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**Childhood sexual abuse and HIV positive status among South African women:
The role of revictimization**

By

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GRGMEG001

A minor dissertation submitted in partial fulfillment of the requirements for the award of
a degree of Master of Social Science in Clinical Psychology

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DECLARATION

This work has not been previously submitted in whole, or in part, for an award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the works, of other people has been attributed, and has been cited and referenced.

Signature:

Signed by candidate

 Date; 23/06/06

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ABSTRACT

South Africa has a very high rate of HIV infection, particularly among women. This exploratory study investigated the role of revictimization in the relationship between childhood sexual abuse and adult HIV positive status among women being treated at district clinics in Cape Town. The present study utilized both psychological and feminist theories to understand internal psychological dynamics and contextual factors that impact on revictimization leading to increased HIV risk. A qualitative feminist methodology with a collective case study design utilizing five in-depth interviews was conducted with HIV positive women who had experienced child sexual abuse. The central findings of the study revealed psychological patterns of negative stigmatization, self-blame, mistrust and isolation which may fuel a dependent need for connection with intimate partners, thereby increasing risk for revictimization. Revictimization was pervasively present in adulthood, with HIV infection being a consequence of ongoing sexual and/or physical assault in long-term intimate relationship. Participants reported not using condoms consistently. For these participants, an incapacity to insist on condom use by partners was understood in the context of ongoing sexual and physical violence and threats by their partners, rather than unassertiveness as has been commonly noted. In essence, it was noted in this study that participants who experienced child sexual abuse were disempowered due to both psychological processes and broader social inequities which made them particularly vulnerable to contracting HIV. However, the findings are provisional due to the methodology utilized. Recommendations for future research and HIV prevention and policy are offered.

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1.1 INTRODUCTION

The human immunodeficiency virus (HIV) is an incurable disease that has posed considerable challenges to both the medical and behavioural sciences. It has led to enormous amounts of research in an attempt to expand, shift and accommodate new understandings (Strebel & Lindegger, 1998). Over the past decade, the previously silent epidemic of HIV in South Africa has become highly visible (Schneider & Stein, 2001). South Africa has a high rate of HIV infection. In a 2004 study by the South African Department of Health, based on 16, 000 women attending antenatal clinics, it was estimated that 29.5% of pregnant women were living with HIV in 2004. The South African National HIV survey in 2005, based on a sample of 12,581 households across South Africa, estimated that 10.8% of all South Africans over the age of 2 years were living with HIV. The highest rate of HIV was found to be between the ages of 15 and 49 years. HIV was most prevalent among women between the ages of 25 and 29 years, and among men between the ages of 30-39 years (Berry, 2005).

There are multiple factors that contribute to the high rate of HIV infection in South Africa. These include behavioural factors, such as unprotected sexual intercourse and multiple sexual partners, and biological factors, such as sexually transmitted infections (Allen, Simelela & Makubalo, 2000; Dolcini et al., 1993; Gisselquist, Potterat, Brody & Vachon, 2003). Underlying determinants include socio-economic factors such as poverty, inequality between men and women, poor education, stigmatization and discrimination (Berry, 2005; Kim & Watts, 2005). It has been shown in research that women's risk of contracting HIV is highest in informal urban settlements, or townships, where economic impoverishment, co-occurring sexually transmitted infections (STI's) and genital ulcer diseases facilitate HIV transmission (Shisana & Simbayi, 2002, cited in Kalichman & Simbayi, 2004). Most HIV positive women are infected through heterosexual sex, in which they are physically more susceptible than men (Berry, 2005).

Social inequities and culturally sanctioned gender roles in South Africa mean that women have less power to protect themselves in sexual relationships, for example by negotiating condom usage (Berry, 2005). Gender based violence is a significant contributor, for example, women who are involved in the sex trade are among the women that have the least relationship power and the highest possibly for violence, sexual assault and HIV infection (Jewkes & Abrahams, 2002, cited in Kalichman & Simbayi, 2004). A study completed in Soweto found that 50.4% of women experienced intimate partner violence, which increases HIV risk (Dunkle et al., 2004). Further, many men in South Africa believe that HIV can be cured by sleeping with a virgin (Berry, 2005). According to Kalichman and Simbayi (2004), 53, 008 rapes were reported to police in South Africa in 2000. According to the 2002 crime statistics of the South African Police Services (SAPS), it was estimated that 15% of rape survivors were younger than 12 and 41% of rape survivors were under the age of 18 years. These statistics however, do not adequately reflect the extent of the problem because this crime is largely underreported. All these issues increase women's vulnerability to contracting HIV.

Gupta (2000) indicates that there has been a definite shift in the public and political rhetoric as it now acknowledges and reflects the gendered nature of HIV. While this rhetoric of gender rights is embedded in political discourse, in laws and in constitutional rights in South Africa, women still remain disempowered in many spheres, including the negotiation of sexual rights in heterosexual relationships (Gupta, 2000; Kalichman & Simbayi, 2004; Kim & Watts, 2005). These power imbalances impact on women's access to and use of services, and also often mean that women carry the painful experiences of coping with the stigma and the discrimination associated with HIV infection (Gupta, 2000). Gupta (2000) also indicates that HIV positive women bear a double burden in that they are women and infected with HIV.

The South African HIV prevention strategy has various foci, such as life skills for youth, popularizing information about HIV in mass media, appropriate access to treatment, and access to condoms. Specific emphasis has been placed on youth and women, who have been identified as the most vulnerable groupings in South Africa for HIV risk. Currently

the mass media strategy focuses on the prevention of infection and overcoming discrimination against HIV-infected individuals, and in essence encourages people to take control of negotiating sexual rights and condom usage in intimate relationships (Berry, 2005; Department of Health, 2006). However, the prevention message urging women to abstain, be faithful and use condoms often fails to reflect the reality of women's lives, particularly in the broader social context that contribute to HIV risk. Where women have low economic status and depend on their partners for support, abstaining from sex or using condoms may not be realistic options. Furthermore, the threat of physical or sexual violence may also impact on being able to use condoms. Although the focus on women is essential, it may be somewhat problematic as it does not account for women with specific vulnerabilities, like those disempowered through childhood sexual abuse. A history of childhood abuse (sexual and/or physical) can impact on a women's capacity to negotiate power in her adult relationships, particularly since child sexual abuse has deleterious impacts on internal psychological processes and dynamics which are compounded by broader social inequities.

Childhood sexual abuse is a pervasive problem in South Africa. Definitions of childhood sexual abuse, in terms of type of unwanted attention, can range from unwanted sexual touching or exposure to abusive sexual intercourse (Breitenbecher, 1999; Lalor, 2004). Childhood experiences of unwanted sexual touching are reported at rates from 5.2% (Madu, 2001 cited in Lalor, 2004) to 26.3% (Collings, 1997 cited in Lalor, 2004). These divergent reports are possibly related to the differing ways of operationalization of this type of sexual abuse; in this instance, touched sexually by force or unwanted genital fondling, respectively). Abusive sexual intercourse is estimated at 7.5% (Levett, 1989, cited in Lalor, 2004), 5.8% (Collings, 1997 cited in Lalor, 2004) and 4.5% (Madu, 2001 cited in Lalor, 2004). According to Jewkes (2004), there are over 20,000 cases of rape and attempted rape of children reported each year to police in South Africa¹.

¹ According to the South African National Policy Guidelines, a sexual offence against a child under the age of 12 constitutes rape and 12-15 years of age constitutes statutory rape.

Several studies have reported a relationship between early childhood sexual abuse and HIV vulnerability (Allers & Benjack, 1991; Arriola, Loudon, Doldren & Fortenberry, 2005; Chin, Wyatt, Carmona, Loeb & Myers, 2004; Mullings, Marquart & Brewer, 2000). Survivors of childhood sexual abuse are more likely to engage in high risk behaviours for HIV such as promiscuity and compulsive sexual behaviours, and drug and alcohol use. Survivors that are sexually compulsive (as a self-soothing mechanism) may be less assertive in terms of negotiating sexual rights and condom usage, and may exhibit sexual passivity (Centre for AIDS Prevention Studies, 2006). Sexual revictimization is also a long-term consequence of childhood sexual abuse. Whitmire, Harlow, Quina, Morokoff (1999) argue that women who have been physically and sexually abused as children are more likely to be revictimized in adult relationships. Similarly, Russell (1984, cited in Herman, 1992) indicates that, while all women are at risk for gender based violence, the chances are doubled when there is a history early abusive experience. The prevalence rate of sexual revictimization in adulthood can range from six to 68% (Wyatt, Guthrie & Notgrass, 1992). A recent South African study of revictimization reported that 74.8% of participants who had experienced child sexual abuse reported physical and/or sexual partner violence and 15.6% reported adult sexual assault by a nonpartner (Dunkle et al, 2004). Several studies cite revictimization as a predictor variable for HIV infection. However, in-depth understandings of this connection are still unclear (Miner, Flitter & Robinson, 2006). Further, most of the research on revictimization has been conducted in western countries, particularly in North America, and there is less data on revictimization in developing countries. Given that South Africa has high rates of childhood sexual abuse (Collings, 1997 cited in Lalor, 2004; Jewkes, 2004; Madu, 2001 cited in Lalor, 2004), it is important to explore the ways in which this may impact on women's later vulnerability to contracting HIV, using a qualitative framework that elucidates how revictimization may act as a pathway to contracting HIV. This would help to guide the development of effective HIV prevention programmes.

1.2 AIM OF STUDY

The central aim of this study is to conduct an in-depth exploration of the narratives of women who experienced childhood abuse and who, in their adult lives, were diagnosed

HIV positive. The specific objective is to explore within the narratives of the participants whether, and how, the concept of revictimization may be linked to them contracting the HI virus.

1.3 STRUCTURE OF THESIS

Chapter 2 provides a theoretical and empirical review of psychological understandings of revictimization as a consequence of childhood sexual abuse and its links to HIV risk. It also provides an overview of feminist theory, which provides a more contextual theoretical framework for the study. Chapter 3 presents an overview of the feminist qualitative research methodology utilized in the study, outlining some of the difficulties and dilemma's faced while completing this research study. Chapter 4 identifies and discusses the themes that emerged from the interview data. Finally, Chapter 5 draws conclusions based on the findings of the study, discusses benefits and limitations of the study, and provides recommendations for future research and policy.

Since the early 1990's, there has been a growing body of scholarship investigating the relationship between childhood sexual abuse and vulnerability for contracting HIV, and various pathways and predictor variables mediating this relationship have been investigated. This chapter will review definitions of the construct of revictimization, reported prevalence rates of revictimization, and studies investigating the relationship between child sexual abuse and HIV. Thereafter, feminist theory, which provides the contextual lens through which the findings of this study will be examined, will be reviewed and discussed.

2.1 REVICTIMIZATION

In the last three decades extensive research has been published on the long term effects of the impact of childhood sexual abuse. Within this literature, the issue of revictimization as a long term consequence of childhood sexual abuse has received some attention (Breitenbecher, 1999; Carey, 1997; Freshwater, Leach & Aldridge, 2001; Gold, Sinclair & Balge, 1999; Krahe, 2000; Maker, Kemmelmeier & Peterson; 2001). Revictimization is a complex construct. Various definitions, prevalence rates and reasons for it occurring have been proposed. While the statistics reported in various studies seem to suggest that women with histories of early sexual abuse are likely to experience abuse in adulthood, little consensus exists on the definition of revictimization or explanations for this phenomenon. Methodological limitations for example retrospective studies rather than prospective studies, working in clinic populations rather than general populations have been cited as some of the difficulties with researching this construct. Definitions of revictimization will be reviewed, reported rates of revictimization will be summarized, and understandings of the causes of revictimization will be discussed.

Definitions

Browne and Finkelhor (1989) noted the vulnerability of victims of sexual abuse to be “revictimized” through experiences of sexual or physical abuse later in life. Maker et al. (2001) explain that the occurrence of multiple sexual traumas (at least one incident of sexual abuse in childhood and then another in adulthood) across the lifespan has been defined as revictimization by researchers. Wyatt et al. (1992) indicate that this is where the difficulty with defining revictimization lies. It is unclear whether the first incident of sexual abuse should be described as genital fondling, being touched inappropriately or sexual intercourse, how many incidences are required before and after 18 years of age, and whether only one sexual assault in adulthood constitutes revictimization. The definition of revictimization was later extended to include at least one incident of physical abuse in adulthood (Maker et al., 2001). This means that revictimization is defined as a woman experiencing one sexual or physical assault in adulthood. The inclusion of physical abuse in the definition of revictimization occurred as a result of the high rate of this type of abuse noted in adult survivors (Carey, 1997; Maker et al., 2001). Clarke and Llewelyn (1994 cited in Freshwater et al., 2001) define revictimization more broadly as the unwelcome re-experiencing of a physically or sexually abusive relationship or behaviour that was first experienced in childhood. For the purpose of this study, revictimization will be defined according to the latter definition because this allows for the inclusion of all types of sexual abuse (from genital fondling to unwanted sexual intercourse) or physical abuse which may be re-experienced in adulthood.

Statistics

Russell (1986) found that 65% of women who were sexually abused by family members, and 61% who were abused by someone outside the family, were sexually revictimized later in life, while only 35% of women with no history of early sexual abuse reported victimization in adulthood. Similarly, a study of a sample of college women found that women with a history of sexual abuse were more likely to be victims of rape or other forms of sexual abuse later than women who had not experienced childhood sexual abuse (Fromuth 1983, cited in Messman & Long, 1996). Stevenson and Gajarsky (1991) report

that 72.3% of women sexually abused in childhood were later revictimized. Wyatt et al. (1992) found that women sexually abused in childhood were 2.4 times more likely to be sexually abused later in life than women who had not been abused, and Cloitre, Tardiff, Marzuk, Leon and Portera (1996, cited in Gold et al., 1999) found a 3.1 times higher likelihood of revictimization. Maker et al. (2001), in their study of 131 women, reconfirmed the relationship between child sexual abuse and later sexual revictimization. They found that 66% of their participants were sexually revictimized in adulthood. In their study, they hypothesized that severity of sexual abuse and the number of sexual perpetrators would be strong predictors of adult sexual assault. Severity of abuse was classified according to Russell's (1986) list of unwanted sexual behaviours. Least severe sexual abuse was, for example, the exposing of sex organs, severe abuse was, for example, touching genitals and very severe abuse was, for example, vaginal or anal intercourse. The researchers concluded that even less severe forms of sexual abuse may be sufficient to place women at high risk for later sexual assault. Several other studies have also reported an association between childhood sexual abuse and revictimization (physical or sexual abuse) in adulthood (Carey, 1997; Marx, Heidt, Gold, 2005; Wyatt et al., 1992).

However, the extent of revictimization in a South African context is not well-documented as most research has been carried out in developed countries, with a disproportionately high number of studies among American college samples (Dunkle et al., 2004). A South African study in Soweto, in which 1,395 interviews with women attending antenatal clinics were conducted, found that among participants who reported child sexual assault, 74.8% reported physical and/or sexual partner violence, and 15.6% reported adult sexual assault by a nonpartner (Dunkle et al., 2004).

Theoretical Understandings of Revictimization

The next section will review the theoretical formulations that have been proposed to explain the phenomenon of revictimization. While these theories provide some insights into revictimization, Rich, Combs-Lane, Resnick & Kilpatrick (2004) argue that they do not adequately explain the mechanisms that lead to revictimization.

Traumagenic model

An early understanding of revictimization was postulated by Finkelhor and Browne (1985). They described the effects of childhood sexual abuse in terms of four traumagenic dynamics. These dynamics have been used by many later researchers to explain some aspects of revictimization (Messman & Long, 1996). This model suggests that child sexual abuse produces a range of psychological and behavioral changes (Mullen & Fleming, 1998).

The first dynamic is that of traumatic sexualization, which refers to “the process in which a child’s sexuality (including both sexual feelings and sexual attitudes) is shaped in developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse” (Finkelhor & Browne, 1985, p.531). This dynamic suggests that women who have been sexually abused learn inappropriate ways of using sexual behaviour such as exchanging sexual behaviour for love and affection, which may lead to later victimization (Lynn, Pintar, Fite & Stafford, 2004; Messman & Long, 1996). Betrayal is the second traumagenic dynamic. This occurs when the survivor discovers that someone meant to protect them has betrayed them. This may lead to feelings of anger, sadness, loss and disappointment and produces conflict between external reality and a needed system of social dependence (Lynn et al., 2004). Survivors may have difficulty developing trustworthy relationships, may avoid intimate relationships, may have impaired judgment about the trustworthiness of others, and may adopt extreme dependency and clinging behaviours in an attempt to achieve a sense of security (Lynn et al., 2004). This may cause vulnerability to future victimization, as survivors may be motivated to initiate or continue relationships with unstable or abusive partners. The third traumagenic dynamic is that victims of abuse may be left feeling powerless and unable to control others, and may find it difficult to act without the expectation that others will victimize them. The passivity that is engendered may result in survivors viewing themselves as incapable of protecting themselves, and they “give up” (Finkelhor, 1988, cited in Rich et al., 2004). Lastly, stigmatization, which refers to “negative connotations”, has been argued to be directly related to feelings of low self-

esteem. These feelings emerge as a result of feelings of badness, shame, guilt and of being “spoiled merchandise” (Messman & Long, 1996, p400). It is theorized that victims internalize this negative view of the self, fail to recognize their own worth, and consequently fail to protect themselves from abuse (Lynn et al., 2004). According to this theory, the experience of repeated victimization may lead to the survivor believing or expecting that their actions will induce further victimization, therefore they may not take preventative action to avoid the victimization (Messman & Long, 1996). The traumagenic dynamics encompass a wide range of risk factors, but it is unclear whether they adequately explain the mechanisms that lead to revictimization in adulthood, as they have not been empirically tested (Messman & Long, 1996).

Repetition compulsion

A prominent theory of revictimization is that of repetition compulsion, which was originally developed by Sigmund Freud (1954). This theory argues that the initial sexual assault is a highly stressful event that the individual is compelled to repeat, in whole or in part, to achieve a sense of mastery, reduce anxiety and find meaning in the initial experience (Lynn et al., 2004). According to Freud (1954), until a person is capable of “working through” the original trauma by remembering, reexperiencing and mastering it, repressed elements will continue to compel the survivor to repeat the experience. This may account for revictimization. A critique of this theory is that it implies a degree of blaming the survivor. There is no reason to believe that survivors want to be victimized and there is little scientific research to support this theory (Lynn et al., 2004).

Object relations theory

Object-relations theorists assert that early interpersonal relationships and attachments impact on early mental representations of self and others. Sexual abuse can lead to negative self-image and to insecure attachments in interpersonal relationships. Drawing on Bowlby’s (1988, cited in Carey, 1997) theory, children have a great need for a secure base or attachment with their caregivers. When children experience patterns of destructive interactions, such as sexual abuse by an attachment figure, threatened attachment and thwarted development result (Carey, 1997). In order to process this, the

survivor has to deny or distort reality. According to object relations theory, experiences are internally “split” (Carey, 1997). Victims introject the badness of the experience (or place the bad onto themselves) in order to preserve the good of the idealized object (the perpetrator), in an attempt to feel protected. These distorted negative mental representations persist over time and lead to maladaptive cognitions and behaviours, such as, increased sexual behaviours, lower level capacity for maintaining moral standards, introjection, boundary disturbances, faulty attributions and self-blame and, as a consequence, a self-defeating personality may develop over time. Beyond maladaptive cognitions and behaviours, these disturbances carry over into the affective area where survivors are prone to feelings of depression, inadequacy, helplessness and lower capacity for investing emotionally in relationships (Carey, 1997). These may leave the survivor predisposed to tolerate or elicit abusive interchanges with others. In this way, the abusive dynamic is reenacted (Lynn, et al., 2004).

Hyperfemininity

Gold et al. (1999) suggest that a possible consequence of an insecure attachment style (such as may result from experiences of sexual abuse) is a hyperfeminine personality, which refers to an extreme adherence to traditional stereotypic gender roles. Rigid adherence to female and male gender roles is associated with a risk of involvement in sexual aggression, as victim or as perpetrator respectively. Murnen and Byrne (1991, cited in Gold et al., 1999) developed a hyperfemininity scale which reflects and measures three dimensions, namely, the importance of relationships with men, the use of sex to gain or maintain a romantic relationship, and the preference for traditional male behaviours. Using this scale, Mckelvie and Gold (1994, cited in Gold et al., 1999) report that women with hyperfeminine personality types have more permissive sexual attitudes, more antisocial tendencies, more psychological symptoms and more consensual and coercive sexual experiences than non-hyperfeminine women. It has been noted that “the research on hyperfeminine women suggests a pattern of behaviour that is anything but excessively feminine” (Gold et al., 1999, p464). Gold et al. (1999) further argue that instead of extreme feminine characteristics, hyperfeminine women seem to act in a way designed to conform to a distorted vision of what a man wants in a woman e.g. being

sexy, attentive to his needs, more interested in his career than her own, and needy of him for her sense of self. In essence, hyperfeminine women are at greater risk for revictimization because they are prone to making poor relationship choices and/or having many sexual partners (Gold et al., 1999).

Contextual analysis

Grauerholz (2000, cited in Marx et al., 2005) proposed a contextual analysis of revictimization. The first level of analysis considers early family experiences and the effects on the initial victimization experiences. The second level of analysis includes delinquent behaviour that may lead to high risk sexual behaviour (e.g. alcohol, and drug use) (Gold et al., 1999; Marx et al., 2005). Rich et al. (2004) in their review confirmed that alcohol use is a significant predictor or risk factor for revictimization. It is argued the insecure early attachments of survivors may lead them to revictimization through involvement in drugs and delinquency (Gold et al., 1999). The third level of analysis is the social structure surrounding the survivor, such as poverty and lack of social support, and lastly the social and cultural factors that influence how survivors are dealt with (e.g. victim-blaming). These may increase the likelihood of revictimization.

Submissiveness and dependency

Mixed research results have been found on the issue of dependency and submissiveness. Some studies, such as Greene and Navarro (1998), Knowles (1993, cited in Breitenbecher, 1999) and Krahe (2000) point to emotional dependency as contributing to revictimization. Krahe (2000) argues that the corrosive effects of abuse on self-esteem may make survivors dependent on social relationships for self worth, resulting in submissiveness. However, other studies have refuted this (e.g. Copeland (1996, cited in Breitenbecher, 1999; Mandoki & Burkhart, 1989). For example, Copeland, (1996 cited in Breitenbecher, 1999) used a sample of 495 participants and compared women who had or had not experienced early childhood sexual abuse and were later raped as adults. In this study, it was concluded that there was no difference between these women in levels of assertiveness.

Cognitive attributions

Cognitive attributions have been postulated as an explanation for revictimization. Gold et al. (1999), in their investigation of a theoretical model of risk for future victimization, found negative cognitive attributions to be a predictor of revictimization. In this model it is suggested that the attributions made about the childhood abuse combined with the victim blaming herself for the abuse, may lead to a model of negative cognitive attributions. In their review they cite numerous researchers who have empirically found an association between negative cognitions and revictimization. Krache (2000) argues that through these negative attributions, survivors may learn that resistances to sexual advances may involve punishment, and are therefore more likely to succumb to men's coercive behaviour.

Social Narrative Model

Lynn et al. (2004) proposed a social narrative model of revictimization. They argue that traumatic interpersonal violence is a contradiction of cultural norms as expressed in shared social narratives. Sexual abuse is a socially inconsistent and secretive event, and survivors cannot rely on traditional cultural stories to explain their experiences. The narrative explanations offered by the perpetrator are also likely to contradict the survivor's experience. When the individual and social narratives do not complement each other, then individual narratives become distorted and a social incoherence exists. Lynn et al. (2004) argue that it is this distortion that leads to narrative incoherence. Becoming involved with an abusive man is familiar and brings the personal and social narratives closer. In this instance, the repeated revictimization is dysfunctionally functional in that it lessens the contradiction between personal and social narratives (Lynn et al., 2004).

Perceptions of threat

Research suggests that there is a relationship between diminished perceptions of threat and sexual revictimization (Breitenbecher, 1999). Van der Kolk (1989, cited in Marx et

al., 2005) posits that survivors of childhood sexual assault exhibit chronic hyperarousal, which then impacts on the survivor's ability to calmly assess and react to subsequent threat. Marx et al. (2005) hypothesize that sustained attempts to regulate negative affect might impair one's ability to detect and properly process threat cues, and possibly result in ignoring salient threat cues. Attention deployment strategies are used to change the focus from the stimuli that elicit fear. Dissociation as a cognitive defense has received attention (Gold et al., 1999; Lynn et al., 2004). Dissociation is a psychological coping response that is used to reduce anxiety associated with overwhelming traumatic experiences by disengaging from the event, avoiding, disrupting or compartmentalizing memory and affect, and emotional numbing in relation to the event. Dissociation is believed to increase the risk of not recognizing and responding to "danger cues". These strategies and poor risk recognition may increase risk for revictimization. (Lynn et al., 2004; Marx, Meyerson, Calhoun & Wilson, 2001).

Sense of self

Developing a secure sense of self is a complex phenomenon that is reliant on a sense of secure connection with caring people (Herman, 1992). Mullen and Fleming (1998) suggest that a secure sense of self encompasses the extent to which the individual feels comfortable with him or herself. Implicit in this is the assumption of trust, both of the self and of others. Van der Kolk (1996) states that trauma that is inflicted by caregiver's impacts profoundly on the person's capacity to trust. When abuse occurs, perceptions of subsequent relationships tend to be filtered through these experiences. Traumatized people often fail to maintain a personal sense of significance and inner worth. It is well documented in research, particularly with survivors of intimate partner violence and sexual abuse, that the abuse violates the autonomy of a person at a basic bodily level (Herman, 1992). A negative self-image as a consequence of abuse may place the person at higher risk for revictimization because they may feel that they deserve the maltreatment (Marx et al., 2005).

Spurious Factors

Breitenbecher's (1999) review highlights some studies which suggest that 'revictimized' women do not actually experience a higher incidence of assault. Rather, the high statistics are better accounted for by the greater willingness of victims of early abuse to disclose later abusive experiences, or by their heightened sense of later experiences as being nonconsensual. These theories therefore suggest that the association between childhood abuse and victimization in adulthood is a spurious one.

Summary

From the above discussion it can be seen that various psychological theories have been postulated to explain revictimization. While some have been empirically investigated, none have received particularly strong support, and other theories have received minimal or no empirical support (e.g. repetition compulsion, dependency) (Marx et al., 2005). Marx et al. (2005) indicate that these inconclusive findings may be a result of limitations in research design (for example, reliance on retrospective self-reports which introduce various types of response and memory biases; and the use of cross-sectional, non-experimental designs that cannot adequately examine the mechanisms that mediate vulnerability), differences in samples (clinical vs community samples - revictimization may be overrepresented in the former), and variable definitions of childhood sexual abuse. Marx et al. (2005) further assert that revictimization theories currently do not adequately explain how and why revictimization occurs, as not all women that are abused in childhood are revictimized in adulthood. Most empirical studies addressing revictimization have investigated predictor variables in isolation, and fewer empirical studies have examined the contextual factors that may lead to an increased risk of revictimization (Rich et al., 2004).

2.2 CHILD SEXUAL ABUSE AND HIV

Childhood sexual abuse and its traumatizing effects were previously unrecognized as experiences related to HIV in adulthood. The disturbing prevalence of childhood sexual abuse, and its possible consequences on behaviours that could lead to HIV

infection, requires the attention of medical and other health practitioners (Zierler et al., 1991). In scholarship on the connections between childhood sexual abuse and HIV, sexual risk-taking (to be elaborated later in section) and reproductive behaviours (e.g. earlier age of pregnancies or unintended pregnancies) have consistently been documented (Anaya, Swendeman & Rotherram-Borus, 2005; Chin et al., 2004, 2004; Krahe, 2000; Lynn et al., 2004; Mullings et al., 2000; Quina et al., 2004; Wyatt et al., 2002; Zierler et al., 1991). These risky sexual behaviours include learning to trade sex for reward or affection, which may lead to promiscuity or sex work (Zieler et al., 1991), increased number of sexual partners (Anaya et al., 2005; Krahe, 2000), and unprotected sex (Allers & Benjack, 1991; Arriola et al., 2005). In the following section a review of literature that indicates the prevalence of associations between childhood sexual abuse and HIV will be presented, followed by a review of reasons that have been hypothesized for increased HIV risk among survivors of child sexual abuse.

Prevalence

In studies completed in the United States and United Kingdom, it has been noted that many women who present with HIV infection have histories of childhood sexual or physical abuse. Brady et al. (1991) studied the charts of 100 women enrolled in an intensive home-based primary medical programme for HIV patients and found that 95% of patients had a lifetime history of sexual abuse while 83% had physical abuse. Allers and Benjack (1991), in their study of the connections between childhood abuse and HIV infection, found that 65% of their sample reported childhood abuse and of these 64.7% reported sexual abuse in childhood. Koenig and Clark (2004), in a review of recent literature, found that child sexual abuse is overrepresented among women with HIV. They indicate that the prevalence of HIV-infected women who have a history of child sexual abuse ranges from 31% to 53%. Mullings et al. (2000) studied 500 women at admission to prison in 1994 and found that 26% of their sample had been sexually abused in childhood and found that these participants were more likely to engage in HIV sexual risk behaviours (e.g. multiple participants, trade sex for money or drugs and sex with a drug user) as compared to nonabused women. In a recent meta-analysis of the relationship of child sexual abuse to HIV risk behaviour among women, it was concluded

that there is a small positive relationship between the two (Arriola et al., 2005). These authors state that the small association which they found may have been influenced by the various ways in which child sexual abuse and HIV risk were defined across studies included in the meta-analysis. Whitmire et al. (1999) undertook a quantitative study in order to understand the effects of early childhood trauma and HIV risk in adults. In their multivariate analysis, they found childhood sexual abuse to be a significant predictor of adult sexual victimization which may lead to increased HIV vulnerability. Martinez, Israelski, Walker and Koopman (2002), in their study of post traumatic stress disorder (PTSD) in women who had been diagnosed HIV positive, found that 32% of the women reported sexual abuse before the age of 16. The above prevalence data indicate that there is a strong association childhood sexual abuse and HIV. However, all of the statistics provided reflect prevalence rates in western developed countries. No information on the prevalence of childhood sexual abuse in HIV positive women could be found in relation to developing countries in general or South Africa specifically.

Explanations for increased risk for HIV

This section will examine some of the predominant explanations that have been postulated for the pathway between child sexual abuse and increased HIV risk.

Multiple sexual partners

Several studies have documented that women who have been sexually abused in childhood are more likely to have an increased number of sexual partners. Arriola et al. (2005) used 23 studies to investigate the variable of multiple sexual partners as an outcome of childhood sexual abuse in relation to HIV risk. They indicate that these studies included 16, 560 participants in total, that 61% of the articles were published between 1997 and 2001, and that the study samples were recruited from the community (as opposed to clinical samples). This meta-analysis found statistically significant support (at a 95% confidence interval) for the hypothesized relationship between child sexual abuse and multiple partners in adulthood increasing HIV risk. Mullings et al. (2000) found that 20.6% of their sample reported having multiple sexual partners. Anaya et al. (2005) found that sexually abused youth living with HIV had significantly more

lifetime partners than their nonabused counterparts. Wyatt et al. (2002) in their study found similar results. They investigated the relationship between history of abuse and HIV risk related factors in various racial/ethnic groups. They found that a higher morbidity rate for HIV in women was attributable mainly to differences in socioeconomic status, exposure to violence and number of sexual partners, rather than ethnicity.

Allers, Benjack, White & Rousey (1993) explain that this increased number of sexual partners among survivors of child sexual abuse may possibly be explained by the notion of sexual compulsivity. Sexual compulsivity is defined as sex used to sublimate needs such as intimacy and affection, and mask feelings such as boredom and isolation. They indicate that this type of sex becomes part of an addictive process. They argue further that this sexual compulsivity is important to account for in the context of HIV, given that multiple sexual partners has been one of the major concerns in HIV prevention. Krahe (2000) offers another interpretation, which is that children who have been sexually abused, learn sexualized ways of behaving which they may not understand to be inappropriate, and this then continues in adolescence and adulthood. If so, this sexualized ways of behaving may present in the form of promiscuity that then places the person at higher risk for HIV.

Unprotected sex

Research indicates that consistent condom use can lead to a 70% to 100% reduction in HIV transmission (O' Leary & Wingood, 2000, cited in Miner et al., 2006). Miner et al. (2006) found that women with a history of childhood sexual abuse are less likely to consistently use condoms. Arriola et al. (2005) similarly found a positive relationship between childhood sexual abuse and unprotected sex in adulthood, among women. Allers and Benjack (1991), in their study of 52 HIV positive participants with histories of childhood sexual and physical abuse, found that adult survivors may lack assertiveness and ego strength to set appropriate and safe limits with sexual partners. They argue that it is this failure to set limits, such as using condoms, which may possibly lead to the transmission of HIV. Quina et al. (2004) defines sexual assertiveness as a women being able to refuse unwanted sex, insist on condom use, and discuss HIV risk with her partner.

They found that women with a history of childhood sexual abuse, rated low on sexual assertiveness. However, a lack of assertiveness is also determined by women's lack of power over their sexuality in heterosexual relationships. The imbalance of power in heterosexual relationships is related to women's low social and economic status, and because men are attributed more power in these relationships (Gupta, 2002). This then makes women vulnerable to contracting sexually transmitted infections and HIV. Chin et al. (2004) also indicate that in sexually abusive situations, the perpetrator dictates what sexual experiences should be engaged in and, as a result, survivors may not develop a sense of their own sexual needs. This may lead to women later in life gravitating toward partners who take control of their sexual needs. Therefore the women may not actively make decisions regarding condom usage but rather take on passive roles, which then contribute to their vulnerability and engaging in unsafe sex practices in relationships.

Alcohol and drug use/abuse

Allers and Benjack (1991) note a connection between child sexual abuse and increased use of alcohol and drug use in adulthood. Brady et al. (1991) similarly found that 72% of their sample reported a lifetime history of alcohol abuse and 62% a history of injecting drug use. Tarakeshwar, Fox, Ferro, Khawaja, Kochman (2005) interviewed 28 HIV positive women and found an association between sexual abuse and illicit substances and explained this use of illicit substances as a means of numbing emotional distress, and feelings of anger and betrayal. They indicated that transmission of HIV may be related to sharing needles, engaging in sex work in order to gain drugs and participating in unprotected sex while being substance impaired. In another study it was found that survivors of child sexual abuse were more likely to be alcohol drinkers, which may in turn increase risky sexual behaviour. However, the effects are not mediated by how heavily women drink. Rather it was found that alcohol use at an early age together with early sexual intercourse are stronger predictors of risky sexual behaviours (Wilsnack, Kristjanson, Vogeltanz-Holm & Harris, 2004).

Adult revictimization

According to Quina et al. (2004) sexual revictimization as an adult has been shown to be closely to HIV risk. They argue that women who have had the experience of revictimization in adult relationships may be unable to refuse unwanted sexual activity and insist on condom usage. Arriola et al. (2005) found a moderate positive relationship for adult sexual revictimization and HIV risk but they do not explain this relationship. Allers et al. (1993), in their clinical case study, explain that revictimizing relationships often include threat or physical harm and it is this that makes it difficult for the survivor to insist on safer sex practices without chances of further harm. Revictimization as a pathway to increasing vulnerability to contracting HIV has been noted in several other studies, but the pathway of revictimization leading to HIV infection is not clearly understood (Brady et al., 1991; Chin et al., 2004; Whitmire et al., 1999; Wyatt et al., 2002).

South African Research

The above factors are some of the explanations for the links between childhood sexual abuse and risk for HIV in adulthood. In South Africa, there is a dearth of research into the association between child sexual assault and HIV, despite the high rates of both childhood sexual abuse and HIV infection. According to Lalor (2004), while the HIV pandemic has led to an increase in research on sexual behaviour in sub-Saharan Africa, this has not significantly contributed to the knowledge of the relationship between child sexual abuse and HIV infection in adulthood. Kalichman and Simbayi (2004) surveyed 272 women in a township in the Western Cape, and assessed for histories of adult (predominately) sexual assault and risk for STI's including HIV. Of the women that reported a history of sexual assault, only 21% were 20 years and younger at the time of the assault. They found that a history of sexual assault was closely related to risk for HIV. They concluded that this link was associated with poverty, lack of power in relationships, and threat or use of violence which creates a barrier to engaging in safe sex practices. In another study in Soweto, it was found that gender-based violence was positively associated with HIV risk (Dunkle et al., 2004). However, since only a small proportion (8.0%) of women experienced early childhood abuse, the researchers

concluded that sexual risk behaviours are also linked to power disparities and experiences of intimate partner violence. In South Africa, it appears that a more comprehensive account of the association between childhood sexual abuse and HIV vulnerability is required.

Summary

From the above it can be concluded that there is an association between childhood sexual abuse and HIV. The bulk of research suggests that the pathway between childhood sexual abuse and HIV in adulthood involves risky sexual behaviours including multiple sex partners, unprotected sex, and alcohol and drug use. A few studies have suggested that the pathway from child sexual abuse to HIV in adulthood occurs through abusive revictimization rather than through risky sexual behaviours, but this pathway remains poorly understood and is in need of further exploration. Most of the studies cited in this review have been conducted in developed western countries, and conceptualized as quantitative studies, thus empirically elucidating the relationship (predominately predictors) between childhood abuse and later risks for contracting HIV. Therefore it is important to conduct more studies of the relationship between child sexual abuse and HIV like this in South Africa and to qualitatively explore the experiences of women in this regard.

2.3 FEMINIST THEORETICAL FRAMEWORK

The literature previously reviewed in the chapter mainly conceptualizes revictimization in terms of internal psychological processes, and conceptualizes the link between child sexual abuse and HIV also in terms of psychological “patterns” of thought or behaviour. There has been little acknowledgment of contextual factors (political, social, economic and cultural) and the role of gender power relations in child sexual abuse, HIV and revictimization. Feminist theory provides a more contextual lens, to supplement the psychological framework in understanding these issues.

Feminist theory is a diverse scholarship with vibrant debate and critique between the various schools of thought. Since the 1970's, it has been critically engaging with the

fundamentals of women's experiences collectively and subjectively. It has also critically engaged in debate regarding empirical research of women's experiences, and has interrogated hegemonic research paradigms. This section presents a brief overview of the history of some of the trends and issues in feminist ideology and important aspects relevant to this study.

Scott (2001) argues that feminist scholarship has been at the forefront of exploring complex ways in which accounts of lived experiences are produced, the interpenetrations of public and private stories, and the importance of the context within which these stories emerge. The strength of feminist thinking has been its critical engagement with both academic discourse and lived experience (Scott, 2001).

In the 1970's, through the women's movements and consciousness raising groups, the link between male dominance and women's personal troubles became apparent. Individual women's experiences were identified to reflect broader social experiences and the notion of the personal being political was proposed (Mulinari & Sandell, 1999). Largely influenced by radical feminism, issues related to patriarchy, social orders and institutions were critiqued and women's experience was understood collectively (Mulinari & Sandell, 1999). This led to insights of gender inequalities and understanding women's everyday oppression (Gupta, 2000; Lancaster & Lumb, 1999). Gender is a culture specific construct, but what seems to be fairly consistent across cultures are the differences between women's and men's roles, access to productive resources and authority in the decision-making process (Gupta, 2000). Men are typically seen as responsible for productive activities outside the home while women are responsible for reproductive and productive activities in the home, leading to inequities in terms of resources, land, credit and education (Gupta, 2000). It is said that, "most of the world's women are poor and most of the world's poor are women" (Gupta, 2002, p.183). Women's vulnerability to HIV is then understood to be related to their economic vulnerability and dependence on men (Gupta, 2002).

In the 1980's, critique from within the women's movement lead to an understanding that while experiences are gendered, they are also embodied in class, ethnicity and sexual identity (Scott, 2001). Three main criticisms evolved in the 1980's: Firstly, that women's experiences were analyzed as gendered while the impact of class, race and sexuality were not analytically considered; secondly, that power relations between women (e.g. across class and ethnic dimensions) were not critically engaged with; and thirdly, that the experience of women as claimed in feminist theory thus far actually represented the experiences of white, middle class, heterosexual women. These critiques lead to an awareness and consequent engagement with the dynamics of race, sexuality and class in shaping the experiences of women (Lancaster & Lumb, 1999; Scott, 2001).

The issue of embodiment in feminism is particularly relevant to understanding both child sexual abuse and HIV. It is argued that the body is embedded in a complex matrix of power relations, in terms of class, race and sexual identity (Alexander & Warren, 2002; Fonow & Cook, 2005; Mulinari & Sandell, 1999), and that as such the physical body itself is a social construct (Fonow & Cook, 2005). Authors on embodiment argue that control over women's bodies is the linchpin of women's oppression (Fonow & Cook, 2005). The body is seen as a site of culturally inscribed and disputed meanings and experiences. Ratele (2001) argues that the sexualisation of gendered bodies is particularly relevant in the South African context. The intersections of race, gender, class and sexuality shapes power and violence in particular ways. Male bodies have more power in intimate relationships (Moolman, 2003). Sexuality is a social construction of a biological drive that is defined by "whom one has sex with, in what ways, why, under what circumstances, and with what outcome" (Gupta, 2000, p1). The power underlying any sexual interaction determines how sexuality is expressed and experienced. The unequal power balance in gender relations translates into unequal power in sexual relations (Gupta, 2000). Men and women's sexuality is different because it enables men to gain power over women's bodies (Oriol, 2005). Maushart (2001, cited in Oriol, 2005) indicates that women's primary sexual pleasure is derived from pleasing men rather than themselves. Male sexual pleasure, on the other hand, demands the use of women as objects for sexual dominance, and denies women control over their own bodies. Oriol

(2005) argues that men's sexual pleasure and refusal to use condoms is connected to masculinity. It is men's belief that they are 'entitled' or have a right to sex and this in turn creates a demand for women who they can 'conquest' or use as sexual objects. Male sexual dominance or masculine gender is achieved primarily through penile penetration, which enables men to separate themselves from that which is considered feminine. Condoms, for example, are believed to pose a barrier to men's established right of sexual pleasure. There is the belief that penetrative sex with male ejaculation inside women is used to establish masculinity and is the fundamental proof of masculinity, which is denied if condoms are used (Oriol, 2005). In this context, women are vulnerable to HIV, because women's bodies become a site of struggle for male sexual pleasure and thereby violate women's rights, bodily integrity and even the right to life (Oriol, 2005). Furthermore, the culture of silence that surrounds sex dictates that women are ignorant and passive in sexual interactions, which in turn acts as a restriction to women's ability to access information about their bodies and sex, and this makes them vulnerable to HIV (Gupta, 2000). While not all men violate women's bodily integrity, and define their masculinity in terms of the act of coitus, it is important to interrogate the notion of gendered bodies both at individual and collective levels in an attempt to connect experiences between individuals and broader society (Alexander & Warren, 2002).

Feminist engagement with postmodern thought legitimated a shift in focus from collective experiences to explorations of subjectivity understood in terms of individuality. This was explored through focusing on issues of language, notions of discourse, the problematization of difference and the practice of deconstruction (Scott, 2001). This meant that explanations shifted from purely structural explanations, for example, sexual violence cannot be explained simply as part of men's nature (Lancaster & Lumb, 1999). Secondly, it was argued that variability between people needed to be taken into account, for example, not all men are socialized in attitudes and behaviours which link to sexual offending. Thirdly, it was argued that power is relational rather than absolute, for example, not all men have power over all women and children (Lancaster & Lumb, 1999). This meant a shift from the construction of theories where women's experiences

were the starting point towards theorizing the construction of discourses of womanhood that make these experiences possible (Scott, 2001; Fonow & Cook, 2005).

Abuse of women and children is a social issue implicating male power (Lancaster & Lumb, 1999; Lenton, 1995; Scott, 2001). Understanding abuse from a feminist context involves understanding the social inequalities that contribute to making women vulnerable. In many patriarchal societies, women are viewed as subordinate to men and are not accorded the same power and rights as men (Watts, Osman & Win, 1995). Gender inequalities are institutionalized in societal structure, and within language (Lancaster & Lumb, 1999). Feminist knowledge about sexual abuse constantly criticizes other knowledges by exploring their contradictions, analyzing the interests that they serve, berating the individualism of the interventions they support, rejecting checklists of indicators and formulaic treatment plans, and returning again and again to the subjugated knowledge's of survivors (Scott, 2001). Feminism is thus a critical engagement with both discourse and lived experience (Scott, 2001). Fonow and Cook (2005) argue that women consent to, resist and reshape the social relations of power within a complex matrix of domination and subordination.

In the context of this study, it is important to examine the connections between child sexual abuse, HIV and revictimization through both understanding internal psychological mechanisms as well as contextual factors (political, social, economic, and cultural factors). Taking all of this into account will provide thick descriptions and allow for engagement with the complexities associated with these phenomena. Therefore, feminism will be used to supplement the psychological theory reviewed earlier in the chapter.

2.4 CONCLUSION

This chapter has focused on the issue of revictimization, a consequence of childhood sexual abuse. It has highlighted the extent of this occurrence, although it was noted that most of the studies of revictimization have been conducted in developed countries. There are numerous theoretical explanations for revictimization, and little consensus about why

or how it occurs. Some of the theories proposed have been empirically investigated whilst others have not. The chapter then focused on the issue of child abuse and its links to creating vulnerability to contracting HIV in adulthood. Various reasons for this vulnerability have been elucidated in literature such as, multiple partners, impulsive unprotected sex, and drug and alcohol abuse. Revictimization has been flagged in several studies as a consequence of childhood abuse that may increase HIV vulnerability, but this pathway is not yet clearly understood. This study will attempt to qualitatively explore whether experiences of revictimization contribute to South African women's vulnerability to contracting HIV. In the last section of the chapter, a review of feminist theory and its trends was presented, which provides a more contextualized theoretical framework. The next chapter will describe the methodology used in the study.

University of Cape Town

This chapter will focus on the methodology utilized in the study. It begins with an outline of some epistemological issues relevant to feminist qualitative research methodology. It then outlines the aims, methods and procedures utilized in the study and address some of the methodological and ethical dilemmas that the researcher confronted while conducting this research.

3.1 FEMINIST RESEARCH METHODOLOGY

Given the vulnerability of women to both childhood abuse and contracting HIV, feminism offers an appropriate paradigm and methodology for this study. At the core of feminist research is the principle of valuing and placing the experiences of the participants as central to the process (Foss & Foss, 1994), and allowing for thick descriptions of the narratives of the participants (Diamond, 2006). This is dissonant to the hegemonic discourse in scientific research in which the “subjects” are separated from the phenomenon being studied. In addition, in feminist research power dynamics in the researcher/participant relationship are thought about and engaged with critically (Presser, 2005). In empirically based positivistic research, the researcher is viewed as the ‘expert’, whereas in qualitative feminist research the participant is the expert or knower sharing their experiences. Given that the experiences of childhood abuse, being HIV positive and their positioning as (black) women may all have created amongst the target participants for this study feelings of disempowerment in relationship with others, feminist research principles and values were deemed most appropriate for this study. While feminism is not a homogeneous body of scholarship, feminist research addresses several principle interconnected goals (Terre Blanche & Durrheim, 1999). The next section will focus on some of these goals.

Traditional scientific positivistic thought on research has been that phenomena under investigation in the social sciences are objectively knowable, that the researcher can be separated from the subject, that personal and historical biases do not confound the

research process, that in essence the process is value-free, and that the researcher can speak on behalf of those being researched (Diamond, 2006). Fonow and Cook (2005) argue that it is through feminist writings on epistemological issues that many of these assumptions have been challenged. Some of the central areas challenged have been, for example: what is knowledge? Who can know and by what means? How do we recognize, validate and evaluate knowledge claims? Feminists have rejected the notion of objectivity as this is believed to perpetuate power relations (Fonow & Cook, 2005; Terre Blanche & Durrheim, 1999). Within the paradigm of objectivity, subjects become the object of investigation of a detached knowledgeable researcher (Terre Blanche & Durrheim, 1999). Feminism takes a critical stance or standpoint in the research process which is made explicit and defended throughout the research process. The 'context of discovery' is challenged and vested power interests made clear, and as such feminist research becomes a moral and political endeavor (Fonow & Cook, 2005; Terre Blanche & Durrheim, 1999). Postmodernist scholars working in postcolonial, race and ethnic studies have highlighted important questions regarding epistemologies of oppressed people. For example, black feminists have asserted that black women have a shared world view of historical resistance (Few, Stephens & Rouse-Arnett, 2003). Fonow and Cook (2005) indicate that this assumption raises the question of whether the positioning of oppressed people, by virtue of their knowledge of both the oppressor's view of reality and that of their own subjugated groups, give them access to truer or better knowledge. Black feminists have also argued that research is for black women, rather than about black women and therefore black women are best placed to conduct this research (Few et al., 2003). This then raised a debate about who is privileged in the epistemological sense (Fonow & Cook, 2005). These are all critical epistemological issues to account for when engaging in any research process, but particularly in research with disempowered populations.

So how does one go about being critically reflexive of these issues? Feminist researchers argue that this entails constantly reflecting on, and writing oneself into, the research process, being sensitive and attuned to the dynamics in the conversation between researcher and participant, and viewing the interview as a conversation in which

information is shared (Diamond, 2006; Fonow & Cook, 2005; Presser, 2005). In addition, the researcher must continuously attend to the significance of gender and gender asymmetry as a basic feature of social life, and incorporate consciousness raising and empowerment of the participants into the research process. Concern for the ethical implications of the research is also critically engaged with; in particular, the researcher must be conscious about exploiting women as objects of knowledge. Lastly, there is an emphasis on the empowerment of women through allowing them to articulate and voice their own experiences in ways that they feel comfortable with (Diamond, 2006; Fonow & Cook, 2005). Furthermore, feminist scholars use their own personal experience as part of the research and consider it always to be admissible. According to Foss and Foss (1994), personal experience means the consciousness that emerges from personal participation in events. Le Guin (1989), cited in Foss and Foss (1994), argues that one experience of an event cannot deny, negate or disprove another experience of that event. In qualitative interviews, the process between the interviewer and participant is a co-construction of reality. Thus, a multiplicity of truths and the valuing of diversity are possible (Diamond, 2005). However, the researcher still has the task of presenting the information in a comprehensible way. So while all experience is admissible and valued, the question becomes: what is focused on when reporting the research findings? According to Foss & Foss (1994), what feminists need to attempt when presenting their participants' narratives is to critically analyze the phenomenon under investigation and use this to develop theory and make links with larger patterns in society.

3.2 AIM OF THE STUDY

The central aim of this study is to conduct an in-depth exploration of the narratives of women who experienced childhood abuse and who, in their adult lives, were diagnosed HIV positive. The specific objective is to explore within the narratives of the participants whether, and how, the concept of revictimization may be linked to them contracting the HI virus. The study aims to achieve this exploration in accordance with the principles of feminist research methodology.

3.3 DESIGN OF THE STUDY

The present study utilized a collective case study as the research design. Case studies are intensive investigations of particular individuals that aim to understand individuals as individuals rather than as members of a population (Terre Blanche & Durrheim, 1999). Collective case study design allows a researcher to jointly investigate a number of cases to explore a particular phenomenon or experience (Stake, 2000). It provides thick descriptions and allows investigations of similarity or dissimilarity, redundancy and variety in and between cases and is an attempt to understand and elaborate on the complexities of the situation being studied (Stake, 2000). Furthermore, it allows the participants to tell their own story and for the researcher to find commonality between these stories, although the stories will be filtered through the researcher's framework of analysis (Few et al., 2003). In the context of feminist research this is a useful design as it validates the experiences of each participant. The overall advantage of this particular design is that it allows for new ideas and hypotheses to emerge from careful and detailed investigation and it promotes critical reflection on existing theories (Terre Blanche & Durrheim, 1999). Some of the limitations include possible problems with the validity of information gathered, and causal links are difficult to test (Terre Blanche & Durrheim, 1999). These limitations, as they apply to the current study, will be further discussed in Chapter 5.

3.4 PARTICIPANTS

The study sampled six black African² women in the Cape Metropolitan area who were HIV positive and had experienced childhood sexual abuse. However, only five interviews could be analyzed as the quality of one recording was so poor, it was impossible to transcribe. Participants were identified by the HIV counsellors at district health clinics from the Blaauwberg and Wynberg areas. These counsellors provide HIV pre-test/ post-test counselling and support to patients. Criteria for inclusion in the study were: a history of childhood sexual abuse, an HIV positive diagnosis, and reasonable

² Although the author does not condone the use of apartheid-era racially defined categories such as 'black' and 'white', these are used in the text insofar as they reflect real structural divides among women from different communities in South Africa.

proficiency in English. The age range of participants was from 20 to 50 years of age. First languages were Xhosa, Zulu and Ndebele. Three of the participants were employed and two were unemployed. One participant had a semi-skilled job in a factory while the other two participants worked as general assistants. One of the participants had completed grade 12 while the other participants had high school education between grades 8 to 11. Two of the participants owned houses in the township areas which they shared with their children and other relatives. The other three participants lived in the houses owned by their relatives. Two of the participants were married previously, one participant referred to her partner as ‘husband’ as he had paid lobola but they had not actually been married (by legal or customary ceremony), and two had been in long term relationships (over 5 years). All of the participants had ended these long-term relationships. Four of the participants reported having no male partners at the time of the interviews and one had recently started a relationship. All of the women had children. Names of the women have been changed in order to protect the identity of participants.

The sample was necessarily small (only five participants) because identifying suitable participants for this study proved to be difficult. The first difficulty that arose was identifying women with childhood experiences of sexual abuse. The HIV counsellors at the district health clinics are lay counsellors with 14 days of training in HIV and counselling skills. They do not routinely ask about early life experiences, as they are trained in, and restricted to, following a standard protocol. This protocol determines the areas to be covered in pre- and post-test counselling interviews; while the interview does explore relationship and sexual history, this is only within the context of the patients’ adult lives. According to one coordinator, patients often disclose issues of intimate partner violence but not necessarily childhood sexual abuse. So finding participants was difficult, but counsellors were willing to source patients who had disclosed childhood sexual abuse to them. If the patient was willing to participate in the study, the counsellor would refer the patient to the researcher. An additional attempt to recruit participants was made by placing posters in the waiting areas in some clinics inviting participation in the study. These posters introduced the researcher as a student interested in exploring the experiences of women that had been sexually abused as a child and who were diagnosed

HIV positive in their adult life. It also indicated that participation was voluntary and anonymous and that all information would be treated confidentially. Women patients interested in participating in the study were asked to contact the HIV counsellor/s at the clinic. Not one response to these posters was received. This reluctance of women to volunteer to participate in the study is understandable. Firstly, women with early sexual abuse histories, plus the stigma of HIV, would most probably be extremely reluctant to volunteer to talk to a stranger about these experiences that are deeply personal and possibly shameful. Secondly, illiteracy may have impacted on the effectiveness of the posters. Therefore, finding women willing to participate in this study was a long and slow process.

A second difficulty entailed the definition of childhood sexual abuse. Most western based textbooks divide development into stages i.e. infancy being roughly from birth to age three, early childhood from three to six years of age, middle childhood from 6 to 11 years of age and adolescence from 11 to about 20 years (Papalia, Olds & Feldman, 2001; Sigelman & Shaffer, 1995). Different physical, cognitive and psychosocial developments are expected in the different stages. But is this fact? Post modernist theory argue that these stages are social constructions of reality based on shared assumptions or perceptions of society, but that there is no objectively definable moment when a child becomes an adult, nor is there a clear linear pattern of developmental unfolding (Papalia et al., 2001). Added to this, can existing definitions be applied in a South African context? For example, according to western textbooks, early childhood ends when children complete preschool and enter into formal education at around the age of six. In South Africa, the majority of children live in poverty-stricken conditions and do not have access to basic necessities, let alone school. Often they may not begin school until older ages than is defined by western textbooks. A further complicating factor in the definition of childhood in South Africa is that from a young age children are expected to perform adult duties or run households because of the loss of their parents to HIV or other diseases. Lastly, there is no consensus in the literature on the age inclusions or exclusions of 'childhood' sexual abuse. According to Arriola et al. (2005), in their meta-analysis of 46 studies which explored the relationship between child sexual abuse and

HIV risk behaviour, the maximum cut off age to define childhood sexual abuse could range from 10 years to 17 years of age. They also noted that how researchers delineated the cut-off age seemed to be determined arbitrarily. For every research paper arguing for the cutoff point to be 14 years, for example, there was another paper that argued for a different cutoff age. They noted that this wide maximum age range complicated operationalization of the construct of childhood abuse (Arriola et al., 2005).

Faced with these different definitions of childhood, I decided to consult the UNICEF position on this issue. According to UNICEF, childhood is defined as below the age of 18 years, as laid down in the Convention of the Rights of Children (www.unicef.ca/press). This definition did not resolve the issue but rather posed another challenge. Including adolescence in the definition of 'child' abuse raises the issue of intimate partner violence, where physical and sexual abuse is experienced within consensual intimate relationships between adolescents. After, some thought it was decided to exclude from the study women who were sexually abused in adolescence within consensual intimate relationships. Therefore, the study included only women who had experienced sexual abuse (up until 18 years) outside of an intimate partner relationship.

3.5 INSTRUMENTS

A semi-structured interview schedule (see Appendix 1) was utilized in the study. This instrument was used as a guideline. The interviews lasted approximately 60 minutes. Interviews are on one level simply conversations but are also highly skilled performances. They elicit in-depth information that allows for exploration of the issues (Terre Blanche & Durrheim, 1999). After reading on feminism and its engagement with research methodology, which emphasizes action and social change, I was unsure that utilizing individual interviews was an ideal means of data collection. Interviews take the participants out of their social contexts. Conducting participatory action research, for example, is an attempt to explore the issues under investigation within their social context and to convey and transfer research skills to participants (Terre Blanche & Durrheim, 1999). Focus groups are attempts to create social contexts, where experience can be

shared and interrogated by the participants (Wilkinson, 1998 cited in Moolman, 2003). Feminists have critically engaged in these debates of methodology and ways of representing social reality (Fonow & Cook, 2005). However, Fonow and Cook (2005) indicate that rather than searching for a perfect method that will “get the real right” (p. 2222), it is important to focus on how the researcher engages with the information. It was this that allowed me to use interviews as a method of data collection despite their limitations. Each interview was audio-recorded and transcribed verbatim.

The interview schedule consisted of five broad open ended areas of investigation. The first area was related to the participants’ experiences of contracting HIV, their knowledge of HIV, their condom usage, and safe or risky sexual practices (including exploring experiences of drug and alcohol use). The next area was aimed at investigating participants’ adult intimate relationships, in particular the relationship with the person from whom the participant had contracted HIV. Previous intimate relationships were also investigated. This format allowed for the exploration of experiences of revictimization. The next area focused on early relationships with significant others and explored the experiences and psychological implications of the participants’ childhood sexual abuse experiences. As this was possibly the most threatening and emotionally distressing aspect of the interview, it was decided that this would be investigated in the middle of interview, once rapport and trust between researcher and participant had been established. The next area focused on mental health support or access. This was an important area to cover as it gave an idea of whether outside assistance and support was sought. The last area was an opportunity for participants to ask any questions that may have arisen as a result of the interview. This open-ended format of the interview was useful because it allowed each interview to be shaped according to the experiences of each participant.

From the second interview, I decided to have more in-depth pre- and post- interview reflections (approximately 15 minutes each) with each participant, discussing issues of power, language, my personal and social investment in the project, and participants’ reflections on the process. This was however not audio-recorded but documented in my

journal. This journal also documented my personal reflections and experiences with each participant and interview and some background information that may not have been audio-recorded. According to Few et al. (2003), a researcher journal allows for contextualizing oneself in the research process.

3.6 PROCEDURE

Permission to conduct the study was gained from the coordinators of Leadership South, one of the non-governmental organizations contracted to provide HIV counsellors to the district health clinics in the Western Cape. In 2004, I had been a co-facilitator providing mentorship to some of the counsellors. Towards the end of the year, I presented my research proposal to the mentorship groups. Based on these presentations, the proposal was accepted. Two coordinators volunteered to assist and liaise with counsellors to provide names of potential participants to me. Names were only provided to me once patients were asked permission by the counsellors to forward their names and telephone numbers to me. They were briefed by the counsellors on the nature and intention of the research and who I was. It was emphasized that participation was voluntary. Patients were also referred based on criteria set out under the section on "Participants". Once this was finalized, names and telephone numbers were provided to me. I telephoned the participants and set up times and places that were most convenient. Mostly, a venue at the local library was utilized, as it was close to one clinic, which meant that patients did not have to make a separate trip to the clinic to participate in the study. Other interviews were conducted in the offices of the clinic that the participant attended. The first 15 minutes were spent developing rapport, gaining informed consent, talking through the language issues, discussing my reasons for and interest in this project and checking that the participants met the criteria for inclusion in the study. Four women who were referred had to be excluded as they had either not experienced childhood sexual abuse or their HIV infection was a result of experiences of intimate partner violence in their adolescence. In these instances, we talked through the reasons why I could not continue with the interview. Also, during the first 15 minutes, the prospective participant and I would talk through the implications of revealing their feelings to me, particularly since I was unable to provide any follow-up. After the initial 15 minute conversation, the taped

component of the interview commenced. At the end of the interview, a further 15 minutes was spent reflecting on the interview and containing the participant's feelings. It was difficult for the participants to articulate their feelings related to the interview process but they seemed appreciative of having an opportunity to share their experiences. Most of the women reported that they felt it cathartic and requested that they be referred back to their HIV counsellor for follow-up. Only one woman required a referral to a mental health outpatient department at a tertiary hospital, as in a brief assessment she met the criteria for clinical depression and she indicated that she was struggling to cope.

This difficulty of articulation brings into question the issue of language in the study. My initial criterion was that the participants be reasonably proficient in English. However, the issue of language was vastly complicated, and I held my condition of 'reasonable proficiency' with much ambivalence and discomfort. Few et al. (2003) indicate that language is a site of political struggle for oppressed groups, because the alternatives are either to be silenced by hegemonic forces or alternatively to engage with the issues of power in and held by language. One way of changing the power dynamics in the research process is by paying close attention to linguistics (Few et al., 2003). Part of preparing for an interview process where power can be mutually held by both participant and researcher is ensuring that, as the researcher, you are able to use the lingo and language of the participants (Few et al., 2003). However, I am not proficient in Xhosa or Zulu or Ndebele, which posed a major problem.

One way of dealing with this was by having a translator present in the interview. After some consideration of both literature and anecdotal reports of other researchers and of psychologists completing community service, and drawing on my experience of using translators in my internship, I decided against the use of translators. A translator is a person with his/her own feelings, beliefs and desires (Swartz, 1998). One of the first issues I considered was the impact on the flow and connection of the conversation when using a translator. Having a translator means that there are two people in the room that are unable to communicate with each other. This inevitably may lead to alliances between two people in the room (possibly the participant and translator; or translator and

interviewer), which may negatively impact on the process. Utilizing translators for topics that are sensitive and highly evocative may bring with it its own dynamics. How the narratives of the participants intersect with that of the translator, may have an impact on the translation (i.e. what is translated and what remains unsaid, based on the judgment of the translator). Having the participants' narratives filtered through a translator might also disturb the connection between researcher/interviewer and participant, particularly if the participant is a survivor of abuse who already may have difficulty forming trusting connections. Another issue was how to select a translator. According to Swartz (1998), in the hermeneutic view of language, the translator is viewed as a culture broker, who can inform the interviewer about the cultural background of the participant. However, the translator may not be able to do this and may have other identities that may be utilized or denied in the process. Lastly, what is translated may be mediated by political factors, that come to be represented in the interview context (Swartz, 1998)

With all these layers of complexity, it was not an easy decision to make, and I needed to sit with my ambivalence and reflect on issues of power throughout the research process. Was I perpetuating a dominant ideology by enforcing conversation in a language that I had chosen, and how was this research process challenging issues of power? Was using the participants' second or third language going to provide the thickened descriptions of experiences that I was hoping for? After my first interview, I reflected on whether I was thinking about the power dynamics sufficiently. I had invited the women in the study to share their difficult stories with me, but had imposed a condition of relative proficiency in English. This constituted a power imbalance, and with much discomfort I realized that I was perpetuating hegemonic ideology in this research process. It was then that I realized that equalizing power implied negotiation between myself and the participants, and a need to include myself as a person (specifically a woman with racial and cultural positioning) in this process. In subsequent interviews, a negotiation in the pre-interview discussion was undertaken with each participant. In this part of the interview, the goal was to negotiate with participants to arrive at a mutual choice of a language which made them feel comfortable. I expressed to them my limitations in terms of language and my discomfort with imposing English. This definitely challenged the dynamics between

myself and each participant and placed me as a person in the process, rather than as an ‘academic’ or ‘professional’ requiring information. Only one participant felt uncomfortable speaking in English and we then asked the coordinator of the HIV clinic to translate, as the participant felt most comfortable with this (although I felt ambivalent, as the coordinators of the HIV clinics are seen as leaders and experts in the field of HIV. I was unsure how the participant’s experiences may be filtered through the coordinator). All other participants felt comfortable conversing in English. The focus on language in the pre-interview seemed to positively impact on rapport and power redistribution, according to the post interview reflections of the interviewees (for example, one participant reflected “it was nice to talk in the beginning, it made me feel important”).

3.7 ETHICAL CONSIDERATIONS

Informed Consent

Informed consent is based on the assumption that information is key to influencing an individual’s ‘voluntary’ decision to participate in a research process. But this does not take into account the multiple forms of inequities that permeate power relations and social dynamics (Castor-Lewis, 1988; Drauker, 1999; Mulder, Rance, Suarez & Candori, 2000). In the context of this study, the target participants were economically and socially disempowered. They had past experiences of being sexually abused by a parental or adult authority figure, which may have powerfully influenced their capacity to refuse to participate in this study. Refusing to participate may have been associated with an unconscious fear that they would be victimized, possibly in the medical system through which they were referred. So in this context what does a participant’s consent to participate in this study essentially mean? Mulder et al. (2000) indicate that in contexts of oppression, where basic human rights have been violated or where there is possibly a lack of knowledge of human rights, researchers offering the voluntary right to agree or refuse participation in a research process may not only be met with suspicion but may seem quite unnatural. Therefore, ethical research can rarely avoid reinforcing existing social inequities and disparate power relations (Castor-Lewis, 1988; Drauker, 1999; Mulder et al., 2000). In essence, participants in this study consented verbally to participating in the study, were informed that they could withdraw from the study and

had the right not to answer any questions that made them uncomfortable and all the participants' queries relating to the outcomes of the study and my reason for conducting this study were dealt with before commencing the interview. In an attempt to reduce barriers and facilitate obtaining consent from potential participants, it was decided that a written contract of informed consent would not be used because of issues of illiteracy in the targeted population of participants, a decision that with hindsight may be interpreted as patronizing. It is unclear whether this was the most appropriate way to obtain consent from the participants. Mulder et al. (2000) argue that obtaining consent through formal protocols may assist the researcher to hold that their endeavours are well-intentioned and beneficial for the participants. However, if informed consent is to be meaningful it has to be negotiated and re-evaluated with those involved rather than neatly tied up in a neat package in the name of the 'higher good', "such as scientific progress, refinement of skills or uncovering the workings of women's global oppression" (Mulder et al, 2000, p.109). Verbal consent allowed for the possibility of negotiation, but with disempowered oppressed women, diagnosed with HIV and having early traumatic experiences, it is possible that they may not have truly felt able to refuse to participate.

Confidentiality

Confidentiality was guaranteed. Participants were assured that all their identifying detail would not be included in transcripts and that pseudonyms would be utilized in the dissertation. All interviews were recorded on a digital voice recorder that on completion was transferred into a secured file, with a password, on the researcher's computer.

Risk of retraumatization

It is the ethical responsibility of researchers to identify all pertinent risks that are associated with the research process (Newman & Kaloupek, 2004). Draucker (1999) indicates that there has been an increase in investigation into the phenomenon of sexual violence, but less is known about the impact of the research process on the participants. In this instance, researching childhood sexual abuse was potentially risky and harmful to the participants as it could raise feelings and emotions that are distressing, and increase symptomology that can potentially be retraumatizing for the participants (Draucker, 1999;

Newman, Walker & Gefland, 1999). In studies that have investigated the impacts of trauma research on participants it has been found that opening the “pandora’s box is a legitimate concern” (Drauker, 1999, p.167). However, these studies indicate that the risks often are outweighed by the benefits. Drauker (1999), for example, in two qualitative studies that she completed on the experiences of sexual violence by male intimate partners found in a post-interview follow up, that none of the women had regrets about participating in the study. The participants indicated that they had dealt with the issues before, had not been distressed by the interview and, while it had stirred up emotions, this had been expected. This was confirmed in other studies, and the conclusion reached has been that, despite the risk of distress, the benefits of relating these experiences in a safe environment outweigh the impact of the former (Campbell, Sefl, Wasco & Athrens, 2004; Griffin, Waldrop & Mechanic; Newman et al., 1999; Newman & Kaloupek, 2004). In the present study, during the interviews I felt, based on my (albeit limited) clinical experiences of working with survivors of sexual abuse, that did not want to venture too much into the actual traumatic acts of sexual abuse. My concern was that opening these traumatic memories would leave the participants with overwhelming feelings that could not be contained in the context of a single conversation. While I had given appropriate thought to follow up for each participant, and made a commitment to offer participants appropriate referral after the interviews, I was concerned that I would not be able to provide an adequate temporary holding space for them during the interview, especially since many revealed that this was the first time they had spoken of their experiences of childhood sexual abuse to anyone. Murphy (2004) indicates that asking survivors of trauma to remember their past experiences comes with an ethical responsibility for dealing with these memories - it cannot be done in the name of intellectual curiosity only. Nonetheless during the interviews participants shared some difficult experiences that did open up painful and distressing feelings. I attempted to deal with this in a way that was respectful but yet responsible in terms of emotionally containing the participants. In the post-interview reflection, the participants indicated that it was useful for them to be able to talk about their experiences, and indicated that they felt relief and that expressing their feelings and have me listen to them was helpful.

Psychological follow-up

Due to the sensitive nature of the issues discussed, I indicated that I would make appropriate referrals to various psychological or social service agencies, if the participant needed additional follow-up. Most of the participants preferred to return to their HIV counsellor for follow-up. I also indicated to the participants that when the thesis was completed, I would personally contact each of them to provide some feedback about the results.

3.9 ANALYSIS

A thematic analysis was utilized to understand and make meaning of the interview data. Thematic analysis is described as a coherent way of organizing interview material. It is arranged according to thematic headings which attempt to lucidly present both the research questions and the preoccupations of the interviewees, elaborate on connections and contrasts and reflect on the power relations in the research process (Banister, Burman, Parker, Taylor & Tindall, 1994). Drawing on guidelines of interpretative analysis of data, the key is to interpret the data from a position of empathetic understanding (Terre Blanche & Durrheim, 1999). The steps in the process are (1) familiarization and immersion in the data. This was achieved by conducting interviews and transcribing the interviews myself and then re-reading transcripts to begin to highlight themes. (2) Coding and inducing themes. Coding requires breaking down a body of data into labeled meaningful pieces. In this study, the cut and paste function in a word processor was used to delineate speech that substantiated themes. Inducing themes is “to infer general rules and classes from instances”, and it is therefore a bottom-up way of organizing information (Terre Blanche & Durrheim, 1999, p.141). In this study, themes were generated throughout the research process, as even while completing the interviews, I already had tentative themes that I thought were emerging, that I documented in my journal (3) Elaboration, which is an attempt to capture the finer nuances and meaning not captured by the original coding, and (4) Interpretation and checking, which requires re-reading themes in an attempt to fix weak points and possible contradictions (Terre Blanche & Durrheim, 1999)

Central issues relevant to both psychological and feminist theory and research were used as guiding markers in reporting the data, in order to link the participants' personal internal experiences to larger patterns of oppression, the positioning of women, the social construction of gender, race and class, violence against women and children, and HIV (Foss & Foss, 1994).

3.10 REFLEXIVITY

According to Fonow and Cook (2005), initially reflexivity was defined as the tendency for feminist researchers to reflect on, examine critically and explore analytically, the process of research. It later included respondents' reflections and feedback on the process. More recently it has come to mean how researchers consciously write themselves into the text. It is about being attuned to the dynamics between the researcher and the participant (Few et al., 2003). Presser (2005) argues that being reflective is being sensitive to our place in hierarchies, so that we disclose the multiple, historically specific positions in relation to both study questions and participants. After each interview I kept a journal reflecting on the experience and process of each interview. This allowed for the inclusion of my own personal experience (Foss & Foss, 1994). It also allowed me to write myself into the analysis as a person with history and consequent biases (Diamond, 2006). I have attempted in various parts of the analysis to include my thoughts and difficulties in the research process. Although it is not possible to relegate my reflections to one small section of the thesis, I would nonetheless like to use this section to reflect on my feelings, personal and social history and their intersection with those of the participants.

I define myself as a black woman, although some people would call me "coloured", a label that I have disowned. I am English-speaking and currently completing a Master's degree in Clinical Psychology. Whilst previously in my life I lived in poor conditions, recently I have become slightly more privileged through my graduate education. By contrast, all the research participants were black "African" women, spoke indigenous languages and lived in conditions of poverty. Most of them were employed in unskilled or semi-skilled work, or were unemployed. In addition, being a trainee clinical

psychologist gave the participants leeway to assume me to be an 'expert' that in some way was able 'to fix' their HIV or their social circumstances. They also seemed willing to give away their personal control and it felt like they were telling me to take their stories, dissect them and hand back a solution. It seemed that in a way I was treated as a medical professional that perhaps treated their disease and bodies as separate to who they were. It took some negotiation to attempt to deconstruct these notions and assumptions about me and the skills that I had. The participants indicated that this was different to the way that they interacted with other professionals and that it was very strange for them.

One of the greatest difficulties I confronted was the guilt that I felt about the women telling me their most intimate stories, which I would use in order to complete this research and subsequently my studies. This was beneficial for me, but what about the participants? For the participants, the process allowed them the opportunity to voice their experiences, which is an important cornerstone of feminist methodology. But my guilt was not appeased, since I found that I took on the participants' need for me to provide a solution or some tangible help. This idealized transference of the participants left me with feelings of helplessness. I increasingly felt the need to find a way to help. Once I understood my anxiety as being partly located in the participants, I was able to confront this need to help more realistically. I wasn't able to provide some magical solution (which I explained to participants), but I could refer them for continued psychological intervention. I also realized that maybe part of the anxiety for some participants was a sense of isolation and a strong need to be with other people who are similarly affected by HIV. Some expressed a desire to help or talk to others in similar situations, in the same way that we had spoken. It was at this stage that I began encouraging the women to talk to the coordinator of the HIV counselling in the clinics to ascertain how they could become involved in counselling. This suggestion was welcomed by participants and this in some way calmed my guilt.

3.11 CONCLUSION

This chapter has outlined the epistemological issues relevant to feminist research and some methodological difficulties in the present study, such as recruiting participants, issues related to language, and equalizing power in the researcher/ participant dyad. The study, grounded in feminist methodology, had an emphasis on women's subjective telling of their experiences, and on critical and analytical thinking about the results of the study. The following chapter will present the results of the study.

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This chapter presents the results of the study. The results are presented in thematic form. Themes highlight similarities and/or differences in experiences and perceptions of participants, and are substantiated with direct quotations from the participants in the study. As the transcriptions are verbatim, the quotes appear with language and grammatical errors. Pseudonyms have been given to each participant in order to maintain confidentiality. The themes are presented in the following broad categories (a) participants experiences of childhood sexual abuse (b) psychological effects of the abuse that could explain later revictimization (c) experiences of revictimization in adulthood, and (d) consequences of an HIV positive diagnosis.

4.1 EXPERIENCES OF CHILDHOOD SEXUAL ABUSE

Four of the five participants in this study experienced childhood sexual abuse perpetrated by close relatives or significant others linked to the family. Following are some excerpts of what participants revealed about their experiences of sexual abuse.

Sylvia was abused by her father at around the age of seven.

Sylvia: [long pause] I'm not sure that I can tell you. I've never told anyone before. Er Er well you see when I was small I think I was about 7 years old, my father used to come into my room and lie in my bed naked. He used to touch me and make me touch him. And he used to rub himself on me [participant crying]

Cynthia was sent to her grandparents as a young child to be cared for because her parents were unable to care for her. There she was raped by her grandfather's brother.

Cynthia: No, I was having abuse at home; because my grandfather's brother was rape me...

Interviewer: So how old were you when your grandfather's brother raped you?

Cynthia: I can't remember. It was painful. A lot of things happening. All those things happening to me. He come to my bed at night (crying)... Cause even if I am sleeping, there was someone touching me in the darkness and all that things happen.

Ntombi was uncertain of the exact age when she was first raped by her cousin. She was sent to her aunt and uncle for financial reasons.

Ntombi Yes. I think I was doing sub B. I don't know how old I was. Eight or seven but less than 10 (years old) I'm sure. ... So in Sub B that I get raped by my cousin. ... So I know if the blood is coming then I get raped... They just boil water and Dettol, or something like that. And then I was crying...

Letti was sent to live with her sister because her mother could not afford to financially support her children after Letti's father died. She was raped by her brother-in-law. She initially did not want to talk about her experiences

Interviewer: We initially started talking about your brother-in-law and what he did to you but we seemed to have moved back to talking about your husband.

Letti: I still feel very sad because of that and it is difficult to talk about right now. So I would prefer to talk about something else.

And later she said;

Letti: Yes [crying]. When I was young I had to go and stay by them because my mother never had enough money and couldn't afford the food for all of us. Because we are 4 sisters altogether and 3 brothers. And then my sister used to work late or used to work night shift because she was a nurse. And then when that happens then he used to come to my room and force me [silence]. He also said that he would kill me if I told my sister what was going on... And I was scared every night because I would not be sure when he was going to lie in my bed [crying]. I hated everything about him. He always smelt of alcohol and would make me touch him and then he would force himself [crying uncontrollably].

Issues of class are particularly pertinent to understanding the experiences of the participants. Most of the participants lived in poverty-stricken conditions with single parents, and some of the participants' families were disrupted by the migrant labour system. As a result their physical care was entrusted to other relatives who could financially support the participants. It was in the homes of these relatives that most participants were sexually violated.

Thandi's experience was slightly different as she lived with her mother and siblings after her father's death and was raped at an older age than the other participants, by a soldier in the aftermath of a political war in Zimbabwe. She was also the only participant that reported being threatened by the perpetrator with a gun, whereas the others were threatened with physical violence.

Thandi was 17 years old when she was raped by a soldier in Zimbabwe and was unable to disclose this to anyone because of the threat to her life.

Thandi: When I was at school, there were these soldiers in Zimbabwe [pause, crying]. He just came to me and said that you must just love me. If you don't I will kill you. And I got related to him ...

Interviewer: [pause] how old were you when this happened?

Thandi: I was just 17 years. Just because these soldiers were going by hitting all the people. It was like a war but the war was finished.

Interviewer: So what happened? Just describe the experiences of what happened to you?

Thandi: I was at school that time. He called me when I was with the other kids. I just went to him. He said they were going by beating people, like threatening people. He said to me if you don't want to be beaten then you can get in love with me.

Interviewer: And then what happened

Thandi: So I got in love in with him. Just because I was scared of being threatened or to be killed. Just because the other people were killed in that time.

Interviewer: So did you have to sleep with him? Or rather should I say did he rape you

Thandi: Ja, raped because he force me with his gun.

Several of the participants reported not being believed about the sexual abuse by the significant adults in their lives.

Interviewer: So when you were a child was there anyone that you could tell about what happened to you?

Ntombi; No, cause they (*her aunt and the cousin that had raped her*) just promised me that they are going to kill me. And when I went home to try to tell my mother I don't want to stay there and I did tell her what is wrong. She say my aunt is looking after me and I must go. And then I did try to tell her one day but she said that I talk lies. She say they are helping you with school and then you talk lies about them. And then I stopped to talk about the rape.

Letti: But I tried to tell her (*her sister*) that I don't want to stay there anymore but she thought that I was just being naughty. She would hit me and say that I must stay. And then I tried to tell her what her husband was doing, but she wouldn't listen to me and she said that I am a liar [crying]. So I never tried to told them again. My mother also said that I must go back that I don't have a choice. I was very heart sore...

Interviewer: ...That was a terrible thing that happened to you and there was no-one that you could talk to about what was happening to you. No-one believed or listened to you.

Letti: Yes, sometimes I wonder if it actually happened or did I just dream about it.

Cynthia: I just try to explain this at home. But at home they don't understand and don't believe me. So at home, so that mother was do that... There's another day that I was getting sick, sick, sick. I was finished. My friends was getting worried because even if I [unclear]. So my friend report it at home. All things they report at home. All things they phone if the bad things happen. My mother was come there and was crying. Find me there and I am laying...

Interviewer: So did she believe you at that point?

P: My mother believed that but my mother was scared for my father. Because I just explain to my mother. My mother said that she can't do anything. My father was wanting me to go there. My father was believing them. For everything because of what they said.

Not being believed was experienced by participants as upsetting, but none of the above participants said that they were angry or had any negative feelings towards the person that did not believe them. A rationalization for this was that their mother's did the best that they could under difficult circumstances.

Letti: No, I don't blame my mother. She is the last one that I will blame. I am not angry with her. She wasn't educated and I couldn't finish my education when my father died. I had to get married so that her burden is lighter. So she couldn't have helped it.

Ntombi: Like I said if your mother talk then you can't talk back. She did what she could. I am not angry with her.

Wilcox, Richards and O'Keeffe (2004) suggest that sexual abuse in childhood is most damaging when the child is not believed about the abuse, because it brings into question their views of reality and the validity of these experiences. For the other two participants, lack of belief was not part of their experience, as Thandi never disclosed the rape she experienced, and in Sylvia's case her mother knew about the abuse and encouraged Sylvia to cooperate as she (her mother) feared abuse by the father. As a result of all this, none of the participants were adequately protected by their carers, which may have entrenched feelings of helplessness with regard to abusive situations.

Suicidal feelings were mentioned by all five participants, and two participants had attempted suicide. Most participants indicated that they had thoughts of suicide at

various points in their lives, particularly around the time of the abuse, and later when diagnosed HIV positive.

Cynthia: I just think about it even all the time...

Interviewer: Did they have to pump your stomach?

Cynthia: No it wasn't that dangerous tablets. Nobody even knew that I had taken the tablets.

Interviewer: Okay

Cynthia: No there was nobody that know. They just see me that I am getting sick.

Interviewer: They didn't know what was going on.

Cynthia: Ja, I didn't talk about it. But sometimes I just think about it and think about doing it again so that I am gonna die...

Interviewer: What made you take the tablets?

Cynthia: I wanted them to see that there was something wrong. That they will do something

Interviewer: Did you think about committing suicide at the time?

Thandi: Ja, I thought of just drinking poison, ja

Interviewer: Was this the first time that you thought about suicide

Thandi: No, I always thought about it especially since a teenager.

Interviewer: Have you ever attempted to commit suicide or thought about it?

Sylvia: No. I have never tried but thought about it many times. Especially with my first boyfriend (*he had physically abused her*). Sometimes I think that maybe that I would be better off ...

Interviewer: When you were younger or when your husband was abusing you did you ever think about committing suicide?

Letti: I used to think about it a lot and once I tried to cut my wrists. My mother-in-law found me lying there and she took me to the doctor. I survived because I never cut myself too deep and my mother-in-law never told anyone. But now I didn't do anything or think about it again. Now, I think about my children and what is going to happen to them and what they will feel.

Suicidality as consequence of childhood sexual abuse has been extensively noted in research (Anaya et al. 2005; Gold et al., 1999; Herman, 1992; Krahe, 2000; Messman & Long, 1996; Miner et al, 2006). Herman (1992) suggests that self-destructive thoughts and attempts may be related to the survivor's attempt to regulate internal emotional states, and it also allows for aggression to be directed inward. Miner et al. (2006) suggest that suicidal ideation and attempts are indicators of increased psychological distress and

consequently lower levels of mental health. But for these participants, who were not believed about the abuse and not protected from it, it may have felt like the only way to escape the childhood sexual abuse.

Not being believed by significant caregivers may have invalidated their experiences of abuse and possibly left participants with feelings of deep betrayal and disappointment that they were not protected by people meant to protect them. From the responses of the participants it seems that these feelings may have been denied or repressed in an attempt to protect this attachment to their mothers (Carey, 1997). The suicidal ideation and attempts may be reflective of the extent of the psychological distress felt by the participants, as noted by Miner et al. (2006).

4.2 PSYCHOLOGICAL EFFECTS OF SEXUAL ABUSE

The interview data indicates some of the psychological effects of childhood sexual abuse that could possibly explain the participants' adult revictimization. These are: negative stigmatization and self blame, and feelings of mistrust of others and dependency on intimate partners.

Negative stigmatization and self-blame

Participants in the study had internalized negativity. They felt that they were intrinsically bad or stupid, and were ashamed of themselves because of their experiences of the sexual abuse.

Sylvia: I feel ashamed of myself and I was feeling bad...

Interviewer: How did this experience of being rape make you feel, feel about yourself?

Thandi: I was sad but I also felt bad about myself. I thought I was bad because he did that. That I maybe I did something, that maybe I must get that kind of life.

Ntombi: I wasn't a good child. [participant crying]. I just tell myself that you fail at everything. I blamed myself and I thought I was stupid. When I grew up, I grew up stupid. When I was in high school then I fell pregnant, they said, "it's because you are stupid [participant crying]. I thought it was because I am stupid"... But if someone tell you that you are stupid, you end up as stupid. You

don't know which is right or wrong and you just stupid and then stupid things always happen to you (*the sexual abuse*), because it must just.

Letti: I thought that I was bad ... I hated myself. I thought that I bad...I worried what my sister would think about me if she knew that her husband was sleeping with me... I hated myself.

Together with internalized negativity, participants seemed to develop negative cognitive attributions of blame for the abuse. They felt that their actions must have contributed to the sexual abuse.

Letti: I thought maybe I was doing something wrong ...Maybe there was something, I did something but I don't know what, maybe I had to get that from him because I was naughty, my sister always said so.

Ntombi: So that's why I blame myself because other's blamed me. Because I didn't care what happened to my childhood. Sometimes it hurts me. I tried to rid myself, to make myself relief because it feels like I got something inside me, that no one knows ... I just wish for the mistake to be gone. That time I just blame myself

Cynthia: ...A lot of things happening. All those things happening to me. I wasn't sure why he was doing that to me. It made me sad. I thought that I am cos cos maybe I did something...

Sylvia: ...I thought that it is my fault my father did that to me, but I don't know what I did...

Thandi: Ja, sometimes I am cross with myself. Why did I do that? I think I am to blame, because if I didn't fall in love, like he told me to, then that would not have happened.

As noted in Chapter 2, negative stigmatization and self-blame as a result of sexual abuse have been widely noted in the literature (Carey, 1997; Finkelhor & Browne, 1985; Gold et al., 1999; Herman, 1992; Krache, 2000; Lynn et al., 2004; Marx et al., 2005; Messman & Long, 1996). According to Finkelhor and Browne (1985), negative stigmatization is directly related to feelings of low self-esteem, which result from feelings of badness, shame, and guilt, such as those reported by participants in this study (Messman & Long, 1996). Object relation theories argue that victims internalize a negative view of the self in order to protect or preserve the attachment relationship with the abuser (Carey, 1997; Lynn et al., 2004). Herman (1992) explains that the profound sense of badness is clung

to and becomes the core around which the survivor's identity is formed and it may persist into adulthood. In addition to this internalized negativity, self-blame may occur. Herman (1992) states that "self-blame is congruent with normal forms of thought of early childhood, in which the self is taken as a reference point for all events" (p.103). Therefore people that are traumatized in childhood may tend to search for faults or stigmatize their own behaviour in an attempt to make meaning of what has happened to them (Gold et al., 1999; Herman, 1992). For the participants in the study, self-blame seemed to be used as a meaning making process. Each participant needed to develop an explanation of the sexual abuse, in the context of the lack of validation of these experiences by the external world. This may have increased self-blame. As discussed in Chapter 2, this internal sense of badness and self-blame may be a predisposing factor for revictimization. Revictimization may occur because the survivor, with these negative thoughts about herself, and guilt for having caused the abuse, thinks that she deserves the future maltreatment and thus may be predisposed to tolerating or eliciting abusive situations with others (Lynn et al., 2004; Marx et al., 2005).

Mistrust and dependency

Herman (1992) indicates that in the normal course of development the child develops a secure sense of autonomy by forming symbolic representations of trustworthy and dependable caretakers. In abusive situations, the development of trust is disturbed due to the complex impact of the traumatic experiences. In this study, the participants spoke about difficulties that they had trusting people, resulting in difficulty developing friendships or being able to trust family members with confidential aspects of their lives. This difficulty with developing trustworthy relationships may have left the participants feeling isolated or possibly disconnected from the external world.

Thandi: ...I am scared. I don't have any friends... I am scared of trusting them now.... I didn't have anyone....

Sylvia: No not really. My friend that stays there in [name of place]. I trust her but I don't trust her because you don't know another person...I told you about my one friend that I told about my HIV. I know other people but I can't told them because I can't trust them.

Interviewer: And as a child did you have friends.

Sylvia: Ja, school friends but I never had a close friend. I couldn't tell anyone what had happened. I was scared. So I rather avoided trouble...

Letti: I never really had friends because I was scared to bring them home. I felt very lonely when I was growing up because I wasn't that close to my sister then as I am now. No-one knew what was going on with me or what I was feeling. I felt like I wasn't really there. I couldn't trust anyone...

Ntombi: I had friends at school, but I was not very close. I was frightened that if I have friends, then, then it would be bad because of my cousin

Participants decided that most people were not trustworthy. These decisions were filtered through their anxieties and fears related to the experiences of the initial sexual abuse. Herman (1992) indicates that lack of a secure sense of internal trustworthiness leads the abused survivor to desperately seek for someone on whom they can depend. For the participants, this person was their long-term intimate partner. Dependency on intimate partners was expressed by three participants.

Ntombi: And then I tried to move on with my life and then we feel love and we get married and everything was fine. And the family was with me. Everything was fine. I was like a queen...

Interviewer: So your whole life revolved around your husband and your children?

Ntombi: Yes, I loved him and my children and I didn't want to be without them.

Cynthia: No, I was in love with that guy. I was at school when, when I met him... So after that I was in love with my husband ... I used to talk to my boyfriend and the aunt of my baby. I tell them what is going on.

Interviewer: It sounds like you felt more accepted by his family than by your own family

Cynthia: Ja, sometimes. I needed to be with him otherwise I would not cope

Letti: I had 2 small children and I was not working...But it wasn't. He lied to me and made me think that he was going to be good to me but he wasn't. And I needed him because I had two children.

This dependency may have been driven by the participants' internal need for protection and care, needs that had possibly not been previously fulfilled as a consequence of being sexually abused. This need for protection may have lead to participants idealizing their intimate partners. This idealization together with the internal denigration of themselves

may explain why the participants tolerated further victimization in their intimate relationships (Herman, 1992; Krahe, 2000). However, these feelings may have also arisen from real economic dependency on their partners. In terms of broader social issues, men's roles are traditionally defined as the being productive outside of the home and are therefore ascribed the roles breadwinners and protectors of the family (Gupta, 2000). Women, on the other hand, have roles that are traditionally defined as being reproductive and productive inside the home. They also have limited access to education and finances, which may foster dependency, in women, on their male partners (Kim & Watts, 2005). In essence, it is likely that the dependency on male partners reported by participants was a function of both internal psychological process and external contextual factors.

4.3 REVICTIMIZATION IN ADULT RELATIONSHIPS

All of the participants were revictimized after the initial sexual abuse. Three participants were physically or psychologically abused as teenagers by members of their family of origin.

Sylvia: I was staying with my aunt. And my aunt was not treating me like her children. After I passed St 10, I came here in Cape Town, to my cousin.

Interviewer: You spoke about your aunt treating you badly, what did she do?

Sylvia: ... She was not working. Her husband was working. So before I go to school, I must wash the dishes, I must do the ironing for her child, I must take her child to the creche. My cousin, her children, they went to school already. So I must stay at home and clean before I go to school. And after school I must cook everything. I must wash the shirts. All the shirts. Whereas her children they didn't wash the clothes. It was only me that did the washing. So I told myself that I must do whatever she told me because I want to go to school [crying]. I want to pass standard 10. Sometimes she want the money for the food to my mummy...

Letti: And when I grew up my sister used to hit me and make me walk to school. I was not allowed to have 2 slices of bread. Otherwise she would scold and hit me. At night I would lie awake and worry about what is going to happen to me.

Cynthia: I wasn't staying nicely at home for all my life. Just because my father also hit me. Because also my father hit me that time when I was pregnant...

Interviewer: Why did your father hit you?

Cynthia: He was hit me, always my father was hit me. Even in front of my kids.

Interviewer: Why did he do that?

Cynthia: [crying] he was blame because of what happened and that you want to go there. You get a baby. You are a slut. I told him that I get the babies because of you. I just told you what's going on there but you did not believe me. You say that I must just go there. That's why I get those babies because of you. The way that you were treating me. And I tried to explain everything but he wasn't one to listen to me [participant crying] ...

Cynthia: They (*husband's family*) were also abusing me.

Interviewer: What kind of things did they do to abuse you?

Cynthia: They just sometimes, their mother if I told her that he is doing that that to me. So sometimes she don't want to listen because I just decide to stay home with my mother. And then his mother say no. He isn't gonna support the kids. They want that babies to stay there because they don't know what is going on there at home.

Four of the participants reported that they were physically abused in their adult intimate relationships. In revictimization literature, alcohol use by the survivor is cited as a reason for increased vulnerability to later victimization (Gold et al., 1999; Marx et al., 2005). However, in this study alcohol consumption by their intimate partners was cited by three participants as the reasons for the abuse occurring.

Interviewer: what did you feel when he was sort of threatening you about this and was it the first time that he sort of treated you in this way or was there previous times?

Thandi: He was doing this always because he was drinking. Ja. especially I was not going anywhere, because when he comes, he would just threaten me. Maybe there is someone that I am going with but I didn't have anyone. Everytime he is drunk then he must fight me and threaten me with many things to kill me

Interviewer: Shoo, so you obviously feared for life

Thandi: ... I was scared of him.

Ntombi: He just hit me once. When we were not here...

Letti: Trust me, he will go and drink and then in the middle of the night he would come back and wake me up and all those type of things... But he would still abuse me.

Cynthia: yes, he was hitting me sometimes about something that I didn't know. Hitting me sometimes. ...Because he would drink and then hit me...

Two of the participants had experiences of abuse which they struggled to identify or call abuse. Initially these participants seemed to be emotionally defended and said that their

relationships were fine and that there were no problems. But upon further investigation it became clear that their partners were physically and sexually abusive toward them.

Ntombi: Ja, my husband was like that. If I got a friend, he just wouldn't like them. My friends must be a married woman and it must be someone who goes to church, no drinking, no smoking... When I was there in [name of place] I didn't wear pants because of his family. When I get here, he say no it is fine. You can wear pants while you are in Cape Town, everything was fine. But when we go home, down to his family then I must wear skirts... He just hit me once... He just promised he was gonna hit me...

Interviewer: I am a bit confused about what you said previously, so I would like to clarify. What was the “things” that he was doing to you before?

Cynthia: Because he wasn't one to support me, treat me bad. I ask him something about the baby and he don't. So it is all that things that he is doing to me. Also that baby I was thinking that I was gonna go home. On that time that the baby girl of mine [unclear].

Interviewer: You keep saying the things that he do to you. Was he verbally or physically abusing you?

Cynthia: Yes, he was hitting me sometimes about something that I didn't know. Hitting me sometimes... He accuse me yes that I have another man.

Interviewer: You said that he hit you?

Cynthia: Ja... [silence]

Interviewer: How often would he hit you?

Cynthia: It was really, hey, painful. It is painful to me that what happened.

This tendency to downplay the abuse may be linked to the concept of hyperfemininity. In this type of personality, as elaborated in Chapter 2, women hold onto rigidly prescribed gender roles. Aggression and violence may be an expectation, so it is not questioned. An alternative explanation may be that being with an abusive man may also be familiar to the participants, so they may never really think about its negative implications and possibly it brings their personal and social narratives closer (Lynn et al., 2004). Additionally, at a broader social level, violence by men has been used as a means to subordinate women and maintain unequal power relations (Gupta, 2000). It may be this norm that lead participants to almost expect violence by their partners, and therefore labeling it as abuse, may have lead to some level of cognitive dissonance for them.

Four of the participants had regular experiences of rape in their intimate relationships. The participants never named their experiences as rape but rather spoke about their partner “forcing” them to have sexual intercourse.

Sylvia: He force me to sleep with him... I told him no I didn't want to sleep with him but he sleep with me anyway... Yes, and sometimes if I am on periods then he want to sleep with me by force. I told him that no I can't sleep with you because I am on periods. He forced me to sleep with him... He said that he can't help the menstruation and he is a man and he want it now. So to avoid that things to have him hit me or him talking ugly...

Cynthia: ...And then he just force me to sleep with him.

Interviewer: How did he force you?

Cynthia; He would just pull my clothes off and force me to open my legs. Sometimes he hurt me [crying] but it never happened all that many times.

Two participants identified a link between being raped and contracting HIV as their partners had visible signs of sexually transmitted infections.

Letti: I didn't know what to do. I didn't know what to do. He was on top of me and was forcing himself on me. That time he knew that he was HIV positive because the nurses and the doctors had told him but I didn't know. And he was forcing me and I was getting sore and I was bleeding.... But as I said there was nothing that I could do because he had paid the lobola... That time when he forced me to sleep with him he had this yellow stuff on his penis that worried me. Also at that time I was stupid. I didn't know about the HIV and STI's so I thought maybe it was just normal...I could not tell my husband no. I had to sleep with because he paid labola. I was also very frightened of him and he made me feel nervous all the time. I was not able to do anything, anything [crying]

Thandi: And the boss was left already for Jo'burg. And we were in our room and he said I want to sleep with you now. And I said, just take the condoms. I ran to my boss's house. It was 7 'o clock and he came and kicked the door and I was scared maybe the neighbours would hear the noise on somebody else's property. And I went back. Even in the private parts he had sores ... Ja, I was. I could not say no because he would say you can't. No ways, no ways...but it made me scared. I felt that I couldn't do anything cos he was always threatening to kill me or something ...

From the above it can be seen that participants had continual experiences of rape and felt unable to assert themselves in their sexual relationship with their intimate partners. This may be due to the psychological effects of early sexual abuse which left them feeling that

they are deserving of abuse, or the participants may have learned through the early sexual abuse that it is the role of the women to satisfy men's sexual desires regardless of their own needs. This may also be related to the feelings of helplessness engendered by not being protected by carers from the child sexual abuse. Therefore in later life they may be less likely to defend or protect themselves against unwanted sexual contacts (Freshwater et al., 2000). However, these experiences of revictimization are also embedded in issues of sexuality, gender and culture. All of the experiences described above allude to the differential power that men and women have in intimate relationships, determined through gendering and sexualizing practices - sexuality is different for men and women because it enables men sex to gain power over women's bodies (Oriol, 2005). The participants had little power and control of their bodies, as the threat of violence by their intimate partners, forced them to comply with their partners' sexual demands. The cultural practice of paying lobola, for example, is perceived to legitimate the physical abuse and rape, as explained by one participant. Further, while the laws of South Africa protect women in intimate relationships against rape, ordinary women often do not have access or knowledge of their rights, in order to protect themselves. Added to this, being victims of child sexual abuse may mean that these women, in this study, may not believe that they have the right to protect themselves. The subservient position of women in intimate heterosexual relationships, the culture of silence around sex, together with the dynamics and/or outcomes associated with early childhood sexual abuse place these women in vulnerable positions and at risk for contracting HIV (Allers et al., 1993; Arriola, et al., 2005; Gupta, 2000). Further, Kalichman and Simbayi (2004) indicate that survivors of abuse are more likely to have blood present when engaging in sexual activity. While this was only reported by one of the participants, two of the participants indicated they were forced to have sex with their partners even when there was visible evidence of a sexually transmitted infection, since sex is coerced in these intimate relationships, it is possible that bleeding and rawness in the vaginal area may have resulted. These abrasions make women physically more vulnerable to contracting HIV (Berry, 2005).

These findings confirm that revictimization can be a pathway between childhood sexual abuse and vulnerability to HIV. But it represents the less dominant explanation for the pathway, because research predominately focuses on increased risk for HIV among survivors of child sexual abuse through high risk sexual behaviour e.g. multiple sexual partners, impulsive unprotective sex, sex work and drug or alcohol abuse (Allers & Benjack, 1991; Allers et al., 1993; Gold et al., 1999; Kalichman & Simbayi, 2004; Krahe, 2000; Madu, 2003). However, all the participants in this study denied ever using illicit substances and only Ntombi indicated that she used alcohol socially (She said, "Just at parties. When there is a party, a big party you see, you drink wine and all those things. But now I don't want to touch those things"). Participants were in long term intimate relationships and never reported risky sexual behaviour, in terms of multiple partners or impulsive unprotected sex.

Sylvia: ... Because I was having one boyfriend here in Cape Town...even in Transkei I was having just one boyfriend

Interviewer: So, I am confused. Was he your first boyfriend?

Ntombi: No, he was the second one because the first one I was still at school. And then I fell pregnant. And he leave me and then I just forget about that one.

Letti: Ja, I had others but the abuse began with him. It affected me deeply. He was my second sexual partner ...

Interviewer: Did you have any other relationships?

Cynthia: After him?

Interviewer: No before him.

Cynthia: No, we were separated. I was in love with another guy. He was my first boyfriend that guy. That time I was just separated from that guy because he went to boarding school. So after that I was in love with my husband.

Thandi: He was the only one since I came here in Cape Town. I just get him. I don't make many boyfriends. In that time I stayed about maybe 4 years without any relationship...

Interviewer: so, you had your first relationship, sexual? when you were 22 and you stayed with him for 3 years and then you had another relationship before this six year relationship.

P: Yes, my first was at 22 but I didn't have any. When I came here it was '96, '97, '98. I started to be involved in the relationship with this guy.

Rather the participants were revictimized by ongoing sexual violence in their relationships, which increased their vulnerability for contracting HIV.

Feelings of powerlessness, helplessness and fear was not only related to experiences of sexual abuse, but were pervasive in the participants' intimate partner relationships.

Thandi: I was scared of him ... Sometimes I was telling myself I was telling him something. But when he comes I was not able to tell him anything.

Interviewer: What stopped you?

Thandi: I was scared. I thought that maybe he was going to do something, that he was going to kill me or whatever.

Letti: So I was unhappy for almost 9 years in the marriage ... Because, I didn't know what else to do. I had 2 small children and I was not working. What was I supposed to do?

Cynthia: ... I was upset the way that he was treating me. I was frightened of him when he was like hitting me and I had children... What was I to do? It's him that just bring me here.

Ntombi: In 1998, he just brought the gun to our house and he [unclear] and he was just cleaning the gun, doing this and just press it by mistake and just shot his friend on his feet.

Interviewer: How did you feel about him having a gun?

Ntombi: It was fine. He was a good man. But sometimes I was scared what he was going to do with it, that's why I thought I mustn't get friends or nothing!

According to Marx et al., (2005) survivors of sexual assault may feel that victimization is beyond their control and therefore it is unavoidable, and they may be left feeling powerless to change their personal circumstances. Finkelhor (1988, cited in Rich et al., 2004) suggests that passivity may be engendered and survivors consequently 'give up'. In this study, participants had feelings of powerlessness, with little sense that change was possible. The fear of their partners seemed to have contributed to their sense of powerlessness. The implications of fear and powerlessness may have negatively impacted on their ability to protect themselves from contracting HIV, by negotiating the use of condoms or controlling when sexual relations took place. But being black women living in poverty already creates a power imbalance to negotiating protection in intimate relationships. In the context of poverty, women may be dependent on their partners

financially, and in these instances it has been shown in research that they will be less likely to succeed at negotiating protection because they may feel that this may lead to economic victimization by their partners (Gupta, 2000; Kim & Watts, 2005). Also, the gender inequalities that are embedded in cultural norms and practices create barriers to protection. Kim and Watts (2005) indicate that refusing sex or suggesting the use of condoms may bring into question issues of fidelity and may incite violence from men. Furthermore, the constant threat of physical and sexual violence may impact on negotiating protection. All of these issues, which are intrinsically bound up in the participants' social identities, may have left the participants with feelings of powerlessness, helplessness and fear in their relationships, which in turn may have reduced their ability to protect themselves from contracting HIV.

For the participants in this study, the issue of condom usage varied. Some of the participants did not know about HIV and therefore never used condoms, others feared, or were threatened with, abuse by their husband/partner if they asked to use condoms, while others trusted their husbands/partners and did not feel that condom use was needed.

Interviewer: And before this were you ever able to use condoms?

Thandi: No,

Interviewer: What do you think was the reason for this?

Thandi: I said, the first time that is nonsense [name] there is no such thing as HIV. These people are just lying. Ja. And my boyfriend, I couldn't ask him to because he would abuse me, maybe hit me. He also said that there was no such thing like HIV

Ntombi: ...no, that time we were not familiar with condoms so I didn't use them. But also we were married so I trust him, so I don't think that time it was necessary...

Interviewer: And did you know about condoms?

Sylvia: Yes

Interviewer: So, did you and your partner ever think of using condoms?

Sylvia: We were using but [pause] the reason why I stopped to using the condoms is him. He said to me, "no, it is a long time that we are using the condoms" and he want the baby. And me I was looking for the baby you see.

And then later when she revealed that her partner rapes her she said;

And even now when I was pregnant, he know that I am positive but he doesn't want to use the condom. He said that you are positive and me I am positive (*not that he was tested*) so what is the use of the condom. So I told him that at the clinic they told to us that we must use the condom. But he say no he is not going to use the condom. He threaten that he is gonna hit me.

Interviewer: when you were with your husband did you use condoms.

Letti: No. That time I didn't know about condoms. I think he knew but he never used it. Just because he knew that he was HIV.

Interviewer: Did you and your husband use condoms?

Cynthia: No, we never used because I trust him

Interviewer; And after you contracted HIV did you and your husband still sleep together and use condoms?

Cynthia: Even the time that I was still pregnant he was still want to sleep with me, without a condom. Even because that time I was come back to the hospital they told me about that. So I told him, "please". Because that time I told he was laugh at me. He said that he wouldn't because he don't care. I said, just for the baby.

Interviewer: So he didn't want to listen to you.

Cynthia: He wasn't want to listen. If he ask me and I say no then he don't listen. He just tell me that he is gonna hit me if I ask again.

It has been shown in research that using condoms decreases risk for HIV (Miner et al., 2006). However, negotiating condom use has various pitfalls related to power inequities. Gupta (2002) also indicates that besides condoms being a prevention method that requires male co-operation, there are other issues that come into play. For example, she says that rural women in South Africa do not like using condoms for fear that it will get lost and perhaps travel into another body part, or for young girls asking to use condoms may elicit a negative response from male partners, because of the norm valuing female virginity. In addition, Zierler et al. (1991) indicate that the safer sex message of using condoms may be missing the point for people whose lives have been complicated by early sexual abuse.

Despite the abuse and consistent revictimizations, participants had possibly an impaired sense of trust in their partners – that is, they were overly trusting of them.

Sylvia: ...I was trusting him on that time.

Ntombi: If there was a problem before, I didn't notice it because I trust him

Letti: And then I met my husband and I thought that I could trust him...

Thandi: I trusted him (*partner*) because it was a long time that I stayed without a boyfriend.

This trust may have been an outcome of early patterns of insecure attachments. Herman (1992) suggests that the survivor's intimate relationships are driven by a hunger for protection, care and secure attachments. In an attempt to gain this, the difficult aspects of the relationship or their partner may be denied or distorted (Carey, 1997). Also, the participants trust in their partners may have been an attempt to develop a secure trusting attachment.

From the above themes it can be seen that the participants in this study were consistently revictimized both physically and sexually over time. It was these sexual revictimizations that directly lead them to being vulnerable to, and subsequently contracting HIV, in their long-term intimate relationships.

4.4 CONSEQUENCES OF HIV POSITIVE DIAGNOSIS

Testing HIV positive

Three of the participants found out about their HIV positive status when they were pregnant and attending antenatal clinics, while the other two participants found out when they began having visible signs of illness. For two participants, their babies had died. Ntombi's baby was stillborn and Cynthia's baby died a few months after birth, although she said that it was not HIV-related. Sylvia baby, however, was 4 months old at the time of the interview.

Sylvia: I found out last year. No not last year, the year before on February, when I was pregnant. They treat me. They made the blood. They told me that I am HIV

Ntombi: Okay, in 1998 erm I fell pregnant. I think the late 1997. I diagnosed it was June, no May 1998. I went to the hospital for the bookings because they was want to check HIV and AIDS. I say yes. I was sure of myself because my husband was a Christian. I was also a Christian. So I thought to myself... I said I am positive, thank you. My mind was thinking about positive attitudes [interruption]

Interviewer: You thought that it was a good thing?

Ntombi: Yes, it was positive... that time your HIV is yours. And then the doctors told me that this baby is tired they must do something to help the baby. And then, they say there is a risk. If they try and help the baby I am going to die. If they try to help me the baby is going to die... After that I found that he gave me HIV. After [unclear] I moved here to stay to someone's house to try to change my life. I was working, so I get the phonecall. They call me, he was vomiting blood, so they think it was TB or something like that... He had another girlfriend and also that girlfriend passed away. That girlfriend was my friend, my best girlfriend.

Cynthia: ...Yes, I was supposed to get the baby that they check me. Cos I was having pains when I went to the hospital. So they check. So that guy was want my results, my before results. Then I got the results [participant speaking very soft] which was positive... I was thinking that he have another relationship outside.

Letti: That was in the year 2000... Ja, what happened was he was here and I was at home in [name of place]. Then he came home sick... I didn't even think that he was going to survive. I didn't even think that he was going to survive. That year it was raining. He and I were always walking in the rain. We walked in the rain because I was always taking him to doctors... That time he knew that he was HIV positive because the nurses and the doctors had told him but I didn't know...:I was diagnosed here in Cape Town. I used to come to the clinic because I was ill. And then they asked me if I want to be tested. And then I agreed.

Thandi: I found out, I didn't want to but my boss said [name] you are getting slim now. What's wrong? I said there is nothing wrong. I went to the clinic in [name of place] and the nurse just checked me. I told her I told her that even my sister is saying to me how, why am I losing weight. But I was feeling weak. I even told the sister that for even if I carry a tray of coffee, I cannot lift it up. She said to me, the better thing for you is to test. I am not going to give you any treatment. I just chose to be tested because I was not going to be given any treatment ...: It was 2000, 99 he got this shingles. I didn't even know the shingles before. I knew just now, just because I get them six months ago. I get them. I said to him, I took him to his family in [place], from there he went to the hospital and the doctor said he must go and test. And he said to me [pause] that, "these nurses are saying that I am HIV positive. They lie. I'm not going for results". I said "why". He said no. From there I was staying at work.

Finding out that they were HIV positive may have been the most negative health consequence of years of sexual abuse that the participants of this study experienced throughout their lives.

Feelings evoked by HIV positive diagnosis

For all of the participants being tested positive for the HI virus evoked strong feelings of pain and shock, this was true even for the two participants that reported that their partners had visible signs of an STI.

Thandi: Ja, I felt that I was going to die... Ja, it was bad ja

Sylvia: I was very sad. I was crying the whole week because I didn't feel like if [long pause] I had it...

Ntombi: ...and then I am stuck and shocked because I didn't understand. And then Saturday I didn't sleep and then on Sunday...

Letti: ... I was really shocked. Because I never expected it. I wasn't involved in a relationship.

Cynthia: I was shocked because I wasn't expecting that it was gonna be like that. But it was happen me. So I was shocked. So after that I go home, after I get the baby. So I go home and then I tell my husband, that they checked me like that

Response of partners to HIV positive diagnosis

Four of the participants disclosed their status to their partners with the hope that he would be tested. However, this was met with resistance and denial by the partner that he could be HIV positive.

Thandi: Ja, I think he went to [name of clinic] but he never went back for the results. Because he said to me those nurses are stupid. They are lying. They saying that he is HIV positive.

Sylvia: ...My boyfriend er I am not staying with him. I phone him and say that I want to see him in my house. Then he came to my house. And I told him that I am HIV positive. So he was worried that day...

Interviewer: Was he tested?

Sylvia: No, he doesn't want to go the clinic. I was begging him. He said no, he can't go to the clinic. If he dies then he must die.

Ntombi: It's my problem. I bring this into the house ...

Interviewer: So could you tell him at that point that he must be tested?

Ntombi: Yes, but he don't want to listen. He don't want to talk to me.

Cynthia: ... He wasn't one to go check the blood. He say no...

This denial by their partners may have been experienced as repetition of the participants' earlier experiences where they were not believed about their sexual abuse.

Self-blame for HIV positive diagnosis

The tendency to self-blame, a pattern developed in relation to the early sexual abuse, extended into participants adult lives and intimate relationships. Most of the participants, thought that they were to blame for contracting HIV and then infecting their intimate partners.

Letti: Ja, I think that I go in and out of feeling that I am to blame. Sometimes I think what would have happened if [pause, crying]. But I blame myself first for getting HIV. I thought I did something that brought this because I cursed him.

Ntombi: ... But when I diagnosed with HIV he said I don't know where you get it. I just blame myself. I'm wrong, I think that I am wrong. I think I done something wrong but I don't know ...

Cynthia: Ja, ja. He was blaming me after that. Because he was just telling her that I was coming to hospital all the time. After that he was just [unclear]. After that it was that he was blaming me... and I thought maybe I did, but I am not sure how because I was only sleep with him.

Sylvia: ...So I thought that if I had no other girlfriend then it is probably something that I did that made me positive, because he never used to treat me bad...

Thandi: He said that maybe I have someone else, someone better. I knew that I never had anyone else but I still thought that I gave him the HIV. Maybe I was bad so that was God's way of punishing me.

This internalization of the blame may have been related to their need to protect and preserve the idealized attachment with their partners that they so desperately needed. But also it may be related to the culturally ascribed notion that women are responsible for reproduction in the homes, therefore any problems related to this becomes the 'fault' of women (Gupta, 2000).

Being blamed by family for HIV positive status

Three of the participants reported that they were blamed by their partner's family for bringing "the disease" into the relationship.

Letti: And his family say that I am the one that gave him the HIV because I left home. My mother in law knew about the forced sex and at least she would listen. But since I left she doesn't care about me anymore.

Cynthia: I say to them (meaning the partner's family) that he give HIV to me. I just go home. And they say don't lie, you find the HIV.

Ntombi: His family said that I bring this into the house and they are the rich family, the good family. They said, we are Christians so we don't have that, something like that.

Being blamed by others again may have reinforced the negative attributional pattern developed earlier in life. Perhaps it reiterated the idea of being damaged or "spoiled goods", as suggested by Messman & Long (1996). But again it may be linked the notion that women's roles are related to reproductive activities in the home, as described in previous theme (Gupta, 2000). So as women they may then bear the burden of blame, given that HIV transmission occurs in relation to reproductive processes.

Revictimized as a consequence of HIV positive diagnosis

Three of the participants were revictimized in various ways by their partners when they disclosed their HIV positive status.

Interviewer: What things did he do that you thought things had changed?

Sylvia: He got a other girlfriend [long pause]. He is not treating me [pause] happy, you see.

Interviewer: Okay.

Sylvia: You see that every time that I go to his house then he has his girlfriend there. Every time. Every time, if he maybe came to my house for the baby. Then the girlfriends of him, they are phoning him and maybe when we are talking then he is rude to me. He swears at me. So he was not treating me well.

Ntombi: ... And then erm at home he didn't need me, he didn't want me to touch my kids, to sleep in the room. I must sleep in the front, I must use my separate everything, even food, everything ... He don't want to talk to me. He don't want to see me. He don't want to touch me, to give me food. I must just stayed like, like er er I can't even wash up ... Then when he (meaning husband) come back he

just went into the house and shouting. He just promised he gonna hit me, if I touch his coffee. Because he bought a coffee, milk and sugar. So he say if you touch my stuff I am gonna hit you but he didn't hit me. I decided to ran away.

Cynthia: The baby was still small and my operation was still fresh...No, not physical fight. Just other things. ...So then he just chase me away from the house.

These participants were abused and ostracized by the very person that they trusted and who had also infected them with HI virus. This may have been the final experience of revictimization in these intimate relationships. This act highlights power inequities between men and women. The women were forced to leave their homes, as their partners had more power, control and also ownership of the homes. Also, participants' bodies were the site of oppression, in that they were physically abused, raped, infected with HIV and then discarded by their partners (Oriel, 2005).

4.5 SUMMARY OF THEMES

All the participants in this study were sexually abused, mostly by relatives, in their childhood years. The sexual abuse had a deleterious impact on their lives, particularly since participants were not believed or protected from the abuse by significant caregivers. There were various psychological patterns that emerged as a consequence of the child sexual abuse that may have contributed to later victimization in adulthood. Negative stigmatization and self-blame seemed to powerfully contribute to creating vulnerability to later victimization. This negativity and self-blame may have lead the participants to believe that they were deserving of the maltreatment. Mistrust was also identified as another pathway to revictimization, as not being able to trust other people may have created a sense of isolation and fuelled a dependent connection with their intimate partners. Dependency may be reflective of internal psychological processes, but may also be related to broader social inequities in South Africa, whereby women have limited access to educational and economic resources and therefore are economically dependent on men.

Revictimization was pervasively present in the lives of participants. For some this started in their teenage years, where abuse was perpetrated by members of their families of

origin, and extended into adulthood where they reported physical and sexual abuse by their intimate partners. All the participants contracted HIV from their long-term intimate partners, often through coercive sexual practices. Being diagnosed HIV positive came as a shock to all the participants, when they were tested either at antenatal clinics or when they had visible signs of illness. Four of the participants disclosed this to their partners and this was met with denial and resistance from their intimate partners. Four of the participants blamed themselves for contracting HIV, which was similar to psychological patterns developed earlier in their lives due to experiences of child sexual abuse. The women also carried the burden of blame and stigma associated with being infected with HIV, as their partner's families attributed blame to them for bringing HIV into the relationship. Some participants were revictimized by being abandoned and rejected by their partners at the stage of being diagnosed with HIV.

Findings of study in relation to previous literature

The findings of this study must be tempered by the limitations of the study, which will be discussed in the next chapter. The findings are similar to other studies in terms of the psychological effects of childhood sexual abuse that create vulnerability to later adult revictimization. The sexual abuse, together with not being believed and protected by others, seems to have created patterns of negative attributions, self-blame, mistrust, and dependency on intimate partners among the participants in this study. All the participants reported revictimization in adulthood, in the form of physical and/or sexual abuse by their long-term intimate partners, confirming patterns of revictimization reported in previous literature (Allers et al., 1993; Arriola et al., 2005; Brady et al., 1991; Chin et al., 2004; Whitmire et al., 1999; Wyatt et al., 2002).

For the participants in this study, the pathway from child sexual abuse to HIV was not located within risky sexual behaviours as noted in previous research. None of the participants reported having multiple sexual partners, as the maximum number of sexual partners the participants had in their lifetime, was two. Neither did they engage in impulsive unprotected sex or abuse illicit substances or alcohol. None of them were involved in sex work. Rather, they reported that their partners used alcohol excessively,

which provoked acts of physical and sexual abuse. Experiences of sexual revictimization and disempowerment in their intimate relationships appear to have led to the participants contracting HIV. The ongoing sexual abuse can be interpreted as a psychological reenactment of early sexual abuse, as the psychological literature suggests, but is also located within power inequalities in sexual relations, where women are viewed as objects of conquest by males, for male sexual pleasure (Oriel, 2005). Participants reported not using condoms consistently. Psychological literature indicates that women who have been sexually abused are less likely to be able to negotiate condom use due to being unassertive. However, for these participants, an incapacity to insist on condom use by partners must be understood in the context of ongoing sexual and physical violence and threats by their partners. Therefore insisting on condom use within these relationships presented real dangers for these women. Being diagnosed HIV positive may have been the most negative health consequence of revictimization for the participants in their intimate relationships. As a result of being diagnosed HIV positive, patterns of internalized negativity and self-blame reoccurred. Their partners and partners' families blamed them for bringing the HIV into their intimate relationships which may have reinforced internalized negativity (Messman & Long, 1996). Lastly, some of the participants were ostracized and abused by their intimate partners. It has been noted in previous literature that women become vulnerable to physical and sexual violence by partners when disclosing their HIV status (Gupta, 2000; Kim & Watts, 2005).

4.6 CONCLUSION

From this it can be seen that there were many similarities between the findings of this study to previous research particularly with regard to the psychological consequences of child sexual abuse that create vulnerability to later revictimization. However, differences were identified with regard to the pathway between child sexual abuse and HIV risk in this study. Revictimization was clearly delineated as the pathway, in the form of ongoing sexual and physical violence within intimate relationships. It is therefore important to engage with the complexities of both psychological and contextual factors in an attempt to understand how survivors of child sexual abuse become vulnerable to HIV

transmission in adulthood. There is clearly a need for both a psychological and a contextual feminist framework in order to fully understand this relationship.

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CHAPTER 5 CONCLUSIONS AND RECOMMENDATIONS

This study aimed to conduct an in-depth exploration of the narratives of women who experienced childhood abuse and who, in their adult lives, were diagnosed HIV positive. The specific objective was to explore within the narratives of the participants the role of revictimization, with the intention of understanding how this contributed to them contracting the HI virus. This chapter will summarize the findings of the study, reflect on the limitations of the study, and then make recommendations for future research and policy development.

5.1 SUMMARY OF FINDINGS

The collective narratives of this study suggest that, for this group of women, child sexual abuse may create vulnerability for later revictimization, and that this vulnerability creates a pathway to HIV transmission. These findings suggest that the pathway to HIV transmission for this group of women was not related to increased risk-taking behaviour like multiple sexual partners, impulsive unprotected sex, and drug and alcohol abuse, as has been predominately documented in previous research. Rather, it occurred through a process of abusive revictimization in intimate relationships. While revictimization has been shown to be linked to HIV risk, this connection has not been clearly expanded. Quina et al. (2004) suggest that it may be related to the inability to refuse unwanted sexual activity and to insist on condom usage, and Allers et al. (1993) similarly explain revictimizing relationships as including threat or physical harm and this makes it difficult for the survivor to insist on safer sex practices without chances of further harm. These suggestions were confirmed in this study. The incidence of rape and physical abuse in intimate relationships lead to feelings of powerlessness and fear among the participants, a reenactment of earlier experiences, which then impacted on their ability to negotiate sexual relations and condom use. Self-blame developed as an internal psychological pattern that facilitated meaning making in terms of the earlier abuse, and appeared to persist into their adult relationships. This internal psychological experience then negatively impacted on negotiating whether sex took place and on negotiating condom usage, because the women may have felt that they deserved the abuse or that they were to

blame for the abuse, therefore they did not have the right to protect themselves. The message that they may have learned through the experience of not being believed by adults about the childhood sexual abuse may have further reinforced the idea that they did not have the right to be protected or ask for assistance. The internal psychological patterns and processes that developed as a consequence of the early sexual abuse appeared to powerfully influence the patterns of behaviour and engagement in their adult relationships. However, added to this are the influences of gender inequities, unequal power relations in heterosexual relationships, and poverty that all contributed to placing these women in very vulnerable positions, and at high risk for HIV. Revictimization and disempowerment in negotiating safe sex practices arise out of a complex relationship between psychological factors (the consequences of child sexual abuse) and contextual factors (gender power relations and poverty).

5.2 BENEFITS AND SIGNIFICANCE OF STUDY

The significance of the study was viewed to be both theoretical and methodological. At a theoretical level it attempted to understand the role of revictimization in the relationship between child sexual abuse and adult HIV risk, which has been mentioned in many previous studies but not explored in depth. This study was an in-depth subjective exploration which elucidated provisional insights into the above phenomena that may serve as a basis for future research and theory-building. As this is an extremely under-researched area in South Africa, this project in some small way has begun to fill the gap in this body of scholarship. The use of both psychological and feminist theory provided a useful integrated framework for understanding how revictimization may contribute to HIV risk. At a more individual level, the study provided a vehicle for mobilizing these participants to become involved in HIV work and programmes aimed at supporting others. The process seemed to be beneficial for participants as it allowed participants to voice experiences that were deeply personal, to name feelings and to have their experiences validated. The process also allowed me reflect on some of my feelings about people living with HIV, which will ground me in my future clinical work, and it facilitated engagement with difficult issues of power and disempowerment in the research process.

5.3 LIMITATIONS OF THE STUDY

This study has various limitations. The first limitation is related to the research design of the study. As indicated in Chapter 3, collective case study design has advantages in terms of providing thick descriptions of phenomena and allowing for the study of individual participants as individuals and not as part of a population. However, there are limitations. Firstly, it may be difficult to determine the validity of the information generated from this type of research design (Stake, 2000). Validity is a central concern of any project and quantitative studies have standardized ways of determining this. In qualitative research, on the other hand, validity is more critically engaged with as it holds the perspective that there are multiple realities that cannot simply be “discovered” (Banister et al., 1994). Validity is thought to be related to the researcher being able to defend and substantiate interpretations (Mason, 1996). In this regard, this study attempted to present findings in a way that has been substantiated by the data but it is tempered by my own positioning in terms of race, class, gender and theoretical orientation. Because of this, other readings of the data are possible, and subsequent readings may therefore yield different interpretations of information.

Secondly, the findings of this study are not generalizable to broader populations, rather they are specifically applicable to these participants (Terre Blanche & Durrheim, 1999). The sample size in this study was small consisting of only five participants. The difficulties related to recruiting participants in this were outlined in chapter 3. In quantitative research, sample size is often used to guarantee the strength of claims made about the results. However, the difficulty with this is that the greater the sample size, the less the researcher knows about individual participants (Banister et al., 1994). In qualitative research, the researcher is inherently interested in the thick descriptions of the phenomena being investigated. Banister et al. (1994) indicate that in a qualitative study every case provides an opportunity to examine in-depth the meanings at work rather than skim over as wide a surface as possible. So despite the fact that only five participants were included in this study, the findings do yield in-depth understandings of the phenomena investigated. However, the findings should be considered exploratory and

provisional, and future research needs to build on these further. This was also based on a volunteer sample, and it is possible that only women with very particular experiences may have been motivated to volunteer for the study.

Thirdly, causal links within the data cannot be inferred from this study. Contracting HIV through intimate partner violence may not only be related to women with experiences of child sexual abuse. Many other women may contract HIV this way, as a result of unequal gender power relations in society. As causal links cannot be inferred from this study, it is imperative that future research be conducted with the aim of establishing whether women with a history of child sexual abuse are at greater risk for contracting HIV through intimate partner violence than other women.

5.4 RECOMMENDATIONS

Research

Firstly, there are no reliable statistics about the relationship between childhood sexual abuse and HIV infection in adulthood in South Africa. The literature review of this study indicates that such prevalence studies have predominately been completed in western developed countries. Previously, child sexual abuse and HIV infection was not recognized as having a connection. But in the last decade, this has received increasing attention. Given the high prevalence of both child sexual abuse and HIV in South Africa, it seems that this warrants closer investigation. Therefore, epidemiological studies are required in order to understand the nature and extent of the relationship between early childhood sexual abuse and HIV risk.

Secondly, while psychological theories are only one way of understanding human behaviour, they are an important way of engaging with the experience of women who have been sexually abused. Allers et al. (1993) recommend that child trauma specialists share their work with clinicians working with HIV infected persons. They argue that a lack of understanding between professionals may lead to misdiagnosis, insufficient treatment strategies and adult survivor's reenactment of earlier experiences, in the context of treatment. This is an important point to take into consideration. This type of fluidity

would promote dynamic thinking about treatment plans. It would also help with identifying who is at risk for HIV infection and lead to different ideas about prevention. Therefore, research into the potential benefits of investigating early histories of sexual abuse, and of providing interventions in the context of HIV counselling and prevention that use both psychological and contextual theoretical factors, is essential.

In this study, the role of revictimization as a possible pathway to HIV infection was noted. Revictimization was embedded in a complex interweaving of both psychological processes and broader social, cultural and economic factors. However, taking the limitations of this study into account, replication of this study in different contexts is required – specifically, studies that explore whether women with child sexual abuse histories are more at risk of contracting HIV through intimate partner violence than other women are.

Policy Development

The study highlights the role of revictimization in intimate relationships as a pathway to increasing risk for HIV infection. Following from the study these are the recommendations in terms of policy development.

As indicated in the methodology, early experiences of sexual abuse and/ or other abuses are not routinely explored as it is not part of the standard protocol utilized by the HIV counsellors at district clinic level. As indicated by the findings of this study, the effects of childhood sexual abuse powerfully impact on later sexual revictimization in intimate long-term relationships, which decreases the capacity to negotiate sexual encounters in a safe way. This needs to be accounted for when conceptualizing prevention strategies and interventions. In a psychiatric context, for example, exploring early experiences of abuse has become an integral part of shaping the clinicians understanding of the difficulties that the person presents with in a mental health context (Allers et al., 1993). In the context of HIV prevention and intervention, not only will internal psychological processes impact on vulnerability to contracting HIV but these dynamics may play out in the relationships with health practitioners and counsellors, and may also impact on following a treatment

regime. Providing a comprehensive psychological understanding and subsequent support for women who have had these early experiences seems to be a key element that is currently overlooked in the South African context. Currently, HIV counsellors are not equipped to work with this. If mental health professionals cannot be employed at district clinic level, then it is recommended that this be taken into account when training counsellors and that ongoing training is provided that will enable them to work with the psychological consequences of abuse. This should then become part of the standardized protocol which will also allow for documentation of the extent of the problem.

Secondly, while South Africa's HIV prevention strategy has identified women as a vulnerable grouping, it does not account for specific vulnerabilities in specific groupings of women. The message is to **A**bstain, **B**e faithful and **C**ondomise. For the women in this study, it was found that they were faithful in long-term intimate relationships, but that in the context of continual sexual and physical abuse these women did not have the power to be able to insist on the use of condoms. Even if women had more access to female condoms or microbicides, this still would be problematic for women who are sexually revictimized on an ongoing basis. In these relationships, power between men and women is skewed, which is reflective of broader social forces and inequities. The addition of internal psychological vulnerabilities makes for layers of complexity that are not easily 'fixed' by the message of negotiating condom use. So the question is how this ABC message of HIV prevention protects women in abusive relationships, and particularly those that have had experiences of childhood sexual abuse, which has further impeded their sense of control over their bodies and sexuality. It is recommended that in the HIV prevention strategy these groupings of women be taken into account and that different ways of protecting and empowering these women be explored.

From my limited experience with working in the mentoring group with counsellors, I have seen that the focus has been on empowerment of women through providing access to knowledge and community resources. However, this may be insufficient as it does not deal with the internal psychological processes that are a consequence of early sexual abuse and which may contribute to HIV vulnerability. Therefore, it is recommended that

access to psychological services is necessary, albeit through the training of HIV counsellors.

5.5 CONCLUSION

In conclusion, this study has attempted to explore the role of revictimization as a possible pathway between child sexual abuse and HIV risk. It seems from this study that sexual revictimization in the context of intimate relationships may place women at increased risk of contracting HIV. It is an area that has received little investigation in the South African context, but is important given the high incidence of both sexual abuse and HIV in this country. This is a problem that needs to be further elucidated through continued research and engagement at all levels in South Africa.

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APPENDIX 1

INTERVIEW SCHEDULE

Thank you for agreeing to participate in the study. Introduce myself, explain the nature of study and why I am engaged in this project, and provide information about confidentiality, anonymity, voluntary participation and that its not compulsory to answer questions if uncomfortable, estimate length of session, and discuss risks and benefits. Obtain consent.

1. Can you tell me about being HIV positive? What did you feel when you found out; did you know when you had contracted and from whom, were you in a relationship at the time, did you disclose it to your partner (probe reaction or why they did not). Did you have knowledge of HIV before contracting the disease? Safe sex practices, risky sexual practices? Condoms? If not what prevented you from using it?
2. Can you tell me a little about the relationship with the person from whom you contracted HIV (probe intimate partner violence, re/victimization; ability to set boundaries, trust in partner, trust of self in intimate relationships, feelings about self in relation to partner). Can you tell me about previous relationships you may have had (again probe as above)?
3. Can you tell me bit about you growing up years, relationships with parents, siblings, other significant people. (Probe childhood abuse and psychological implications e.g. cognitions about themselves, depression, interpersonal relationships – attachment/ (dis)connection, coping strategies)
4. Have you had any experiences of being hospitalized/ seen psychiatrist/ psychologist for emotional difficulties? Can you want to tell me about this?
5. Are there any questions that you would like to ask?

(Note: Background information and language issues discussed before interview, and reflections of interview process after)