Additionally, re-living experiences of rape triggers previous symptoms of mental illness similarly experienced when previously raped. This all results in progressing in recovery very difficult. This finding is supported by Dollman (2019) where the author found that previously existing symptoms were not only triggered with each new assault but also worsened in severity despite recovery attempts.

Findings also demonstrated that experiencing rape several times forced the survivor to experience the trauma response repeatedly. This prevents recovery from progressing. Campbell et al. (2009) also found that repeated experiences of rape during survivors' lifespans had a cumulative effect on well-being because it prevented the continuity of recovery.

5.2.7 Self-Blame Level

When exploring factors that worsened mental health, it was found that survivors internalised the blame reflected by family, friends, and overall society and this resulted in feelings of shame and guilt, both of which negatively impacted their self-esteem. Moreover, not only did incidents of sexual assault trigger self-blame, but it also caused the survivors to internalise this blame due to rape misconceptions. This finding is supported by a study that explored the relation between stigma and sexual assault survivors' severity of trauma symptoms. Deitz et al. (2015) discovered that that rape myths alone did not result in the worsening of trauma symptoms. Rather, experiences of trauma symptoms worsened when survivors internalised the stigma by believing the rape myths.

While many participants internalised shame and guilt, there were other survivors who experienced empowerment and healing following counselling, which strengthened their well-being. This was suggested to be facilitated through four factors. Firstly, it was found that counselling enabled a safe space, helped survivors restructure their life and normalised the feelings they experienced. In doing so, survivors were able to forgive themselves, which led to prevention of self-blame. Secondly, the recovery process was improved when survivors took ownership of their recovery by choosing to practice healthier coping mechanisms. Thirdly, survivors expressed that seeking justice and talking about their experience improve recovery. Finally, survivors accepting that their sexual assault occurred enabled their healing because this prevented denial and engaging in unhealthy coping mechanisms.

These four factors and the impact they have on the recovery process is supported by literature that investigated the coping mechanisms amongst sexual assault survivors and the impact this had on their psychological well-being. Walker-Williams et al. (2013) discovered that the knowledge and awareness gained through therapy assisted survivors to rebuild their lives. Furthermore, overcoming their experience of sexual assault was largely due to taking ownership of it. Similar to the fourth factor mentioned above, honing existing coping skills to be more positive was a productive way to gain a sense of self-efficacy and confidence.

The factors discussed above, particularly those which improve or worsen mental health, resilience, and recovery are summarised in the table below:

Table 6: Factors Worsening or Improving Mental Health, Resilience and Recovery

ECOLOGICAL LEVEL	WORSEN	IMPROVE
INDIVIDUAL LEVEL	Biological Factors: • High or low sex drive • Inconsistent eating patterns • Irregular sleeping patterns Psychological Factors: • Repression and dysregulation of emotions • Fear and distrust of men • Remembering the event Sociological Factors: • Employment status • Socio-economic status • Fear of external judgement when disclosing • Fear of being a burden on loved ones.	Biological Factors: • Exercise Psychological Factors: • Creative expression • Normalising emotions Sociological Factors: • Social support • Financial stability
ASSAULT LEVEL	• Weapon use and death threats • Worsened reactions to trauma	
MICROSYSTEM	• Negative reactions to social reactions to disclosure, such as disbelieving the survivor and enforcing silence about the sexual assault. • Lack of social support in being open about rape through inappropriate remarks and change in relationships.	• Positive social reactions from family through protection, encouragement, and support.
MESOSYSTEM	• Insensitive and victim-blaming interactions with legal and healthcare professions • Poor case management, confidentiality issues, and lack of privacy when disclosing	• Individual and group therapy accessed through NGO-based sexual assault centres. • Hearing stories about other survivor's experiences
MACROSYSTEM	• Misconceptions about rape • Families can be ignorant about rape, and this may influence whether rape	• Raising awareness through education, specifically with boys, men, the rape survivors themselves.

	- is acknowledged - Maternal history of rape where mothers cannot assist their daughters due to not coping with their own experiences of rape.	
CHRONOSYSTEM	- Repetitive rape has a negative impact on self-worth and recovery - Repetitive rape may trigger mental illness and worsen recovery attempts - One rape incident that acts as catalyst	
SELF-BLAME	- Internalised blame from family and friends, leading to feeling of shame and guilt - Internalised stigma from rape myths - Healthy coping mechanisms enabled women to cope with feelings of shame and guilt while unhealthy coping mechanisms exacerbate shame and guilt.	- Counselling - Taking ownership of recovery - Seeking justice - Accepting that the sexual assault incident occurred and beginning recovery

5.3 Interactions with Self-Blame Factors on the Ecological Model

The third theme of this discussion explores how different factors on the ecological model interact with the self-blame level to impact female survivors' mental health. The self-blame level as a multi-level meta-construct was put forward by Campbell et al. (2009) who suggested that every ecological level shapes factors on the self-blame level. This study found interactions between self-blame level and other levels, which will now be discussed.

On the individual level, interactions between self-blame and mental health were highlighted. As a result of blaming themselves, survivors' mental health worsened and this led to engaging in unhealthy coping mechanisms, such as substance abuse. Additionally, it was found that survivors who disclosed their assault felt like a burden on their loved ones and this triggered feelings of insecurity and guilt. In a similar way, survivors' mental health also improved when engaging in healthy coping mechanisms in that feelings of shame and guilt disappeared when engaging in activities or exercise. Furthermore, a positive interaction between self-blame and counselling strategies can be found on the individual level where HCWs who normalised survivors' feelings during counselling sessions helped improve the self-esteem of survivors.

On the microsystem level, interactions with the self-blame level were evident because survivors' experienced feelings of shame and guilt that resulted from negative interactions with family, friends, and partners. Negative interactions included inappropriate comments or changes in personal relationships, specifically when survivors disclose their rape experiences. Findings suggested that

survivors internalised these responses and interactions and reflected it onto themselves, feeling shame and blame.

On the mesosystem level, victim-blaming and secondary victimisation from legal and healthcare professionals resulted in survivors internalising this blame. Differing to this on the same level, group and individual therapy accessed through the rape centre was found to counteract self-blame due to the empowerment mechanisms that therapy offers to survivors. For example, some survivors found other survivors' experiences insightful and helpful for their recovery. Through other survivors sharing their personal stories about rape, this may raise awareness and improve recovery because victims, who have not sought help, may recognise that they were sexually assaulted and possibly seek assistance. Additionally, by sharing stories, this would prevent other survivors feeling alone and isolated, and instead help them feel understood.

On the macrosystem level, self-blame was emphasised in how survivors internalised myths about their rape and the contribution this had to self-blame and feelings of shame. For example, a survivor may blame themselves for wearing the clothing they wore prior to being sexually assaulted. Through blaming themselves, they are internalising the misconception that sexual assault happens based on clothing. Contrary to this, prevention of self-blame was also highlighted on this level. It was demonstrated that counselling enabled a space where survivors' feelings were normalised. By counsellors normalising and validating feelings, this enabled the survivor to forgive themselves and avoid self-blame.

Regarding the interaction between the chronosystem and the self-blame levels, acts of rape that occurred repeatedly throughout a survivor's life seemed to have a major contribution to internalised blame and feelings of worthlessness.

5.4 Study Limitations

This research was not without limitations. One limitation was that the sample size was small. There were two main reasons for this. Firstly, many of the women at the rape crisis did not fit the inclusion criteria and secondly, the centres at which this research was conducted had few clients attending the service for the researcher to approach. Due to time constraints, the researcher was unable to approach other centres. Due to a small sample size, the generalisability to other contexts outside of the Western Cape, or South Africa, is limited.

The second limitation is related to the findings on the assault level. The assault level explored factors linked to the characteristics of the sexual assault incident. The findings within this category were limited and this was due to two reasons. Firstly, many of the survivor participants seemed to feel

uncomfortable when detailing the specifics about their assault with the researcher. Secondly, the questions were not structured to question or probe the survivor on the specific details due to the extreme sensitivity of the topic. Despite this limitation, the researcher was able to gain useful information despite interviewing a population that would naturally be sensitive.

The third limitation is that the sample was specific to only female survivors and HCWs. It would have been beneficial to the study if friends, family, and other service providers were interviewed as this would have directly informed the microsystem and mesosystem levels. Despite these limitations, the study offers further understanding into the factors that improve or worsen sexual assault survivor's process of recovery and their well-being.

CHAPTER SIX: RECOMMENDATIONS AND CONCLUSION

This qualitative study aimed to explore how factors on the ecological model contribute to mental ill-health, resilience, and recovery in female sexual assault survivors. It had three objectives: 1) to explore female survivors' subjective experiences of mental health related to their sexual assault incident, 2) to explore how factors on the ecological model improve or worsen female survivors' mental health, and 3) to explore how factors on the self-blame level of the ecological model interact with other levels to impact female survivors' mental health. This final chapter will discuss the recommendations and conclusions drawn from the research based on these three objectives as well as the findings.

6.1 Recommendations

The following recommendations for improving recovery are suggested based on the research findings.

6.1.1 Treatment to Improve Chances of Recovery

This study highlighted several elements that can be incorporated into existing psychological treatment for survivors. These may be useful to strengthen the chances of recovery amongst survivors.

Results reflected that survivors are impacted by social interactions with family, friends, or partners, especially if these interactions are negative. Additionally, it was demonstrated that positive interactions contribute to the well-being of the survivor. Therefore, it is recommended that families, friends, or partners of survivors should be involved in the recovery process to strengthen the chances of positive interactions. This can be facilitated through education about survivor support and crisis response as well as through participation in family-based group therapy.

The findings also emphasised individual level factors that contribute to increasing chances of recovery. These factors, particularly those reflecting as biopsychosocial principles, should be incorporated into recovery treatment interventions. For example, findings highlighted creative expression as a factor that improves the process of recovery. Therefore, it is recommended that therapy interventions should involve creative expression, such as journaling or art. Further to this, interventions should also ensure to address issues of self-blame and shame through self-expression or talk therapy. It is particularly important that interventions include elements that are group-based. This is because findings emphasised the validation features of group therapy which may lessen the effect of self-blame due to other survivors discussing similar feelings of shame.

6.1.2 Interventions

This study emphasised suggestions for interventions that should aim at specifically preventing sexual assault. Firstly, rape myths impact the survivor, and therefore it is recommended that awareness is raised to address rape myths and stigma. This can be done by developing prevention programmes that focus on de-stigmatising sexual assault survivors, introducing concepts of consent and improving ways to assist survivors. These programmes should be facilitated by NGOs and schools and target an audience of men and boys.

Additionally, many survivor participants experienced insensitive and victim-blaming interactions with legal and healthcare professionals, despite the fact that policies, like the VEP, exist to prevent secondary victimisation in South Africa. Findings also highlighted survivor experience of poor case management, confidentiality issues and lack of privacy amongst professionals and services. Due to these two major problems in legal and healthcare settings, it is recommended that VEP guidelines should be reviewed to understand where gaps in management of victims exist, especially in areas of secondary victimisation, victim-blaming, case management, and responding to crisis. Thereafter, training programmes with legal and healthcare professionals should be developed that incorporate these gaps so that management of victims can be improved.

6.1.3 Further Research

Due to the limited data that was available from this study on the assault level, further research should be conducted to explore factors on this level. This research should be focused on the impact that weapon use has on the development of mental illness amongst sexual assault survivors as this was a prominent theme that emerged during this study. Further research should also be conducted on the self-blame level and its interaction with the other levels on the ecological model. This would be especially useful in understanding how to incorporate prevention of self-blame into therapeutic interventions. Additionally, similar research should be conducted to understand how self-blame relates to rape myths and victim-blaming.

6.2 Conclusion

Sexual assault is highly prevalent in South Africa and has a detrimental impact on the mental well-being of survivors. Along with mental ill-health, the recovery process of sexual assault survivors is also affected by challenges within legal and healthcare services. Additionally, other sociological aspects such as personal relationships, secondary victimisation, and misconceptions about rape, are experienced alongside service challenges. These issues demonstrate a need to explore survivors' perspectives to understand what factors increase their chances of resilience and recovery.

This study aimed to use Campbell et al.'s (2009) ecological model to understand how factors contribute to mental ill-health, resilience, and recovery in female sexual assault survivors. In understanding this, conclusions were drawn about the factors that improve or worsen the resilience and recovery of sexual assault survivors. Findings revealed that survivors experienced a range of mental health problems, such as depression, anxiety, panic attacks, and dissociation. They also used various healthy and unhealthy coping mechanisms to manage these problems, such as exercise and creative expression or substance use and denial of emotions. Aligning with the second objective that explored how factors on the ecological model improve or worsen female survivors' mental health, the various levels demonstrated both positive and negative factors that impact mental well-being, recovery, and resilience. The most prominent factors that positively impacted recovery and well-being included healthy coping mechanisms, therapy, hearing other survivors' experiences as well as positive social interactions with family, friends, and partners. Furthermore, findings highlighted the importance of demystifying rape myths and raising awareness through education. Differing to this, negative factors, such as lack of social support, negative social interactions with professionals as well as internalised stigma and blame, play a role in worsening survivors' mental health. Moreover, other negative factors, such as misconceptions about rape, ignorance about rape in families, weapon use, repetitive rape and maternal history of rape contributed to hindering the process of recovery.

Drawing from the factors explored in this study, recommendations were made on ways to strengthen the recovery process and therefore increase the well-being of survivors. These recommendations included strengthening psychological treatment for survivors, developing educational and training programmes, and conducting further research. This study was significant because it enabled survivors to share their perspectives on what ecological factors increased their risk to mental ill-health or improved their resilience and chances of recovery. It is vital that survivors' perspectives are heard so that ecologically relevant interventions are developed on individual, familial, and societal levels.

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APPENDIX A: RESEARCH REQUEST LETTER

[Date]

[Name of Centre]

Dear Sir/Madam/Name of contact person,

RE: Request for Permission to Conduct Research at [Name of Centre]

We are conducting a qualitative study that aims to explore the factors that improve and worsen the mental health, resilience, and recovery of female survivors of sexual assault. The research forms part of Lucca Munnik's MPhil in Public Mental Health which she is completing through the Alan J. Flisher Centre for Public Mental Health (CPMH) at the University of Cape Town. She is supervised by Dr Thandi Davies from CPMH and Dr Petal Petersen Williams from the South African Medical Research Council.

We are hereby seeking your consent to conduct research at [centre name]. The data collection methods include interviewing seven women who are using your centre. In addition, up to four healthcare workers at your centre will be kindly asked to attend one focus group.

Please note that no personal information is required from the participants for this research and all information gained from this study will be strictly confidential. The participant's identity as well as details about the centre will be kept confidential and contact details will be handled by the researcher and not disclosed to anyone else. All interview and focus group transcripts will be marked with a pseudonym that cannot be linked to the participants. Names or contact details will not appear in any report or publication. In addition, anonymity of [centre name] will be ensured through de-identification. In other words, the name of the centre will not appear in any of the transcripts or findings and results.

If you require any further information on this research, please contact Lucca Munnik at mnnluc002@myuct.ac.za or Dr Thandi Davies at thandi.davies@uct.ac.za.

Kind regards,

Lucca Munnik

APPENDIX B: SURVIVORS INFORMATION SHEET

We are conducting a qualitative research study that aims to explore the mental health experiences of female sexual assault survivors. The research forms part of Lucca Munnik's MPhil in Public Mental Health which she is completing through the Alan J Flisher Centre for Public Mental Health (CPMH) at the University of Cape Town. She is supervised by Dr Thandi Davies from CPMH and Dr Petal Petersen Williams from the South African Medical Research Council.

We would like to invite you to be part of the study. There are two parts to this study. For part 1 of the study, we kindly ask you to complete a questionnaire that will focus on your mental health. Depending on the results of this study, you may be invited to the part 2 of the study. Part 2 involves a 60-minutes audio recorded interview based on a schedule of question that will help us gain more insight into your experience of sexual assault and mental health.

No personal information is required for this research and all information gained from this study will be strictly confidential. Your identity will be kept confidential, and your contact details will be handled by the researcher and not disclosed to anyone else. All interview and focus group transcripts will be marked with a pseudonym that cannot be linked to you. Names or contact details will not appear in any report or publication. Your participation is completely voluntary, and you may withdraw at any time without giving any reason.

If you require any further information on this research, please contact Ms Lucca Munnik at mnnluc002@myuct.ac.za or Dr Thandi Davies at thandi.davies@uct.ac.za.

APPENDIX C: SCREENING TOOL INFORMED CONSENT

Title: Risk and Resilience: Exploring the Ecological Factors that Impact the Recovery of Sexual Assault Survivors at Two Centres in the Western Cape

Researcher: Lucca Munnik

Introduction

This consent form is to ensure agreement that you are partaking in a screening tool assessment as part of a study that aims explore your experiences of mental health and sexual assault. This research is being undertaken because it forms part of Lucca Munnik's Master of Philosophy degree in Public Mental Health. Before you agree to take part, it is important that you understand what it involves. This consent form is to help you decide if you want to take part in this study. Please feel free to ask if you have any questions. You should not agree to this request unless you understand and agree to all that is involved.

Expectations

If you agree to take part in this screening tool, you will be asked questions about your mental health. The screening tool should take up to 15 minutes to complete. Based on the results of the screening tool, you may be asked to take part in a one-hour interview. If you agree to take part in an interview, you will be asked questions about your experiences of sexual assault and mental health. We will also need your permission as to whether we can audio-record your interview.

Potential Risks and Discomforts

We do not expect that the research will expose you to any risks. If any of the questions make you feel uncomfortable, you do not have to answer that question. You can also stop at any time. If you feel distressed, please let the researcher know and she will refer you to a mental healthcare worker.

Potential Benefits of Taking Part in the Study

There are no direct benefits to you for taking part in this study.

Confidentiality and Privacy

Any information of yours will remain confidential and your identity will remain anonymous. The researchers will not share the information with anyone unless you are going to hurt yourself, hurt someone else or you are involved in the neglect or abuse of a child. Legally, the researchers must report this.

Anyone who is working with any of the information you share must sign an agreement not to share the answers you wrote on the screening tool. Your responses on the screening tool will be checked to see if you should be invited for an interview. After they have been checked, they will be stored in a password-protected file on the researcher's laptop. The only confidential information will be on the consent forms, which will be stored separately from the interview data in locked filing cabinets. These consent forms will be destroyed after five years of completion of these activities. We will use the information you provide to write up a dissertation and publish a paper in an academic journal. Your name will not appear anywhere in any published material.

Participation and Withdrawal

Participation is voluntary. You can choose not to participate in this screening tool assessment. If you decide to participate, you may choose to stop your participation at any time. There will be no consequences. You may also refuse to answer any questions that you do not want to answer.

Reimbursement

There will be no reimbursement for your participation in this screening tool.

Rights of Participants

This study has been approved by the University of Cape Town Faculty of Health Science Human Research Ethics Committee (HREC). If you have any questions about your rights as a participant, concerns or complaints, please call the chairperson of the UCT ethics committee on 021 650 1236 or via email at hrec-enquiries@uct.ac.za.

Point of Contact

If you have any questions or concerns about the research, please contact the principal investigator of the study, Dr Thandi Davies (thandi.davies@uct.ac.za) or Lucca Munnik (mnnluc002@myuct.ac.za).

Indicating Consent

Please initial next to each item to show that you agree to what is required (leave blank if you do not agree):

Initials	Expectations
	I agree to take part in the study, which has been fully described to me. I will answer questions today.
	I understand that my participation in this screening tool assessment is completely voluntary, and there will be no penalty if I choose not to participate.

Signing this consent form indicates that you have read this consent form (or have had it read to you), that your questions have been answered to your satisfaction, and that you _____ (full name) voluntarily agree to participate in this research study.

Signature and Printed Name

Date

Person Obtaining Consent (Signature and Printed Name)

Date

APPENDIX D: K-10 SCREENING TOOL

KESSLER PSYCHOLOGICAL SCALE (K10)

This questionnaire will ask questions on your mental health. Please tick the answer that is most relatable you.

Name:	All of the time (score 5)	Most of the time (score 4)	Some of the time (score 3)	A little of the time (score 2)	None of the time (score 1)
1. In the past 4 weeks, about how often did you feel tired out for no good reason?					
2. In the past 4 weeks, about how often did you feel nervous?					
3. In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?					
4. In the past 4 weeks, about how often did you feel hopeless?					
5. In the past 4 weeks, about how often did you feel restless or fidgety?					
6. In the past 4 weeks, about how often did you feel so restless you could not sit still?					
7. In the past 4 weeks, about how often did you feel depressed?					
8. In the past 4 weeks, about how often did you feel that everything was an effort?					
9. In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?					
10. In the past 4 weeks, about how often did you feel worthless?					

Thank you for answering this questionnaire! If you require any further information on this research, please contact Lucca Munnik at mnnluc002@myuct.ac.za or Dr Thandi Davies at thandi.davies@uct.ac.za.

PARTICIPANTS NEEDED

The purpose of this research study is to explore the factors that improve and worsen the mental health, resilience, and recovery of female survivors of sexual assault.

To participate in this research, you must:

- Be older than 18 and female.
- A healthcare worker at a sexual assault centre.
- Have worked at the centre for longer than a month.

Participation in this study involves:

- Attending one focus group with three other healthcare workers.
- Give consent to participate.
- Give consent to be audio-recorded.

If you would like to participate, please contact Lucca Munnik (researcher):

078 728 3749

MNNLUC002@myuct.ac.za



APPENDIX F: SURVIVORS INTERVIEW CONSENT FORM

Title: Risk and Resilience: Exploring the Ecological Factors that Impact the Recovery of Sexual Assault Survivors at Two Centres in the Western Cape

Researcher: Lucca Munnik

Introduction

This consent form is to ensure agreement that you are partaking in an interview as part of a study that aims to explore the factors that improve and worsen the mental health and recovery of female survivors of sexual assault. This research is being undertaken because it forms part of Lucca Munnik's Master of Philosophy degree in Public Mental Health. Before you agree to take part, it is important that you understand what it involves. This consent form is to help you decide if you want to take part in this study. Please feel free to ask if you have any questions. You should not agree to this request unless you understand and agree to all that is involved.

Expectations

If you agree to take part in an interview, you will be asked questions about your experiences of sexual assault and mental health. We are asking your permission to audio record these interviews so that we can transcribe them. The interview will last about an hour.

Potential Risks and Discomforts

We do not expect that the research will expose you to any risks. You will never be pressured to answer any of the questions. If any of the questions make you feel uncomfortable, you do not have to answer that question. You can also stop at any time. If you feel distressed, please let the researcher know and they will refer you to a mental healthcare worker.

Potential Benefits of Taking Part in the Study

There are no direct benefits to you for taking part in this study.

Confidentiality and Privacy

Any information of yours will remain confidential and your identity will remain anonymous. You may choose a pseudonym (fake name) that can be used for the duration of the interview. The researcher will not share the information with anyone unless you are going to hurt yourself, hurt someone else or you are involved in the neglect or abuse of a child. Legally, the researcher must report this.

Anyone who is working with any of the information you share must sign an agreement to not share what you say during the interview. Discussions will be audio recorded, transcribed, and checked. After

they have been checked, they will be stored in a password-protected file on the researcher's laptop. We will ensure that only a pseudonym will be used for the audio recordings and transcripts. These audio recordings will then be deleted once the transcripts have been completed and checked. The transcripts will be destroyed after five years of completion of these interviews. The only confidential information will be on the consent forms, which will be stored separately from the interview data in locked filing cabinets. These consent forms will be destroyed after five years of completion of these activities. The University of Cape Town's ethics committee will have access to all data. We will use the information you provide to write up a dissertation and publish papers in academic journals. Your name will not appear anywhere in any published material.

Participation and Withdrawal

Participation is voluntary. You can choose not to participate in this interview. If you decide to participate, you may choose to stop your participation at any time. There will be no consequences. You may also refuse to answer any questions that you do not want to answer.

Reimbursement

We will give you a food voucher to the value of R100 to thank you for your participation in this interview today.

Rights of Participants

This study has been approved by the University of Cape Town Faculty of Health Science Human Research Ethics Committee (HREC). If you have any questions about your rights as a participant, concerns or complaints, please contact the UCT ethics committee on 021 650 1236 or via email at hrec-enquiries@uct.ac.za.

Point of Contact

If you have any questions or concerns about the research, please contact the principal investigator of the study, Dr Thandi Davies (thandi.davies@uct.ac.za) or Lucca Munnik (mnnluc002@myuct.ac.za).

Indicating Consent

Please initial next to each item to show that you agree to what is required:

Initials	Expectations
	I agree to take part in the study which has been fully described to me. I will answer questions today.
	I understand that my participation in this interview is completely voluntary, and there will be no penalty if I choose not to participate.

Please also provide initials to show whether you agree to this interview being audio recorded (leave blank if you disagree):

Initials	Expectations
	I agree to the interview being audio recorded.

Signing this consent form indicates that you have read this consent form (or have had it read to you), that your questions have been answered to your satisfaction, and that you _____ (full name) voluntarily agree to participate in this research study.

Signature and Printed Name

Date

Person Obtaining Consent (Signature and Printed Name)

Date

APPENDIX G: SURVIVORS INTERVIEW GUIDE

COMPREHENSION OF INFORMATION

- What is the purpose of my research?
- What do you think is going to happen during this interview?

INTRODUCTION

1. Can you tell me why you attend this service?
 - **Probe:**
 - If comfortable, can you please explain what happened?
 - Was the perpetrator someone you knew?
 - How did you feel after the event?

INDIVIDUAL FACTORS

a. Mental Health

2. Have you been diagnosed with a mental illness?
 - **Probe:** Were you diagnosed before or after your incident of assault?
3. Has your experience of sexual assault had any impact on your physical well-being? Examples of impact include: insomnia, feeling irritable or heart pounding when reminded of the event?
 - **Probe:** What things do you do that help you cope with this physical impact?
4. Has your assault incident had any impact on your emotional health. Examples of impact include: reliving the experience or losing interest in previously enjoyed activities?
 - **Probe:** What things do you do that help you cope with this emotional impact?

b. Coping

5. Can you think of a few other things that help you cope with your experience of sexual assault?
 - **Probe:** Do you still engage in these actions?

MICROSYSTEM

6. Have you ever discussed your sexual assault with family or friends?
 - **Probe:** How did they respond?
 - **Probe:** What are some things they said to you?
 - **Probe:** How did this make you feel?
7. Can you explain the type of support you received from family or friends?
8. Did the experience of sexual assault change your relationship with people? If so, in what way?
9. What do you find would benefit your recovery regarding the social aspects of your life?

MESOSYSTEM

a. Legal System

10. Did you seek any legal assistance after your incident of assault?

- **Probe:** If so, please tell me more about your experience.

b. Did you report your sexual assault to the police?

- **Probe:** If so, please tell me more about your experience.
- **Probe:** Please describe the way the police officers treated you?

c. Medical System

11. Have you received any assistance from other healthcare facilities?

- **Probe:** Did you find it helpful or unhelpful to your recovery? Why?
- **Probe:** Please describe how they treated you?

12. Have you received any mental health treatment? If so, what did or does this entail?

- **Probe:** Medication, therapy, counselling?
- **Probe:** What parts of the treatment do you find help you recover from your experience of sexual assault?

13. What previous assistance have you received that you found benefited your recovery?

14. What type of assistance would you like in the future for your recovery?

MACROSYSTEM

15. What have you heard about rape through people you know or media you watch and read?

16. How did being exposed to these comments about rape make you feel?

17. Do you agree with what have people have told you?

- **Probe:** What do you believe about rape?

18. Has anyone you know made any comments about your incident of sexual assault? Please give examples.

CHRONOSYSTEM

19. Can you explain any other time where you experienced unwanted sexual contact or sexual assault as a child or adult?

20. If yes, did multiple events of sexual assault effect your recovery process?

- **Probe:** How did this effect your well-being and recovery?

DEBRIEFING PHASE

21. We have come to the end of our interview: I just want to check in with you about how you are feeling now after speaking about these things.

22. Is there anything else you would like to chat about or ask me before we end?

APPENDIX H: HEALTHCARE WORKER FOCUS GROUP CONSENT FORM

Title: Risk and Resilience: Exploring the Ecological Factors that Impact the Recovery of Sexual Assault Survivors at Two Centres in the Western Cape

Researcher: Lucca Munnik

Introduction

This consent form is to ensure agreement that you are partaking in a focus group as part of a study that aims to explore the factors that improve and worsen the mental health and recovery of female survivors of sexual assault. This research is being undertaken because it forms part of Lucca Munnik's Master of Philosophy degree in Public Mental Health. Before you agree to take part, it is important that you understand what it involves. This consent form is to help you decide if you want to take part in this study. Please feel free to ask if you have any questions. You should not agree to this request unless you understand and agree to all that is involved.

Expectations

If you agree to take part in a focus group, you will be asked questions about your experiences of sexual assault and mental health at the centre that you work in. We are asking your permission to audio-record these FGDs so that we can transcribe them. The focus group will last about an hour.

Potential Risks and Discomforts

We do not expect that the research will expose you to any risks. You will never be pressured to answer any of the questions. If any of the questions make you feel uncomfortable, you do not have to answer that question. You can also stop at any time. If you feel distressed, please let the researcher know and she will refer you to a mental healthcare worker.

Potential Benefits of Taking Part in the Study

There are no direct benefits to you for taking part in this study.

Confidentiality and Privacy

Any information of yours will remain confidential and your identity will remain anonymous. You may choose a pseudonym (fake name) that can be used for the duration of the focus group. The researcher will not share the information with anyone unless you are going to hurt yourself, hurt someone else or you are involved in the neglect or abuse of a child. Legally, the researcher must report this.

Anyone who is working with any of the information you share must sign an agreement to not share what you say during the focus group. Discussions will be audio recorded, transcribed, and checked. After they have been checked, they will be stored in a password-protected file on the researcher's laptop. We will ensure that only a pseudonym will be used for the audio recordings and transcripts. These audio recordings will then be deleted once the transcripts have been completed and checked. The transcripts will be destroyed after five years of completion of these FGDs. The only confidential information will be on the consent forms, which will be stored separately from the focus group data in locked filing cabinets. These consent forms will be destroyed after five years of completion of these activities. The University of Cape Town's ethics committee will have access to all the data. We will use the information you provide to write up a dissertation and publish papers in academic journals. Your name will not appear anywhere in any published material.

Participation and Withdrawal

Participation is voluntary. You can choose not to participate in this focus group. If you decide to participate, you may choose to stop your participation at any time. There will be no consequences. You may also refuse to answer any questions that you do not want to answer.

Reimbursement

We will give you a food voucher to the value of R100 to thank you for your participation in this focus group today.

Rights of Participants

This study has been approved by the University of Cape Town (UCT) Faculty of Health Science Human Research Ethics Committee (HREC). If you have any questions about your rights as a participant, concerns, or complaints, please contact the UCT ethics committee on 021 650 1236 or via email at hrec-enquiries@uct.ac.za.

Point of Contact

If you have any questions or concerns about the research, please contact the principal investigator of the study, Dr Thandi Davies (thandi.davies@uct.ac.za) or Lucca Munnik (mnnluc002@myuct.ac.za).

Indicating Consent

Please initial next to each item to show that you agree to what is required:

Initials	Expectations
	I agree to take part in the study, which has been fully described to me. I will answer questions today.

	I understand that my participation in this focus group is completely voluntary, and there will be no penalty if I choose not to participate.
--	--

Please also provide initials to show whether you agree to this focus group being audio recorded (leave blank if you disagree):

Initials	Expectations
	I agree to the focus group being audio recorded

Signing this consent form indicates that you have read this consent form (or have had it read to you), that your questions have been answered to your satisfaction, and that you _____ (full name) voluntarily agree to participate in this research study.

Signature and Printed Name

Date

Person Obtaining Consent (Signature and Printed Name)

Date

APPENDIX I: HEALTHCARE WORKER FOCUS GROUP GUIDE

Welcome everyone and thank you all for agreeing to participate in this focus group discussion. Today, we will be discussing your views on what makes it easier or more difficult for women who experience sexual assault to recover. Before I begin, I want to point out that when I ask the questions, there is no right or wrong answer. In fact, your personal experience with the survivors is important. If you could share these experiences as examples, that would be helpful.

As mentioned in the consent form, the focus group will be recorded so that I can remember the discussion later. Our discussion will be treated confidentially, and your name will not be attached to any comments you make. Are there any questions before we start the interview?

ECOLOGICAL MODEL

a. Individual Factors

1. What are your thoughts about the socio-demographics of survivors and how this might affect their well-being? In other words, does age, marriage status or employment impact the way they may cope with their experience?
 - **Probe:** Why?
2. When working with these women, what common coping mechanisms do they adopt?
 - **Probe:** Are these coping mechanisms helpful or unhelpful?
 - **Probe:** Why?
3. What assistance do you think survivors need in order to recovery and improve their well-being in all aspects of their lives? Aspects refer to biological, psychological, and social realms.
4. When working with survivors, what type of assistance benefited their recovery?

b. Microsystem

5. From your experience, how do friends, family, and peers normally respond to the survivors of sexual assault?
 - **If positive response, probe:** In what ways does this social support benefit the well-being of survivors?
 - **If negative response, probe:** How does it hinder the well-being of survivors?

c. Mesosystem

6. *Secondary victimisation* refers to the behaviours and attitudes of providers that are victim-blaming and insensitive, and that can worsen the trauma of the victim. Have you heard any stories that the survivors have told that involved them facing secondary victimisation from any legal agencies or medical systems?

d. Macrosystem

7. In what ways does culture and societal beliefs impact the well-being of survivors? Please provide examples from your clients.
8. Have you found that survivors often internalise stigma of rape? Please provide examples from your clients.

ASSAULT AND CHRONOSYSTEM

9. How do the characteristics of the sexual assault (i.e., severity, type of weapon used, if a weapon was used, number of perpetrators) impact the survivor's reactions to the assault after it has happened? For example, if a weapon was used during assault, did this increase the survivor's likelihood of anxiety?
10. What influence do the characteristics of the sexual assault have on the survivor developing resilience?
 - **Probe:** Which characteristics make them less likely to develop resilience?
11. As healthcare workers, you probably know *revictimisation*. For those of you who don't, this refers to when an individual has experienced sexual assault multiple times. This includes sexual assault experienced during childhood. How does revictimisation impact the survivor's well-being?
12. What impact does multiple rape experiences across a survivor's lifespan have on their ability to recover? For example, do child sexual assault survivors who have been raped as adults have difficulty recovering?

DEBRIEFING

Thank you for your time and for sharing your thoughts on the subject of this research. I will arrange a feedback session where I will give summary of my findings once the research is complete. Are there any questions about this focus group? Please feel free to contact me via email should you have any later on. My details are on the information sheet.