

**TRAUMA-INFORMED STRENGTHS-BASED GROUP
INTERVENTION GUIDELINE FOR FEMALE SURVIVORS OF
ADULT SEXUAL ASSAULT**

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Thesis accepted in fulfilment of the
requirements for the degree *Doctor of Philosophy
in Psychology* at the North-West University

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PREFACE

THIS DISSERTATION CONSISTS OF THREE SECTIONS:

SECTION A: Overview of the study.

SECTION B: *Phase One:* Rapid review (*Manuscript 1*)

Reports on a rapid review of current evidence-based interventions for adult survivors of sexual assault.

Phase Two: Empirical study: Convergent mixed-methods study (*Manuscript 2*)

Reports on the quantitative findings of the convergent mixed-method study. Outlines the prevalence of and correlations between posttraumatic stress disorder (PTSD), psychological well-being (PWB), resilience, and posttraumatic growth (PTG) in a sample of female survivors of adult sexual assault (FSASA).

(*Manuscript 3*)

Reports on the themes highlighted within the recovery journeys of a sample of FSASA. Compares survivors that show few signs of recovery (FSR) to survivors that show significant signs of recovery (SSR).

Phase Three: Trauma-informed strengths-based group intervention guideline (*Manuscript 4*)

Outlines the guideline that was designed applying the Design and Development Intervention Model.

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

Section A provides an overview of the study and includes a literature review. Section B consists of three phases. Phase One includes a rapid review, which was conducted to

synthesise the evidence-based interventions currently available for sexual assault survivors. Phases Two and Three consist of two manuscripts outlining the findings of an empirical study (convergent mixed-method). The quantitative section used validated psychometric measures and a demographic questionnaire to measure demographic variables between PTSD, PWB, resilience, and PTG in a sample of 50 FSASA. The qualitative section used constant comparative analysis to identify and compare themes related to participants' recovery journey in the study distinguished as those that showed FSR to those that showed SSR. Phase Four combines the findings from the rapid review and the empirical study into a fourth manuscript outlining the proposed guidelines for mental health professionals (MHPs) when conducting a trauma-informed strengths-based group intervention for South African FSASA. Lastly, Section C provides the conclusions drawn from the study, with a specific focus on the contributions and limitations of the study as well as recommendations for future research.

It is worth noting that the reader can expect some duplication of content across the three phases. This is due to the article format that was selected in compiling this dissertation.

DECLARATION

I declare that the study *Trauma-informed strengths-based group intervention guideline for female survivors of adult sexual assault* is my own work. To cite and recognise all the sources used in my dissertation, I adhered to the reference and editorial standards outlined in the American Psychological Association's (7th edition) Publication Manual.

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CONFIRMATION OF LANGUAGE EDITING

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To whom it may concern,

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“Owning our story and loving ourselves through that process is the bravest thing that we will ever do.”

— ***Brené Brown***

ABSTRACT

High prevalence rates of sexual assault perpetrated against women are well documented, both nationally and internationally. Although this type of trauma can lead to numerous adverse long-term effects, some survivors overcome it and experience positive changes in themselves and their lives. Although traditional pathogenic or deficit-based models have dominated literature, a paradigmatic shift towards a salutogenic or strengths-based approach is becoming evident in emerging literature. This shift encourages mental health professionals (MHPs) and researchers to focus on positive and adaptive post-trauma outcomes that incorporate potential areas of positive psychological changes, such as emerging growth, and spiritual and existential adaptive outcomes.

Thus, a more detailed understanding of the interactions between indicators of distress and psychological well-being (PWB) is required. This intervention research is comprised of three phases and four manuscripts. A rapid review was conducted in Phase One to investigate evidence-based interventions available to female survivors of adult sexual assault (FSASA) (Manuscript 1). In Phase Two, a convergent mixed-method study was conducted to investigate real-life examples through an online survey targeted at South African FSASA residing in the Gauteng Province. The quantitative section of this study measured and correlated several variables, namely posttraumatic stress, PWB, resilience, and PTG in the sample (Manuscript 2). Validated psychometric instruments used included the PCL-5 (DSM-5 clinician checklist for PTSD), the Mental Health Continuum (MHC-SF), the Adult Resilience Measure (ARM) and the Posttraumatic Growth Inventory (PTGI). The qualitative data consisted of participant answers to open-ended questions on their recovery experiences. This data was analysed to compare the themes apparent in the recovery experiences of participants that showed SSR to those who showed FSR (Manuscript 3). In Phase Three, the rapid review and empirical study

findings were integrated to develop a trauma-informed strengths-based group intervention guideline for FSASA (Manuscript 4). The main barriers to service delivery were highlighted during stakeholder consultations, namely i) insufficient training opportunities for staff, and ii) financial constraints. These prevented clients from returning for additional sessions, impacting recovery rates. Both quantitative and qualitative findings were discussed for the convergent mixed-methods study. Findings from the quantitative section showed that participants experienced high levels of trauma, with most participants experiencing more than one sexual assault. Participants received both formal and informal support and more than half attended psychotherapy. A total of 68% of the participants scored above the diagnostic threshold for PTSD; however, the participants viewed themselves as doing well mentally. Average levels of resilience were observed with personal resilience scores surpassing relational resilience scores. Correlational analysis indicated that PTSD decreased and PWB increased as time passed after the assault and the duration of therapy was correlated with better mental health. For the qualitative section, barriers to accessing support included apprehension and distrust of self and others, lack of resources and informal support. Informal support included emotional validation and active support. More positive counselling experiences were reported by women in the SSR group than in the FSR group. Experiences and symptoms related to PTSD, resilience and PTG were reported in both groups. A strengths-based trauma-informed group intervention guideline was developed from these findings. MHPs (psychologists, social workers, counsellors) can apply these guidelines in facilitating and enhancing resilience processes, PWB, and PTG-enabling outcomes in FSASA.

Key terms

Posttraumatic growth, Posttraumatic stress, Psychological well-being, Resilience, Sexual assault

OPSOMMING

Hoë voorkomssyfers van seksuele aanranding wat teen vroue gepleeg word, is internasionaal en nasionaal goed gedokumenteer. Alhoewel hierdie tipe trauma tot talle nadelige langtermyn-effekte kan lei, oorkom sommige oorlewendes dit en ervaar positiewe veranderinge in hulself en hul lewens. Alhoewel tradisionele patogene of tekortgebaseerde modelle die literatuur oorheers het, word 'n paradigmatische verskuiwing na 'n salutogene of sterkpuntgebaseerde benadering duidelik in opkomende literatuur. Hierdie verskuiwing moedig geestesgesondheidswerkers en navorsers aan om te fokus op positiewe en aanpasbare post-trauma-uitkomst wat potensiële areas van positiewe sielkundige veranderinge insluit, soos opkomende groei, geestelike en eksistensiële aanpasbare uitkomst. As sodanig is 'n meer gedetailleerde begrip van die interaksies tussen mates van distress en sielkundige wellstand by vroue wat seksuele aanranding tydens volwassenheid ervaar het, nodig. Hierdie intervensienavorsing bestaan uit drie fases en vier manuskripte. In fase een is 'n vinnige oorsig gedoen om bewysgebaseerde intervensies te ondersoek wat tans beskikbaar is vir oorlewendes van seksuele aanranding by volwassenes (Manuskrip 1). In fase twee is 'n konvergente gemengdemetodestudie gedoen om werklike voorbeelde te ondersoek deur gebruik te maak van 'n aanlyn opname wat gerig is op volwasse Suid-Afrikaanse vroulike oorlewendes van seksuele aanranding wat in die Gauteng-provinsie woon. Die kwantitatiewe gedeelte van hierdie studie het die volgende veranderlikes gemeet en gekorreleer: posttraumatiese stres, sielkundige welstand, veerkragtigheid en posttraumatiese groei in die steekproef (Manuskrip 2). Gevalideerde psigometriese instrumente wat gebruik is, sluit in die PCL-5 (DSM 5 klinikuskontrolelys vir PTSV), die Geestesgesondheidskontinuum (MHC-SF), die Volwasse Veerkragtigheidsmaatreël (ARM) en die Posttraumatiese Groeivoorraad (PTGI). Die kwalitatiewe data in die studie

bestaan uit antwoorde op oop vrae wat die ervarings in verband met hulle herstellingsproses. Die temas in beide deelnemers wat tekens van herstel getoon het en die wat minder tekens van herstel getoon het is geïdentifiseer en 'n vergelyking is onderneem (Manuskrip 3). In fase drie is die vinnige oorsig en empiriese studiebevindings geïntegreer om 'n trauma-ingeligte sterkpunte-gebaseerde groepintervensieriglyn vir vroulike oorlewendes van seksuele aanranding by volwassenes te ontwikkel (Manuskrip 4). Twee hoofhindernisse vir dienslewering is tydens konsultasies met belanghebbendes uitgelig, die eerste was onvoldoende opleidingsgeleenthede vir personeel, tweedens het finansiële beperkings kliënte verhinder om vir bykomende sessies terug te keer, wat die herstelkoers van oorlewenis beïnvloed het. Beide kwantitatiewe en kwalitatiewe bevindings is bespreek vir die konvergente gemengde metodes studie. Bevindinge van die kwantitatiewe afdeling het getoon dat deelnemers hoë vlakke van trauma ervaar het, met die meeste deelnemers wat meer as een seksuele aanranding ervaar het. Deelnemers het beide formele en informele ondersteuning ontvang en meer as die helfte het psigoterapie bygewoon. 68% van die deelnemers het bo die diagnostiese drempel vir PTVS behaal. Ten spyte van hierdie hoë gemiddelde telling vir PWB het aangedui dat die deelnemers hulself geestelik goed beskou het. Gemiddelde vlakke van veerkragtigheid is waargeneem met persoonlike veerkragtigheidstellings wat relasionele veerkragtigheidstellings oortref. Korrelasie-analise het aangedui dat PTVS afgeneem het en PWB toeneem het namate die tyd verloop het na die aanranding en die duur van die behandeling gekorreleer is met beter geestesgesondheid. Vir die kwalitatiewe afdeling was hindernisse vir toegang tot ondersteuning vrees en wantroue teenoor die self en ander, 'n gebrek aan hulpbronne en informele ondersteuning. Informele ondersteuning het emosionele validering en aktiewe ondersteuning ingesluit. Meer positiewe beradingservarings is deur vroue in die SSR-groep gerapporteer as in die FSR-

groep. Ervarings en simptome wat verband hou met PTSV, veerkragtigheid en PTG is in beide groepe gerapporteer.

Geestesgesondheidswerkers (sielkundiges, maatskaplike werkers, beraders) kan hierdie riglyne toepas in die fasilitering en verbetering van veerkragtigheidsprosesse, sielkundige welstand en posttraumatiese groei wat uitkomste by vroulike volwasse oorlewendes van seksuele aanranding moontlik maak.

Sleutelterme

Posttraumatiese groei, Posttraumatiese stres, Seksuele aanranding, Sielkundige welsyn, Veerkragtigheid,

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GLOSSARY OF TERMS

Included in this glossary are key terms used recurrently throughout the study.

Sexual assault: According to the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, sexual assault occurs when someone sexually violates another person without consent (Republic of South Africa, 2007). More specifically, sexual assault is when a person intentionally sexually touches another person without the person's consent or coerces or physically forces a person to engage in a sexual act against their will (Cameron et al., 2015). Behaviours that fall within this category include i) attempted rape, ii) fondling or unwanted sexual touching, iii) forcing a victim to perform sexual acts, such as oral sex or penetrating the perpetrator's body and iv) penetration of the victim's body, also known as rape (RAINN, 2020). All the above behaviours are considered part of sexual assault for this study.

Posttraumatic stress: Characteristic symptoms following exposure to one or more traumatic event(s) in line with The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) criteria (American Psychiatric Association, 2013a, 2013b). These can include fear-based re-experiencing and emotional and behavioural symptoms. These symptoms are characterised by the intrusion, avoidance, negative alterations in cognition and mood, and marked alterations in arousal and reactivity, causing significant impairment in the person's functioning.

Psychological well-being (PWB): The culmination of emotional, mental, and social well-being; a state known as flourishing or optimal functioning (Keyes, 2000).

Resilience: The psychosocial concept of resilience refers to an individual's adaptation and healthy development in the face of life stressors or strains; it encompasses the capacities needed to adapt successfully to significant adversity (Hetherington & Blechman, 2014; Kersting, 2003; Luthat et al., 2000; Masten, 2011).

Posttraumatic growth (PTG): The experience of significant positive psychological change arising from the struggle with a major life crisis (Calhoun et al., 2000). People who have experienced PTG report changes in five domains, namely appreciation of life; relating to others; personal strength; new possibilities; and spiritual, existential or philosophical change.

Intervention guideline: Clinical practice guidelines are concise practical documents that outline the most important clinical factors for therapists to consider when treating different psychological disorders or employing specific intervention techniques (Australian Psychological Society, 2013). Accordingly, intervention guidelines are formulated by experts in the field and act as a go-to document that outlines the best available research and clinical expertise and takes the client's characteristics, culture and preferences into account while addressing their needs (American Psychological Association [APA], 2021).

Group-based Intervention: Group interventions, which are used in healthcare for mental health recovery, behaviour modification, peer support, self-management, and health education, are therapies that are given to groups of people rather than to individuals (Biggs et al., 2020).

Trauma-informed: The trauma-informed approach encourages people in an organisation or system to recognise the signs of trauma and respond by encouraging safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and an awareness of cultural, historical and gender issues, to resist re-traumatisation of clients (Substance Abuse and Mental Health Services Administration, 2014). During interventions, clinicians following this approach exhibit i) trauma awareness; ii) an emphasis on safety; iii) a commitment to encouraging opportunities to rebuild control for the survivor, and iv) a strength-based approach (Guarino et al., 2009; Hopper et al., 2010; Yatchmenoff et al., 2017).

Mental health professional: MHP refers to a professional trained to offer counselling services to FSASA. For this research, psychologists, social workers and registered counsellors are included.

LIST OF ABBREVIATIONS

4Ps	Predisposing, Precipitating, Perpetuating, and Protective Factors
ACTH	Adrenocorticotropin Hormone
AIP	Adaptive Information Processing
APA	American Psychological Association
ARM	Adult Resilience Measure
ARM-R	Revised Adult Resilience Measure
BWRT	Brainworking Recursive Therapy
CBT	Cognitive Behavioural Therapy
CFA	Confirmatory Factor Analysis
CFA	Comparative Fit Index
CPT	Cognitive Processing Therapy
CT-PTSD	Cognitive Therapy for PTSD
D&D Model	Design and Development Model
DRC	Democratic Republic of Congo
DSM-5	<i>Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition</i>
EFA	Exploratory Factor Analysis
EMDR	Eye Movement Desensitisation and Reprocessing
FSASA	Female Survivors of Adult Sexual Assault
FSR	Few Signs of Recovery
G4-F	Group 4-Focus, F ormulate, F acilitate, and F ollow-up
GBV	Gender-based Violence
HPA	H ypothalamic- P ituitary- A drenal
IES	Impact of Events Scale
IGTP	Integrative Group Treatment Protocol
IPV	Interpersonal Violence
IRT	Image Rehearsal Therapy
JBI	Johanna Briggs Institute

LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
LI	Lifespan Integration
MAP	Mental and Physical
MBSR	Mindfulness-based Stress Reduction
MHC	Mental Health Continuum
MHC-SF	Mental Health Continuum-Short Form
MHP	Mental Health Professionals
MLI	Modified Lifespan Integration
MRI	Magnetic Resonance Imaging
NACOSA	Networking HIV & AIDS Community of Southern Africa
NGO	Non-governmental organisations
NWU	North-West University
PAF	Principal Axis Factoring
PCA	Principal Component Analysis
PCL-5	PTSD checklist for DSM 5
PET	Prolonged Exposure Therapy
PICO	Population, Intervention, Control, Outcomes
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PSQI	Pittsburgh Sleep Quality Index
PTCI	Posttraumatic Cognitions Inventory
PTG	Posttraumatic Growth
PTGI	Posttraumatic Growth Inventory
PTSD	Posttraumatic Stress Disorder
PWB	Psychological Well-being
RCT	Randomised Control Trial
RMSEA	Root Mean Square Error of Approximation
RRC	Resilience Research Centre
S2T	Survivor to Thriver
SAPS	South African Police Service

SIT	Stress Inoculation Training
SNS	Sympathetic Nervous System
SPSS	Statistical Package for the Social Sciences
SRMR	Standardised Root Mean Square Residual
SSR	Significant Signs of Recovery
STD	Sexually Transmitted Diseases
STTS-R	Satisfaction with Therapy and Therapist Scale-Revised
TABS	Trauma and Attachment Belief Scale
TEARS	Transform Education About Rape and Sexual Abuse
TIC	Trauma-Informed Care
TLI	Tucker-Lewis Index
USA	United States of America
WAI-S	Working Alliance Inventory Short-Form
WHO	World Health Organisation
WITS	University of Witwatersrand

SECTION A: OVERVIEW OF THE STUDY

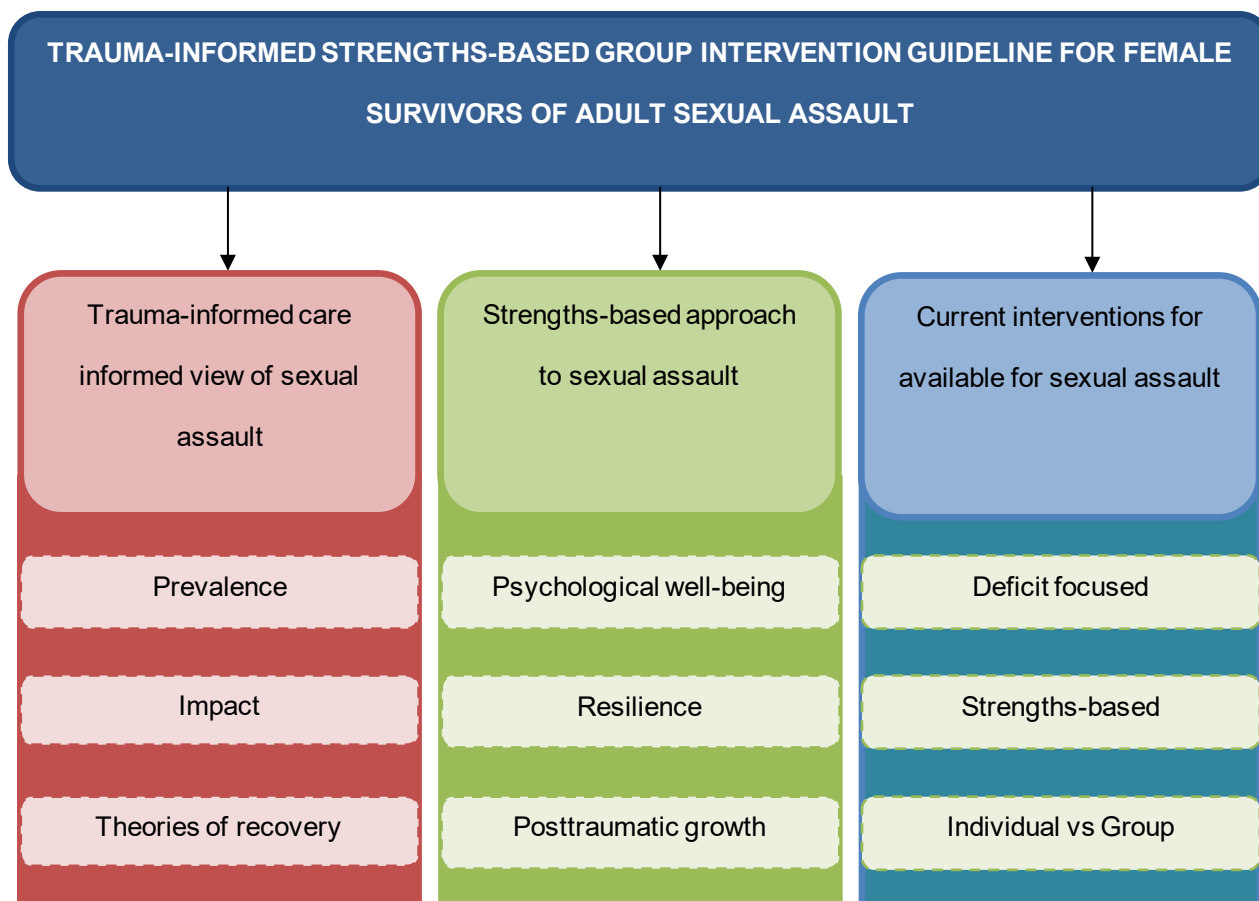
1. INTRODUCTION

This study aims to design a trauma-informed, strengths-based group intervention guideline for female survivors of adult sexual assault (FSASA). This section offers a literature review that contextualises the problem statement addressed in the research. This summary includes an outline of the purpose statement, objectives, research questions, and the study design map. Under research methodology, the central theoretical argument, the conceptual framework, the paradigmatic perspective, the research approach, the type, and the model are discussed. Thereafter, the ethical aspects considered for each section of the study are outlined along with the study's contributions.

2. LITERATURE OVERVIEW

The following section provides a literature review to contextualise the study. Several themes were investigated, namely trauma-informed view of sexual assault (prevalence, impact, and context of interventions), strengths-based approach to sexual assault including psychological well-being (PWB), resilience, and posttraumatic growth (PTG) in sexual survivors and current interventions available to sexual assault survivors (deficit-focused and strengths-based). The figure below outlines these themes.

Figure 1: Literature overview



2.1 Trauma-informed View of Sexual Assault

Ranjbar and Speer (2013) found that healthcare professionals can significantly impede sexual assault survivors’ recovery process if they are inexperienced, adhere to rape myths and stereotypes and treat survivors in a disrespectful or inconsiderate manner. As a result, professionals are encouraged to seek appropriate training and adhere to the latest research-supported interventions to be effective when working with this vulnerable population. There is a clear balance within the trauma-informed care (TIC) approach between recognising trauma symptoms, keeping the difficulties inherent in the path to recovery in mind, and the strong inclination towards empowering survivors to participate actively in this process by emphasising their strengths. The trauma-informed approach encourages people in an organisation or system to i) recognise the signs of trauma; ii) respond by encouraging safety, trustworthiness and transparency, peer support,

collaboration and mutuality, empowerment and an awareness of cultural, historical and gender issues, and iii) resist re-traumatisation of clients (Substance Abuse and Mental Health Services Administration, 2014). During interventions, clinicians following this approach exhibit trauma awareness, emphasise safety, are committed to encouraging opportunities to rebuild control for the survivor, and use a strengths-based approach (Guarino et al., 2009; Hopper et al., 2010; Yatchmenoff et al., 2017). In order to develop a trauma-informed approach, it is essential to be cognisant of the factors that impact the prevalence of sexual assault, the impact that it has on the survivor and the recovery process itself.

2.1.1 Prevalence of sexual assault

Sexual assault is a broad term that can encompass various forms of sexual violence. The World Health Organisation (WHO) states that sexual assault includes physical or other force to obtain or attempt sexual penetration (WHO, 2013). The definition provided by the American Psychological Association (APA) expands on this definition by defining it as unwanted sexual activity, including touching, kissing and sexual intercourse that occurs when the victim cannot give consent or with force, threat of force, intimidation or coercion (VandenBos, 2007). Overall, sexual assault can be defined as any sexual activity that occurs without the explicit and enthusiastic consent of all parties involved or that occurs using force, threat of force, coercion or manipulation. These definitions emphasise the importance of consent and the need for unambiguous communication between sexual partners. Since this study was conducted within the South African context, the legal definition of sexual assault in South Africa is used. According to the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, sexual assault occurs when someone sexually violates another person without consent (Republic of South Africa, 2007). More specifically, sexual assault is when a person

intentionally sexually touches another person without that person's consent or coerces or physically forces a person to engage in a sexual act against their will (Cameron et al., 2015). Behaviours that fall within this category include attempted rape, fondling or unwanted sexual touching, forcing a victim to perform sexual acts (such as oral sex or penetrating the perpetrator's body) and penetration of the victim's body, also known as rape (RAINN, 2020). All the above behaviours are considered part of sexual assault for this study.

There are several reasons why gathering accurate global sexual assault statistics is a complex task. Firstly, there are differences between the behaviours defined as sexual assault across countries (Dartnall & Jewkes, 2013). Although marital rape is seen as a criminal offence in many countries and within international law, 127 countries have not criminalised it (Turquet et al., 2012). Since these offences are not criminalised, they do not feature in national statistics, potentially underrepresenting the scope of the problem.

Secondly, many prevalence studies report the occurrences related to the broader term 'sexual violence'. This term includes sexual acts performed with force or under coercion, including sexual abuse, molestation, trafficking, exposure to pornography, genital mutilation and harassment in addition to rape/sexual assault (Dartnall & Jewkes, 2013). These studies do not necessarily differentiate between the different types of acts, making direct comparison difficult. Although global sexual violence prevalence rates have declined over time, victimisation rates of females in low-development index countries, are increasing (Borumandnia et al., 2020).

Shen et al. (2022) conducted a systematic review and meta-analysis that explored the global prevalence of sexual violence perpetrated against pregnant women. They found that approximately one in three pregnant women had been victims of sexual violence in their lifetime and that women in developing countries were 3% more at risk (Shen et al.,

2022). Abrahams et al. (2014) found that 7.2% of women aged 15 years or older had experienced non-partner sexual violence worldwide. In 2018, the WHO reported that this number decreased to 6% (WHO, 2021a). Upon further inspection of these statistics, it is apparent that South Africa has one of the highest rates of sexual violence globally (21%) (Abrahams et al., 2014; Adar & Stevens, 2000). More recent national statistics report an increase of 10.35% in reported sexual offences between 2015 to 2017 (AfricaCheck, 2019; Statistics South Africa [StatsSA], 2018), during which 70 813 sexual offences were committed (StatsSA, 2018), translating into one in every 500 individuals experiencing a sexual offence in South Africa during that period.

With these statistics in mind, we focus on studies that explored sexual assault exclusively. The WHO defines rape as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object (WHO, 2020). Dworkin et al. (2021) synthesised studies that included sexual assault perpetrated by partners in studies published between 2010 and 2019. Their results indicated that global prevalence rates ranged from 0-59.2% for women, 0.3-55.5% for men and 1.5-18.2% for lesbian, gay, bisexual, transgender and queer (LGBTQ) samples. An interesting trend was noted regarding the prevalence of sexual assault cases reported to the South African Police Service (SAPS) during the Covid-19 pandemic (SAPS, 2022). An increase in reported cases was observed from April to June 2018 until just before the pandemic in April to June 2019 (11 387 vs 12 094). When restrictions were at their most stringent during Level Three to Five lockdown periods (April-June 2020), there was a 6.7% decrease in reported cases. During Level One and Two restrictions (April-June 2021), the number of reported cases increased again, reminiscent of pre-covid levels (12 094 vs 12 702), and then decreased again slightly when restrictions were lifted (April-June 2022; 11 855). These fluctuations in prevalence indicates that alcohol restrictions and after-hour

movement restrictions could have inhibited the prevalence of assault during intoxication and stranger perpetrated assault. It is important to note that this decrease may not be reflective of changes of prevalence in sexual assault where the perpetrator is in an existing relationship in which women are less likely to report.

Lastly, underreporting is a significant concern for the validity of sexual violence and sexual assault statistics. Older individuals from ethnic and cultural minorities, sexual and gender minorities, people with disabilities, mental health difficulties, financial vulnerabilities, and problematic substance use may experience barriers when seeking treatment for sexual assault (Bach et al., 2021). Such barriers include limited access to formal support and insufficient training and awareness among service providers regarding best-practice support for survivors. Even if an individual does not form part of the above, they may still hesitate to report feelings of shame, guilt and embarrassment, not wanting to be ridiculed by friends and family, or minimising the event's seriousness (Stoner & Cramer, 2019). In cases where an intimate partner is a perpetrator, social stigma about sexual victimisation, fear, financial implications, and difficulty identifying sexually violent behaviours as abuse can prevent reporting (Wright et al., 2022). In South Africa, specifically, rape is not reported to the police due to fear of not being believed or experiencing victim-blaming, fear of retaliation from perpetrators, or fear of being unable to deal with the complex court process (Artz & Smythe, 2008). Considering that it is estimated that only one in 25 women report their sexual assault to the police (Machisa et al., 2011), the statistics outlined above cannot be seen as a reliable or accurate representation of the enormity of this crisis in South Africa.

Income level and employment status have been found to significantly impact survivor recovery due to the financial pressures that can contribute to post-assault depression (Abrahams et al., 2020; Mgoqi-Mbalo et al., 2017). In describing the socio-demographic

and health characteristics of a rape cohort in South Africa, Abrahams et al. (2020) highlighted that survivors often have lower levels of education, live in areas with poor infrastructure and experience poverty. These findings show that survivors often battle other factors affecting their mental health in conjunction with trying to heal from the sexual assault that could inhibit their access to mental health resources. Therefore, it is not surprising that poor treatment follow-up and lack of psychological support have been reported in many studies (Linden et al., 2005). Furthermore, sexual violence is more common among cultures that foster beliefs of perceived male superiority and social and cultural inferiority of women (Kalra & Bhugra, 2013). In South Africa, for instance, a belief that a lack of sex affects mental health negatively has historically led to a legitimising of sexual violence (Armstrong, 1994). It becomes difficult for sexual assault survivors to heal in a challenging sociocultural environment created by the rape-prone culture, systemic racism, cultural variations in how people respond to rape, and the acceptance of rape myths (Campbell et al., 2009).

Dunkle et al. (2004) identified two risk factors for sexual assault during their interviews with women attending antenatal clinics in Soweto, South Africa. These included experiencing sexual abuse in childhood and forced first intercourse. Thus, adult survivors who also experienced sexual abuse in childhood are more likely to engage in high-risk behaviours such as impulsivity and alcohol abuse that may make them more vulnerable to re-victimisation (Kalichman et al., 2002; Noll et al., 2019). Furthermore, secondary victimisation by the legal system (victim blaming, minimal help) predicts higher levels of distress whereas supportive intervention structures and programs in the community predict less distress following sexual assault (Campbell et al., 2009). Supportive structures may increase the likelihood of reporting and prosecution of offenders which could lower prevalence rates. With the high prevalence rates of sexual assault noted, it

is imperative to understand how this trauma type can affect survivors. A discussion about the impact of sexual assault on the survivors' life follows below.

2.1.2 Impact of sexual assault

Numerous studies have consistently shown that the impact of sexual assault on the mental health of individuals is one of the most severe of all traumas, causing multiple, long-term adverse outcomes (Boyd, 2011; Briere & Jordan, 2004; Broman-Fulks et al., 2007; Campbell et al., 2009; Chivers-Wilson, 2006; Kilpatrick & Acierno, 2003; Krakow et al., 2001; Tamuli et al., 2013; Temple et al., 2007). For ease of reading, the long-term negative outcomes of rape can be categorised into difficulties in physical health, sexual behaviour, mental health, and intra- and interpersonal functioning. It is important to note that these functional impairments impact each other and difficulties in one area will likely coincide with dysfunction in another. A brief explanation of each category follows below.

2.1.2.1 Physical health difficulties

Changes in cortisol levels and brain functioning during and after a sexual assault has been investigated in several studies; these changes affect the efficacy of treatment modalities employed. Two involuntary physiological responses that survivors display during the assault have implications for treatment. The first is tonic immobility, a catatonic-like reaction of motor inhibition accompanied by bursts of both muscle hypo- and hypertonicity, suppression of verbal behaviour, sporadic eye closure, and tremors that resemble those associated with parkinsonism (Bovin et al., 2008). This response is often engaged in situations where voluntary escape and resistance fail or are unavailable (Kalaf et al., 2017; Möller et al., 2017). Physiologically, this response is associated with drops in body temperature and heart rate, as well as an increase in respiration rate and different electroencephalogram patterns (Nash et al., 1976). During an episode, midbrain-raphé neurons' electrical activity may change and serotonin levels may fluctuate (Wallnau &

Gallup, 1977). Despite being immobile, survivors remain conscious the entire time and frequently vividly recall and repeat their thoughts, sensory experiences, and emotions - including the experience of immobility (Bovin et al., 2008; Rubin & Bell, 2023; TeBockhorst et al., 2015). Unsurprisingly, this reaction during the assault is associated with higher levels of posttraumatic stress disorder (PTSD) and depression (Kalaf et al., 2017; Möller et al., 2017; Rubin & Bell, 2023). Furthermore, this experience increases psychological and pharmacological treatment resistance due to the shame and guilt caused by the memory of not responding during the assault (Bovin et al., 2014; Hageraars & Hageraars, 2020; Lima et al., 2010; Matos & Pinto-Gouveia, 2010; Moor & Farchi, 2011). Another involuntary response that survivors may experience that increases self-blame is sexual arousal during the assault. Levin and van Berlo (2004) explain that women can display involuntary signs of arousal or orgasm during a sexual assault due to physical sexual stimulation, not necessarily in response to the event itself. It is essential to understand these responses since an erroneous conclusion from the victim and the offender that the assault was wanted (Levin & van Berlo, 2004) may lead to intensified guilt and shame that may predict sexual problems. This physiological reaction has also been found to influence the extent of jurors' perceptions on victim credibility during court cases (Starosta & Schuller, 2020), showing that this may influence successful prosecution of perpetrators if not understood within the legal system.

Sexual assault that occurred after the victim has been rendered incapacitated or unable to consent through substance use can lead to significant distress and self-blame (may be referred to as drug-facilitated sexual assault) (Hall & Moore, 2008; Schwartz et al., 2000). Victims of these types of sexual assaults are often viewed more negatively by victims' partners and the police as they are more likely to assign blame to the victim (Gauntlett-Gilbert et al., 2004). Although survivors of this type of sexual assault

experience impaired memory and therefore show fewer hyper-arousal and overall PTSD symptoms, no differences were found in re-experiencing symptoms (Fields et al., 2022). Fields et al. (2022) explain that the impairment in memory limits the applicability of evidence-based treatments since the survivor cannot cognitively connect the intrusions to the re-experiencing symptoms.

Self-blame attribution plays an important role in the coping mechanisms used by sexually assaulted individuals with PTSD (Moor & Farchi, 2011). Increased activity has been found in multiple brain structures (including the lingual gyrus and nearby regions) during trauma recollection that is associated with cognitive distortions which traumatised people display (Daniels et al., 2011). Berman et al. (2018) used structural and resting-state functional Magnetic resonance imaging (MRI) on women who experienced sexual assault in adulthood and found several neural underpinnings associated with self-blame in this population. Lastly, the connection between self-blame and intrusion symptoms among participants who had experienced sexual assault was mediated by the lingual cluster's gray matter volume and RS-FC with the anterior fusiform.

Several studies have investigated how sexual assault influences the physical health of survivors. The seriousness of injuries that occurred during the assault increases the likelihood that survivors will seek medical attention and as a result be referred for mental health services (Resnick et al., 2000). In terms of general health, female survivors seek medical care more frequently due to their poor perception of their physical health and are therefore more prone to use sick leave (Campbell & Soeken, 1999; Golding, 1994, 1999; Golding et al., 1997; Golding et al., 1988; Jina & Thomas, 2013; Resnick et al., 1997).

Women with histories of sexual victimisation have been found to have more general health problems, gynaecological symptoms, and sexually transmitted diseases (STDs - which seriously affect health and future sexual practices) (Campbell et al., 2006;

Campbell et al., 2003; García-Moreno et al., 2013; Golding, 1996, 1999; Koss et al., 2001). Gastrointestinal symptoms such as vomiting, abdominal pain, diarrhoea, and bloatedness are reported twice as often among sexually assaulted women (Golding, 1994). Concerns related to weight, weight changes and symptoms of anorexia are also more prevalent in this cohort (Laws & Golding, 1996). An increased prevalence of chronic conditions has also been found in survivors, including cardiopulmonary and neurological-type symptoms (Golding, 1994; Leserman, 2005). Furthermore, a history of sexual assault impacts reproductive health as well as sexual difficulties (Van Berlo & Ensink, 2000). Symptoms such as genital burning, painful intercourse, medically explained and unexplained dysmenorrhea, chronic pelvic pain, menorrhagia, sexual dysfunction and menstrual irregularity are shared within this population (Campbell et al., 2006; Golding et al., 1996, 1998). Sexual violence increases the odds of unintended pregnancy, resulting in dire consequences on young women's health and socioeconomic well-being (Ajayi & Ezegbe, 2020). Finally, factors such as the number of assaults experienced, the relationship to the perpetrator, the level of threat to life or physical injury during the assault, and contextual factors such as serving in the military at the time of the assault all increase the likelihood of gynaecological health difficulties (Campbell et al., 2006; Golding et al., 1998).

2.1.2.2 Sexual difficulties

Two post-assault sexual behaviour patterns are noticeable in literature; one trend indicates a decrease in sexual behaviours, and the other shows an increase in risky sexual behaviour. Sexual dysfunction in the first pattern is associated with avoidance, indifference to having sex and difficulties achieving orgasm. Avoiding sexual activity and intimacy after a sexual assault is understandable, as these contexts can elicit traumatic memories and conditioned anxiety (Deliramich & Gray, 2008). Aside from the

gynaecological problems listed above that could lead to avoidance or pain during sexual intercourse, psychological and neurological explanations have been offered for this phenomenon as well. As mentioned, Levin and van Berlo (2004) explain that women can display involuntary signs of arousal or orgasm during a sexual assault due to physical sexual stimulation, not necessarily in response to the event itself. Misunderstanding these responses can lead to prejudice and incorrect conclusions surrounding the victim's reciprocation of physical responses during the sexual assault (Levin & van Berlo, 2004), thus leading to intensified guilt and shame that may predict sexual problems. A loss of sexual self-esteem that decreases the frequency of sexual contact and decreases satisfaction and pleasure in sexual activities has also been noted (Orlando & Koss, 1983).

When under stress, the sympathetic nervous system (SNS) becomes activated and releases catecholamines like norepinephrine, which raises blood pressure, heart rate, and glucose availability (Bremner et al., 1996). The body returns to its original state if the stressor is non-traumatic. However, the homeostasis of the individual is altered after trauma leading to the development of PTSD (Rellini & Meston, 2006). Southwick et al. (1995) explain that women with PTSD show impairments in the hypothalamic-pituitary-adrenal (HPA) axis marked by higher levels of the adrenocorticotropin hormone (ACTH), a downregulation of glucocorticoid receptors and lower levels of cortisol. Low amounts of cortisol may promote excessive SNS activity, which could result in excessive use of energy and an unfavourable response to stress (Rellini & Meston, 2006). Concerning this dynamic, the SNS has a higher baseline activity in child sexual abuse survivors with PTSD than in women who have not experienced childhood sexual abuse (Yehuda, 2006). SNS baseline levels naturally increase during sexual activity, however, the excessive activation of these levels in women with a history of childhood sexual abuse and PTSD

could explain the high incidences of sexual arousal difficulties in this population (Rellini & Meston, 2006).

In contrast to this lack of desire, some studies have also linked sexual victimisation with increased sexual activity and risky sexual behaviours. Women who experience higher levels of depressive and anxiety symptoms may use increased sexual behaviour as an affect regulation strategy (Littleton et al., 2013). Deliramich and Gray (2008) found that risky sexual behaviour was strongly related to increased posttraumatic alcohol usage, stating that this maladaptive coping mechanism could increase the risk of re-victimisation. With this pattern, adult survivors who also experienced sexual abuse in childhood have been found to have more sexual partners, be more likely to engage in high-risk practices and be more likely to have multiple STDs in their lifetime (Kalichman et al., 2002). These survivors are at high risk for re-victimisation and are more prone to experiencing drug-facilitated sexual assault (Cividanes et al., 2018; Mokma et al., 2016). In cases where pre-existing mental health conditions are poorly managed before a sexual assault, the post-assault mental health sequelae in survivors can be worsened (Campbell et al., 2009).

2.1.2.3 Intrapersonal difficulties

Numerous studies over decades have consistently shown that the impact of sexual assault on the mental health of individuals is one of the most severe of all traumas, causing multiple, long-term adverse outcomes (Boyd, 2011; Briere & Jordan, 2004; Broman-Fulks et al., 2007; Campbell et al., 2009; Chivers-Wilson, 2006; Kilpatrick & Acierno, 2003; Krakow et al., 2001; Tamuli et al., 2013; Temple et al., 2007). Behavioural and psychological reactions associated with rape include feelings of helplessness, powerlessness, disgust, self-blame, guilt and shame, problems coping with trauma reminders, difficulties resuming pre-rape sexual relations and impairments in social

functioning (Friedman et al., 2007; Kalichman et al., 2002). A meta-analysis of studies investigating the link between sexual assault victimisation and psychopathology found that sexual assault is associated with an increased risk for the severity of most psychiatric disorders (Dworkin et al., 2017). Psychiatric diagnoses often associated with sexual assault include major depressive disorder, alcohol dependence, generalised anxiety disorder, obsessive-compulsive disorder and PTSD (Payne & Edwards, 2009; van der Walt et al., 2014; Womersley & Maw, 2009). Sexual violence exposure is also positively associated with alcohol use and suicidal behaviours (ideation, making a suicidal plan and suicide attempts) in survivors (Scheer et al., 2021; Ullman, 2007; Ullman & Najdowski, 2009). Interestingly, alexithymia is associated with many of the severe mental health disorders listed here (Pinna et al., 2020). Alexithymia is a psychological trait that is characterised by difficulties identifying and characterising emotions, difficulties telling them apart from bodily experiences, and an externally focused way of thinking (Bagby et al., 1994). Survivors with this trait struggle to describe their emotions and therefore they may find the emotional disclosure that assists in adaptive trauma processing extremely challenging (Balderrama-Durbin et al., 2013; Ennis et al., 2023; Frewen et al., 2008). As a result, alexithymia is positively associated with PTSD in sexual assault survivors to a significant extent (Cloitre et al., 2002; Frewen et al., 2008, 2012; O'Brien et al., 2008).

The behavioural, somatic and psychological reactions associated with rape are closely related to PTSD symptomology (Padmanabhanunni & Edwards, 2016). Therefore, it is not surprising that rape is associated with the highest frequency of PTSD when compared to other traumatic events (Dinan et al., 2004; Foa & Rothbaum, 2001; Kaminer et al., 2008; Padmanabhanunni & Edwards, 2013). PTSD is characterised by three broad categories of symptoms, namely re-experiencing, avoidance and hyperarousal (American Psychiatric Association & Association, 2013). Re-experiencing causes distress as it

comes in the form of intrusive images, nightmares or flashbacks where memories of the trauma intrude into involuntary consciousness. Avoidance can occur in a cognitive or behavioural form in terms of distraction to avoid reminders of memories of the trauma, during the suppression of thoughts and images or numbing of emotions. Physiological hyperarousal includes being jumpy or easily startled, as well as being over-vigilant. Several indicators signify that the survivor may be at risk for developing chronic PTSD. These include persistent dissociation, rumination, disorganised memories of the trauma or inability to recollect some aspects of the trauma, maladaptive coping strategies, depression, and the presence of physical reminders (for example, scars) and overall severity of symptoms (Brewin et al., 2002; Dunmore et al., 2001; Ehlers & Clark, 2003; Halligan et al., 2003; McNally et al., 2003; Rachman, 2001).

The impact that a sexual assault will have on an individual may differ based on their personality structures and psychological development before the rape (Amanat, 1984; Combs et al., 2018; Miller & Resick, 2007). Several studies have found a strong association between neuroticism and difficulties adjusting psychologically after a sexual assault (Borja et al., 2009; Cox et al., 2004; Yalch et al., 2022). Both an increased likelihood of encountering trauma and the development of trauma-related psychopathologies such as PTSD are linked to higher degrees of neuroticism (Kotov et al., 2010; Lahey, 2009; Miller, 2003; Widiger, 2009). Higher levels of extraversion, agreeableness, and conscientiousness, on the other hand, are linked to fewer psychopathologies and overall better life outcomes (Kotov et al., 2010; Ozer & Benet-Martinez, 2006). Some studies have looked at how different personality types influence the re-organisation phase of recovery. The pre-symbiotic personality type is marked by tendencies for isolation, withdrawal, mistrust, and disengagement (Amanat, 1984), reminiscent of Cluster C personality disorders (Avoidant and Schizoid). The women in

these studies scored low on positive temperament, describing themselves as unenthusiastic, lacking interests, prone to experience intense negative emotions, detached, self-effacing and humble (Miller & Resick, 2007). During the re-organisation phase, these characteristics are reinforced through reliving experiences, preoccupation and fantasy, depression, hypoactivity and somatisation (Amanat, 1984). Another subset of survivors was categorised as symbiotic personalities, trusting people that tend toward dependency (Moss, 2011). According to Amanat (1984), these individuals become more dependent, showing regressive tendencies and intense phobic reactions in the re-organisation phase. The last personality structure identified by Amanat (1984) is the post-symbiotic personality, which is outgoing, assertive, and marked by autonomy and independence traits. Amanat (1984) noted increased hyperactivity, irritability, lifestyle changes, agitation, depression, intellectualisation, self-reproach, guilt, shame, compulsive behaviour, and eventual repression during the re-organisation phase of this group. In a more recent study, Miller and Resick (2007) distinguished between FSASA that displayed simple PTSD (lower pathology) and two clusters of complex PTSD (externalisation versus internalisation of distress) following sexual assault. The internalising cluster is similar to the pre-symbiotic personality structure outlined by Amanat (1984). Survivors in this cluster showed the highest rates of comorbid major depression in the three groups. This finding was supported by Combs et al. (2018), who found that a premorbid personality disposition to internalise distress was positively correlated with increased anxiety and depression. The externalising cluster endorsed more features of Cluster B personality disorders (borderline, antisocial, narcissistic, and histrionic). These individuals scored high on disinhibition and negative temperament scales that included impulsivity, chronic nervousness, exhibitionism and manipulation (Miller & Resick, 2007). This group showed a tendency to use sex to accomplish

nonsexual gains and risky self-destructive sexual behaviour and used maladaptive means such as self-mutilation, angry outbursts, suicide threats and substance use to reduce distress (Miller & Resick, 2007). Furthermore, Combs et al. (2018) found that a premorbid personality disposition to act impulsively when distressed positively correlated with increased drinking behaviour following sexual assault.

With regards to this personality type, it has become apparent that the psychological sequela resulting from childhood sexual abuse appears to be a strong predictor of adult sexual assault (Cloitre et al., 1996; Gidycz et al., 1993; Schwartz, 1997; Ullman & Najdowski, 2009). Firstly, an association has been found between childhood sexual assault and coercive sexual assault in adulthood (Walsh et al., 2007). Furthermore, drinking problems and impulsivity are more common among adult survivors of sexual abuse (Ullman & Najdowski, 2009) which in turn puts these women at higher risk for sexual assault (Testa et al., 2005). Although survivors of childhood sexual abuse may suffer profound and long-lasting trauma, clinical experience and research have shown that these effects vary in intensity depending on the individual and their environment (Bogar & Hulse-Killacky, 2006; Finkelhor, 1990; Ratican, 1992). Hyman and Williams (2001) discovered that women who had undergone incest or child sexual abuse coupled with physical force as well as those who had been incarcerated as teenagers were less likely to be resilient. Poverty and multiple indices of victimisation were found to be particularly relevant risk factors (West & Johnson, 2006).

Some studies, however, have indicated that certain determinants and processes lead to resilience in sexual abuse survivors. Resilient child sexual assault survivors were more likely to have completed high school and benefited from a stable upbringing (fewer moves and less parental drug use) (Hyman & Williams, 2001). Processes that enabled resilience in these survivors in adulthood were engaging in positive coping strategies, refocusing

and moving on, engaging in active healing and achieving closure (Bogar & Hulse-Killacky, 2006). Innate and learned characteristics amongst these survivors were seen as being interpersonally skilled, feeling competent and having high self-regard, being spiritual and experiencing helpful life circumstances (Bogar & Hulse-Killacky, 2006).

Maladaptive coping mechanisms are prevalent in sexual assault survivors, irrelevant of childhood sexual assault. Coping mechanisms that lead to higher levels of depression, anxiety and PTSD involve avoidance behaviours such as withdrawal and disengagement (Campbell et al., 2009; Ullman, 2007). Survivors who display avoidance coping are at high risk for suicide following the assault, and therefore the survivor's risk for self-harming behaviour should be assessed and managed appropriately (Frazier, 2000; Frazier et al., 2005; Masho et al., 2005; Runtz & Schallow, 1997; Ullman, 2004; Ullman & Brecklin, 2002a; Ullman et al., 2005; Valentiner et al., 1996; Westefeld & Heckman-Stone, 2003). Conversely, adaptive strategies involve expressing emotions, seeking social support, and reducing stress (Campbell et al., 2009; Frazier et al., 2005; Valentiner et al., 1996). The coping strategies that a survivor employs are highly reliant on their perceptions of their role in the event.

The effects of sexual assault are correlated with post-assault social cognitions such as self-blame, fundamental beliefs about oneself and others, and feelings of control (Frazier, 2003; Koss et al., 2002). Frazier (2003) found that beliefs that a future assault was improbable and feeling that one had control over the healing process were connected to decreased distress, whereas behavioural self-blame and rapist blame were both related to higher levels of distress. Koss et al. (2002) found that characterological self-blame and maladaptive beliefs about self and others were related to higher levels of distress. These studies indicate that interventions focused on cognitive distortions may be particularly helpful amongst this population.

The psychological dynamics noted above can have a significant influence on interpersonal relationships. Thus, interpersonal dynamics will be discussed next.

2.1.2.4 Interpersonal relationship difficulties

Numerous studies have investigated how the victim's post-assault distress is affected by the characteristics of the assault (Dworkin et al., 2017; Kilpatrick et al., 2013; Ullman et al., 2007). Characteristics relevant to this system include the perceived dangerousness of the perpetrator and the relationship between the victim and the offender (Campbell et al., 2009; Ennis et al., 2023). How dangerous the victim perceived the perpetrator and their consequential responses during the assault may be related to the severity of PTSD symptoms (Cascardi et al., 1996). Assertive responses (forceful responses) may include verbal and physical responses such as yelling, running away, or attacking the perpetrator (Davis et al., 2004; Testa et al., 2005) and have been associated with less severe sexual assault (Clay-Warner, 2002; Ullman, 1997). In contrast, diplomatic responses are less direct and are protective behaviours that avoid emotionally or socially hurting or embarrassing the perpetrator (saying politely that you are not interested, changing the subject or using humour) (Davis et al., 2004; Norris et al., 2004) that are usually used in ambiguous situations (Nathanson, 2010). These responses have been associated with both less and more severe sexual assault (Clay-Warner, 2002; Rizvi et al., 2008). Several studies have found that the severity of the assault can predict the risk of PTSD in victims of sexual assault (Abrahams et al., 2013; Acierno et al., 1999; Kaysen et al., 2010; Ullman & Filipas, 2001). There are two studies that found that depression and PTSD were more likely if the victim experienced injury during the sexual assault (Cook et al., 2013; Tiihonen Möller et al., 2014). In contrast, Abrahams et al. (2013) found that women who experienced assaults that involved a weapon and multiple perpetrators were less likely to experience depression. This contradictory finding could be explained by their sample who

reported more interpersonal support with stranger perpetrator rape than with intimate partner perpetrated rape.

In cases where the sexual assault was perpetrated by a stranger, survivors reported more negative social reactions from others during disclosure (Ullman et al., 2006). The reactions from informal supporters play a significant role in survivor recovery. Positive social reactions lead to less distress, whereas negative reactions lead to increased risks for depression, anxiety and PTSD (Campbell et al., 2009). A meta-analysis of international research conducted by Olatunji et al. (2010) suggests that the psychological difficulties that result from sexual assault exert a significant negative impact on social functioning and relationships with 'close others'. Specific trauma-induced symptoms related to mental health discussed above, such as emotional numbing, irritability/anger, and detachment from others, could evoke negative responses from close others (Beck et al., 2009). McCann et al. (1988) found that social stereotypes of sexual assault may lead to survivors developing negative internal representations about safety, power, trust, esteem and intimacy. Negative internalisations and beliefs often set people up for increased self-defeating behaviours and interpersonal challenges (Salim et al., 2021). Survivors frequently have difficulty maintaining relationships or feeling close to others because they lack certainty about the reliability of others (Clark et al., 2014). This, in turn, creates ambivalence about relationships. These findings are especially disconcerting as social support has emerged as an essential factor in coping with the short and long-term aftermath of sexual assault (Brewin et al., 2000; Ozer et al., 2003). Ahrens and Aldana (2012) found that, although most relationships were either strengthened or remained strong following the disclosure of sexual assault, many survivors described that their relationships deteriorated following disclosure.

The abovementioned factors indicate the importance of multidisciplinary interventions for sexual assault survivors. Common reactions during assault, such as tonic immobility and involuntary arousal, should be explained to survivors to normalise these reactions and thus decrease self-blame. Sexual difficulties should be addressed on a medical and psychological basis, with psychological interventions focusing on cognitive perceptions related to intimacy and the mind-body connection. As noted above, drug-facilitated sexual assault survivors present with significant memory impairment related to the event itself. With these limitations, emphasis on peritraumatic processing and ongoing appraisals of threat have been particularly helpful (Ehlers & Clark, 2000; Gauntlett-Gilbert et al., 2004).

Given the neurological basis of PTSD following sexual assault, patients should be offered referrals for psychopharmacological intervention. Furthermore, these findings emphasise the value of exposure therapy, which lessens lingual gyrus reactivity to phobic imagery (Hauner et al., 2012). Pierce et al. (2023) conducted a systematic review and meta-analysis of MRI studies that investigated the therapeutic interventions that promote PTG in adults living with PTSD. According to their analysis, PTG was significantly impacted by Cognitive Processing Therapy (CPT), Eye Movement Desensitisation and Reprocessing (EMDR), and Prolonged Exposure Therapy (PET) throughout treatment.

In the next section, the sexual difficulties related to recovery from sexual assault are discussed. Psychological symptoms that survivors display because of sexual assault focus intervention efforts. Alexithymia, emotional dysregulation, cognitive distortions, and maladaptive coping mechanisms need to be targeted during psychotherapy. A comprehensive understanding of the survivor's pre-morbid psychological functioning can guide counsellors to identify clients that may require more extensive interventions and referrals. In addition, it may indicate who may be at risk for substance use disorders or

suicide following the assault. However, this understanding also highlights possible personal strengths that can be harnessed during recovery.

2.1.3 Theories outlining recovering from sexual assault

With an understanding of factors that may affect the levels of post-assault distress, we now turn our attention to the recovery process. Mental health professionals (hereafter MHPs) aim to assist survivors through the process of recovery while considering the factors discussed in the previous section. Several theories outline the recovery processes common among sexual assault survivors, the most prominent of which are discussed below.

The first such theory was developed by Burgess and Holmstrom (1974) when they coined the term 'rape trauma syndrome' to describe the three phases that victims of all types of sexual violence typically go through. The acute phase occurs immediately following the assault when the survivor is in crisis and experiences a wide range of emotional reactions categorised as expressive (shaking, crying, or yelling) or controlled (flattened affect, appearing outwardly calm and subdued). The second phase is often marked by high levels of denial and is termed outward adjustment; here, survivors shift their focus from the assault to normal daily activities. Long-term re-organisation is the final phase and involves the survivor integrating the assault into their view of themselves and resolving their feelings about the assailant.

Positive transformations in beliefs and behaviour can manifest in different forms. Veronen and Kilpatrick's (1983) seminal work described four models where sexual assault could lead to positive life changes. The first model is where women reassess their life priorities and goals to take better care of themselves following a sexual assault (threat to life appreciation model). In the second model, women access psychosocial services they have not previously been exposed to, enabling them to expand their psychosocial

resources (system-mediated change model). In the third model, their involvement with anti-sexual assault activists alerts women to other forms of oppression that they may have been experiencing, thereby prompting an increase in assertiveness and improved life outcomes (consciousness-raising experience model). The fourth model highlights the beneficial downward social comparison that some women use to promote recovery and positive coping efforts when confronted with the stereotypes about women coping poorly with sexual assault (rape as a challenge model).

Several researchers have developed recovery models centred around the ecological framework. These models focus on factors that are relevant to different systems that individuals function in and how these factors reciprocally influence each other to impede or facilitate recovery. Consequently, these researchers advocate for interventions that go beyond the individual level and seek to impact larger social constructs. The earliest model identified three broad factors, namely pre-assault variables (life stress before the assault - such as mental health issues and demographic variables of the survivor), sexual assault variables (relationship to the perpetrator) and post-assault variables (coping mechanisms and social support) (Ruch & Leon, 1986). A model developed by Wyatt et al. (1990) focused on the factors that influenced women's initial and lasting attitudes toward sex and intimacy following a sexual assault. Their findings indicated that women's unfavourable initial and enduring attitudes about sex and intimacy were predicted by higher levels of self-blame, significant police or other agency participation, more repeated rapes per episode, and intensity of the abuse. Another model proposed that rape response and recovery consists of four components, namely person (age, pre-trauma functioning, cognitive attributions of the trauma), assault characteristics, environment (social support, community attitudes) and intervention (appropriate clinical care) (Koss & Harvey, 1991). Building upon these models, Neville and Heppner (1999) included aspects such as the

broad sociocultural context and ethnic-specific context, race and ethnicity, racial/ethnic cultural adherence variables (traditions that assist in recovery) and culture-specific attributions (ways in which the individual's culture ascribes meaning to the event). The most recent ecologically-focused model outlining factors that may affect sexual assault recovery is the one proposed by Campbell et al. (2009). In addition to highlighting factors reported in the previous models, Campbell et al. (2009) added self-blame as a meta-construct that results from interactions across all levels of the social ecology.

The survivor does not necessarily have to forget what happened or stop experiencing any symptoms to recover from the trauma. Instead, a survivor's level of involvement in the present, the development of attitudes and skills to regain control of their life, the ability to forgive oneself for guilt, shame, and other negative thoughts, and the acquisition of stress-reduction techniques are what constitute successful recovery (Matsakis, 1996). From a survivor's perspective, being recovered involves accepting the experience, being freed from negative states, regaining control and trust and receiving help from and being believed by others (Ranjbar & Speer, 2013). These aspects are strongly related to the strengths-based approach. A qualitative meta-synthesis of articles reporting on survivors' perspectives of recovery found some interesting results (Draucker et al., 2009). The domains of healing identified were managing memories, relating to others, seeking safety, and re-evaluating oneself. The process for obtaining these was calling forth the memories, regulating relationships, constructing a realistically safe lifeworld, and restoring a sense of self (Draucker et al., 2009). To assist survivors in the recovery process, it is essential to look at literature investigating the survivors who have overcome the challenges outlined above.

2.2 Strengths-Based Approach to Sexual Assault

Considering the global crisis that is sexual assault, as well as the resulting long-term adverse outcomes for its survivors, it cannot be disputed that recovery is imperative. Whilst a considerable amount of literature is available on the adverse effects of sexual assault, the WHO (2013) reported that recovery is possible by applying appropriate research-supported interventions. The emergence of strengths-based approaches enables us to challenge some of the conventional deficit-driven approaches when understanding trauma and trauma recovery (Jones-Smith, 2013; Rashid, 2015). This approach focuses on capitalising on the individual's strengths to enable recovery (Biswas-Diener et al., 2011; Clifton & Harter, 2003) by promoting resilience-driven coping processes and PTG-enabling outcomes (Ai & Park, 2005; Prati & Pietrantonio, 2009). It is important to note that this paradigm shift does not ignore or minimise the trauma, problems, and adversity. Rather, as opposed to the pathogenic or deficit-based model, the starting point is not the problem. When the focus is on what the survivor is lacking, lowered positive expectations and dependency is fostered which blocks opportunities for change (Hammond & Zimmerman, 2012). Instead, the strengths-based approach seeks to validate the struggle the survivor experiences and the strengths, capacities and competencies that arise from their struggle to recover from these heinous experiences (Saleebey, 2013). Below is a discussion focusing on the strengths-based approach with specific reference to aspects related to the survivors' PWB, resilience and PTG, as documented in literature.

2.2.1 Psychological well-being and sexual assault

Individuals do not simply seek relief from distress but are motivated by experiences of love, joy and meaning (Bonanno, 2004; Linley & Joseph, 2005). The WHO (2006, p. 28) defines optimal health as a "state of complete physical, mental and social well-being and

not merely the absence of disease or infirmity". This definition adds the concept of well-being to the definition of health and highlights the domains that should be considered in measuring health and wellness, and with that, the broader concept of PWB comes into play. PWB is a multidimensional concept that involves different aspects of the self, such as affect, cognition and behaviour (Wissing & Van Eeden, 2002). Keyes (2009a) offers the perspective that PWB is the culmination of emotional, mental, and social well-being that they see as a state known as flourishing or optimal functioning.

Seligman's (2011) PERMA theory suggests that flourishing arises from five well-being constructs, namely positive emotion, engagement, relationships, meaning and accomplishment. In this theory, positive emotions refer to hedonic feelings such as happiness, pleasure and comfort (Khaw & Kern, 2014). Arousal in any form, even physiological arousal linked to happy emotions, may be avoided by those with PTSD (Roemer et al., 2001; Tull et al., 2007). Positive and negative emotional dysregulation have both been found to contribute to heightened posttraumatic stress and maladaptive coping (Weiss et al., 2020). However, if an individual can regulate their emotions, positive emotions can broaden an individual's thought-action repertoire which builds enduring personal resources for the individual (Fredrickson, 2004). Higher levels of optimism and gratitude diminish the connection between sexual assault-related PTSD and suicidal ideation (Kumar et al., 2022) and increase agency (Li et al., 2022). Since optimism and gratitude are strengths that can be developed in psychotherapy, these findings offer an important target for intervention when working with sexual assault survivors.

The mental health continuum (MHC) highlights three indicators of positive mental health - emotional, social, and PWB (Keyes, 2002). Emotional well-being encompasses the subjective experience of more satisfaction in a life marked by experiencing more positive than negative affect (Keyes, 2002). In this model, social well-being relates to

optimal functioning in interactions with others and encompasses social acceptance, social actualisation, social contribution, social coherence and social integration (Keyes, 2007). The last indicator is PWB, which refers to positive functioning in the six dimensions of PWB (Ryff & Keyes, 1995). These six dimensions are self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth; the dimensions focus on the individuals' evaluations of their public and social lives (Keyes, 2005). Each dimension is described below, followed by an outline of relevant studies indicating the presentation of these dimensions in trauma survivors.

The self-acceptance dimension encompasses the ability to be self-aware and accept one's strengths and weaknesses to display positive self-regard (Ryff & Singer, 2008). Numerous studies have highlighted the central role of self-blame and shame following sexual assault (Kline et al., 2021; Miller et al., 2010; Sigurvinsdottir & Ullman, 2015), these are negatively associated with self-compassion (Bensimon, 2012; Crapolicchio et al., 2021; Neff, 2003). To thrive, survivors must move past self-blame and cultivate high levels of self-compassion. Survivors that have self-compassion exhibit higher levels of social connectedness, life satisfaction, adaptive coping mechanisms, self-determination, and self-concept accuracy (Keyes, 2002; Neff et al., 2007). In one study, deeper self-knowledge of their strengths (such as personal resilience and ability to forgive themselves) allowed women who experienced childhood sexual abuse to be kinder to themselves (Walker-Williams et al., 2013).

The positive relations with others dimension focuses on an individual's ability to convey empathy, warmth, affection and the capacity to engage in close relationships and deep friendships with others (Ryff & Singer, 2008). It is related to Seligman's relationship construct (Seligman, 2011). As noted earlier in this section, sexual assault disclosure can have a significant negative impact on interpersonal relationships (Ahrens & Aldana, 2012;

Olatunji et al., 2010). However, several studies have also found that sexual assault survivors reported enhanced connections with others following the trauma (Borja et al., 2006; Burt & Katz, 1987; Draucker et al., 2009; Frazier et al., 2001; Frazier et al., 2004; Guerette & Caron, 2007).

The autonomy dimension encompasses self-determination or independence and is marked by an internal locus of control and being able to self-regulate emotions (Ryff & Singer, 2008). The mental health difficulties reported by many sexual assault survivors may harm their internal locus of control. To empower survivors, self-defence has been shown to enhance self-determination and self-efficacy (Beaujolaïs, 2023). During their intervention, women who experienced childhood sexual abuse progressively began to redefine themselves as survivors instead of passive victims (Walker-Williams & Fouché, 2018).

Environmental mastery refers to an individual's ability to create or change an environment to suit their personal needs and capacities (Ryff & Singer, 2008). Sexual assault can alter fundamental cognitive schemas about safety and lead to exaggerated risk assessment and interpersonal mistrust (Ehlers, Clark, et al., 1998). This alteration of cognitive schemas can have a significant impact on the extent to which survivors experience environmental mastery. However, survivors who engage in anti-sexual assault activism have reported higher levels of coping, self-efficacy, greater community connection and more meaning in life (Strauss Swanson & Szymanski, 2021).

The purpose in life dimension focuses on the individual's ability to create meaning and direction in life to live an authentic life aligned with personal goals and strengths (Ryff & Singer, 2008). Given the significant impact that sexual assault can have on a person's cognitive structure, it is not surprising that spiritual change appears evident among sexual assault survivors (Frazier et al., 2006; Kennedy et al., 1998). Survivors may rely on their

spiritual beliefs in a time of crisis to make sense of and cope with the sexual assault (Ahrens et al., 2010). Positive religious coping strategies include practices that increase a person's sense of spirituality and connection to others as well as their sense of closeness to God, whereas negative religious coping involves religious discontentment, struggle and disconnection (Pargament et al., 2001). Higher levels of positive religious coping appear related to increased positive adjustment and less negative psychological adjustment (Ano & Vasconcelles, 2005).

Personal growth refers to a positive, continual and dynamic process of developing one's potential and enhancing personal resources (Walker-Williams, 2012). This dimension encompasses openness to new experiences and confronting the challenges posed in different life stages (Ryff & Singer, 2008). Acceptance coping plays an integral role in the perceived personal growth experienced by sexual assault survivors (McFarland & Alvaro, 2000). Personal growth in this population is related to making meaning of their experience, regaining a sense of power and control and establishing meaningful connections despite being triggered and disillusioned (Strauss Swanson & Szymanski, 2020).

Within this model, PWB is seen on a continuum where an individual is either languishing (a deficit in mental health) or flourishing (an abundance of mental health). Joubert et al. (2022) found that most trauma survivors at community-based clinics in Gauteng experienced multiple traumatic events and their hope, positive affect, and life satisfaction were all low. Within this sample, participants who could access professional help and transition into finding adaptive coping strategies experienced more hope, positive affect, and life satisfaction. As noted above, numerous studies have investigated languishing among sexual assault survivors; however, fewer studies have focused on women who are in the middle of the continuum (resilient) or those that are flourishing

(PTG). The individual's overall functioning is impacted by how resilient they can be in the face of life stressors and traumatic events.

2.2.2 Resilience in sexual assault survivors

It has long been apparent that among trauma survivors, a group of individuals can maintain good health and lead a good life despite all they have gone through (Antonovsky, 1987). The psychosocial concept of resilience refers to an individual's adaptation and healthy development in the face of life stressors or strains; it encompasses the capacities needed to successfully adapt to significant adversity (Hetherington & Blechman, 2014; Kersting, 2003; Luthar et al., 2000). The capacity to adapt is significantly influenced by the protective and risk factors prevalent in an individual and group's lives. To develop a resilience-enabling intervention, MHPs should find a balance by routinely assessing risk exposure and protective factors' availability. Wright and Masten (2005) defined protective factors as qualities of a person or context that predict better adversity outcomes. In contrast, risk factors are considered measurable characteristics in a group of individuals or situations that predict adverse outcomes (Wright & Masten, 2005). Several protective factors have consistently been associated with resilience in different ways amongst different populations following various adverse events (Luthar et al., 2000). Resilience factors associated with adults include personal resourcefulness, good self-esteem, internal locus of control, sense of humour, mastery, optimism, social and problem-solving skills, secure attachments and religious affiliation (Connor & Davidson, 2003; Kobasa et al., 1982).

Ungar (2018) explains that resilience encompasses the capacity to navigate the psychological, social, cultural and physical resources that sustain our well-being and negotiate for these resources to be provided in meaningful ways. Rather than being a static outcome, resilience is promoted by an interplay between protective factors within

the individual and environmental factors that facilitate better outcomes (Liebenberg & Moore, 2018; Masten, 2014). Due to this interplay, Tedeschi and Kilmer (2005) noted that assessing factors associated with positive adjustment, competence in core domains, and healthy outcomes under adversity might be more practical than resilience, per se.

Studies investigating resilience amongst sexual assault survivors indicate that unique adjustment trajectories are discernible amongst trauma survivors within the initial four months of the assault and that adaptive outcomes are most common (Bonanno, 2004). Survivors who reported decreased posttraumatic symptoms between the first two months are likely to continue improving (Steenkamp, 2011). The factors that appear to contribute most significantly to the trajectory of symptoms in sexual assault survivors were peri-traumatic dissociation, attributions about the sexual assault, and negative trauma-related cognitions (Steenkamp, 2011). Survivors' specific coping strategies have also consistently proven to be strong predictors of post-trauma adjustment (Cole & Lynn, 2010). Strategies that foster the cognitive and emotional processing of the trauma - generally referred to as adaptive coping strategies - have been associated with positive adjustment post-trauma (Walser & Hayes, 2006). These adaptive coping strategies include cognitive reappraisal or restructuring, approach or problem-focused coping, and acceptance. Making sense of the assault and reporting some benefits, although it is negatively associated with trauma-related symptom severity, suggests that constructing meaning is adaptive and associated with PTG (Dunlap, 2005).

Iacoviello and Charney (2014) report that psychosocial factors associated with resilience include optimism, cognitive flexibility, active coping skills, maintaining a supportive social network, attending to one's physical well-being, and embracing a personal moral compass. Social support, in the form of emotional and tangible support, has been found to lead directly to positive outcomes among survivors. The social support

networks most salient to everyone during adulthood, such as friends and intimate partners, have the most significant effect on sexual assault survivors' outcomes (Leech & Littlefield, 2011).

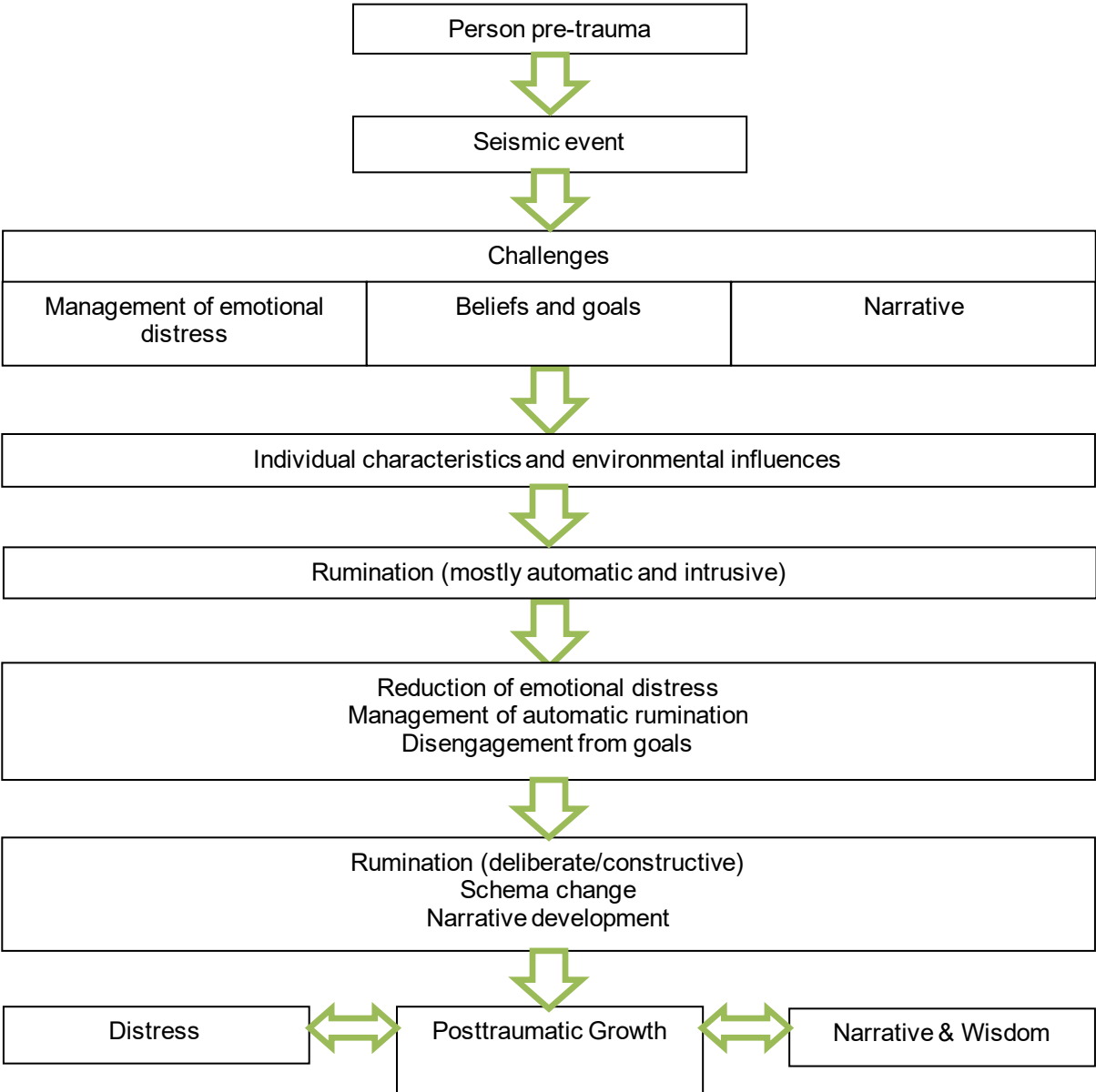
South African studies have identified some factors that impact resilience within female survivors of different forms of interpersonal violence (IPV). More equitable gender norms (Kuo et al., 2022) and other social support indicators such as social connectedness, stronger network ties and perceived supportive communities are key factors in fostering resilience among this population (LoVette et al., 2022; Machisa et al., 2018). Conversely, factors such as recent and severe IPV and adverse reactions to disclosure were associated with lower levels of resilience (Machisa et al., 2018). The occurrence of resilience is a personal characteristic that enables PTG (Orbke & Smith, 2013; Tedeschi & Calhoun, 2004; Tedeschi & Kilmer, 2005).

2.2.3 Posttraumatic growth in sexual assault survivors

Over the last few years, numerous researchers (Johnson et al., 2007; Joseph & Linley, 2008a; Pals & McAdams, 2004; Tedeschi & Calhoun, 2004) have begun to turn their attention to investigating why and how some people can grow and thrive through their struggle with recovering from a traumatic experience, hereby transitioning towards a higher level of functioning and self-actualisation than they experienced before the trauma. PTG can be seen in the success with which individuals coping with the aftermath of trauma reconstruct or strengthen their perceptions of self, others, and their philosophy of life (Tedeschi & Calhoun, 1996a). It is also described as the experience of significant positive change arising from the struggle with a major life crisis (Calhoun et al., 2000). It is important to note that the distress associated with traumatic events is not denied when investigating PTG.

The dominant model in PTG literature was developed by Tedeschi and Calhoun (2004). A schematic representation of this process is presented below, in Figure 2. In their model, Tedeschi and Calhoun (2004) describe how PTG results from a particular coping process. This process aims to restructure a coherent post-trauma life narrative; it has a quality of transformation or a qualitative change in functioning and includes a future perspective (Tedeschi & Calhoun, 2004). The process begins after an individual has experienced a traumatic or seismic event.

Figure 2: A comprehensive model of posttraumatic growth (Adapted from Calhoun & Tedeschi, 2006; Fouché & Walker-Williams, 2016)



This event then challenges the individual's pre-trauma beliefs and goals, ability to manage emotional distress, and narrative. Initially, high levels of emotional distress are experienced when the individual experiences traumatic symptoms; through interventions, the individual is taught how to manage this distress more effectively (Wagner & Linehan, 2006). Taku et al. (2009) explain that while attempting to reduce this emotional distress, the person engages in the process of recurrent intrusive (nonconstructive) rumination or deliberate (constructive) rumination. Accordingly, intrusive rumination occurs where the person will dwell on the event but struggles to make meaning of their assumptive world. In contrast, during deliberate rumination, the person will deliberately analyse the seismic event, find meaning, and reappraise it until they can make sense of and build a new assumptive world and narrative which integrates the traumatic incident (Taku et al., 2009).

Intrusive re-experiencing and ruminative brooding are not significantly associated with PTG, whereas deliberate rumination is positively associated with PTG (Stockton et al., 2011). The challenge then lies in how the individual integrate the experience into their current beliefs, either altering the current beliefs and goals or adding new ones into the narrative of their lives (Calhoun et al., 2006). Fouché and Walker-Williams (2016) report that through PTG, the individual has not only survived the trauma but also can recognise transformational character strengths known as the 'thrivers identity' due to successful cognitive processing, increased emotional awareness (catharsis), and the reconstruction of a coherent life narrative (meaningful, comprehensible, and manageable). Several researchers note that the extent and process of coping is influenced by the person's characteristics and environmental influences. Personal characteristics include resilience, optimism, and psychological resources, and environmental influences refer to the availability of external supportive resources (Calhoun et al., 2010; Orbke & Smith, 2013; Tedeschi & Calhoun, 2004; Tedeschi & Kilmer, 2005). Factors most related to positive

life change after the sexual assault were social support, a religious coping approach and having an internal locus of control (Frazier et al., 2004; Kunst, 2011; Zoellner & Maercker, 2006).

Tedeschi and Calhoun (2004) note that PTG is evident in changes in five distinct growth domains, namely relationships with others, new possibilities, personal strength, spiritual change, and appreciation for life. A review of studies investigating PTG amongst sexual assault survivors indicates that the nature of PTG differs in this population (Ulloa et al., 2016). Findings predominantly reported positive changes in the quality and satisfaction of their relationships with others due to support following disclosure, as well as experiencing increased empathy (Borja et al., 2006; Burt & Katz, 1987; Draucker et al., 2009; Frazier et al., 2001; Frazier et al., 2004; Guerette & Caron, 2007). Greater appreciation for life (Frazier & Burnett, 1994), spiritual change (Frazier et al., 2006; Kennedy et al., 1998), personal strength (Burt & Katz, 1987; Draucker et al., 2009; Frazier et al., 2004) and advocacy for other survivors (Burt & Katz, 1987; Draucker et al., 2009) were also reported.

Findings related to the course of PTG in sexual assault survivors offer inconsistent results. Whereas some studies found that increased time since the assault increased positive changes (Borja et al., 2006; Burt & Katz, 1987; Frazier et al., 2001; Grubaugh & Resick, 2007), others found no correlation between these variables (Gwynn, 2008; Kennedy et al., 1998). Frazier et al. (2001) reported that increased empathy and negative beliefs about fairness and safety were evident. In their study, the most growth occurred between two weeks and two months, when appreciation for life and the ability to recognise strengths were evident. However, in contradiction to this trajectory, Borja et al. (2006) indicated that survivors would likely only report growth six months after the assault.

As with resilience, many South African studies on PTG have focused on youth instead of adults (Hall & Olf, 2016; Sirikantraporn et al., 2018), and studies investigating PTG in adults are sparse. Peltzer (2000) found low scores of PTG when investigating trauma symptoms because of violent crime in an urban South African community. A study that garnered particular attention among researchers investigating PTG in South Africa is that of Walker-Williams (2012). In their dissertation, they investigated the prevalence of coping behaviour, PTG and PWB in women who experienced childhood sexual abuse. In this study, 58% of the participants manifested constructive coping, 60% manifested PTG, and 42% manifested PWB, with higher levels of PTG reported in previous studies. Moderate to high correlations were found amongst the scales utilised in the study, indicating conceptual coherence amongst constructive coping, PTG and PWB (Walker-Williams et al., 2012).

2.3 Current Therapeutic Interventions for Sexual Assault Survivors

The following section outlines the current therapeutic interventions available for adult sexual assault survivors, divided into interventions within the deficit-based paradigm and the strengths-focused approach. Thereafter, individual and group interventions available to this population are discussed.

2.3.1 The deficit-based approach

Therapeutic interventions for FSASA described in the literature primarily focus on the deficit-based approach, which focuses on alleviating dysfunctional symptoms and behaviours (Parcesepe et al., 2015). Numerous therapeutic frameworks emanating from this approach appear to have been successfully applied to sexual assault cases. The therapeutic approaches considered for this study are highlighted in the guidelines recommended by the National Institute of Clinical Excellence (2005). In treating PTSD and other resulting symptoms in adults following a sexual assault, most interventions

whose efficacy is supported by research are cognitive behavioural treatments (Parcesepe et al., 2015; Powers et al., 2010; Vickerman & Margolin, 2009; Wilson et al., 2001). These approaches are research-supported Cognitive Behavioural Therapy (CBT). Below is a brief explanation of these modalities, delineating their strengths and criticisms.

Cognitive models highlight the central role of psychological factors such as appraisals, beliefs and coping strategies in the development and persistence of PTSD (Ehlers & Clark, 2000). These treatments include Stress Inoculation Training (SIT), PET, CPT and EMDR. More recently, the cognitive therapy for PTSD developed by Ehlers and Clark (2000), (named CT-PTSD) and the CPT developed by Resick et al. (2002) have shown promise within this population. During a systematic review of interventions to reduce distress in adult victims of sexual violence, a meta-analysis revealed that specific cognitive and behavioural interventions (CPT, PET, and EMDR) had a statistically significant effect on PTSD and depression symptoms in comparison to the control group (Regehr et al., 2013). Although specific techniques are used in particular approaches, they have a considerable commonality (Edwards, 2009). Schnyder et al. (2015) list them as i) psychoeducation about PTSD and the impact of traumatic events; ii) exposure therapy aimed at facilitating the processing of trauma memory and iii) cognitive restructuring of problematic cognitive appraisals associated with the trauma and its sequelae.

Despite the advantages highlighted in the literature, such approaches also have shortcomings which may pose significant implications for clients and practitioners alike. Firstly, Gaston (2018) highlights the importance of attrition rates in interventions, reflecting the applicability and tolerability of a therapeutic outcome. A meta-analysis by Bradley et al. (2005) that investigated studies published between 1980 and 2003 on psychotherapy for PTSD found that the dropout rate was 20% on average for all therapies

relating to traumatic stress. To investigate what these rates could be attributed to, another meta-analytic review found that the attrition rate was higher (26%) when a trauma-focused component was involved in comparison to CBT, which excluded a trauma-focused component (19%) (Barrera et al., 2013). Secondly, increased mental health challenges, including substance use relapse, suicide attempts, psychotic episodes, and mania, have been observed during treatment (Gaston, 2018). Lastly, significant residual symptoms such as trauma reminders, detachment and depression remained after patients completed trauma-focused therapy (Larsen et al., 2019). Even though protocols for these treatments are available and have been proven effective (Foa et al., 2008; Vickerman & Margolin, 2009), these interventions are underutilised on both an international and local level due to concerns regarding transportability from randomised clinical trials to clinical practice (Borntrager et al., 2009; Higson-Smith et al., 2005). Padmanabhanunni (2017) systematically reviews treatment outcome studies in South Africa to investigate this concern. This review highlighted that all studies evaluating the effectiveness of cognitive behavioural treatments in South Africa are case study based. The findings are of unknown generalisability (Hodkinson & Hodkinson, 2001); therefore, the overall effectiveness of these interventions within our context has not been adequately investigated.

Nevertheless, these studies offer important information, such as taking cognisance of contextual factors that could complicate treatment engagement, for example, safety and support in the external environment, language difficulties, human immunodeficiency virus (HIV) infections because of rape, and multiple traumatic events (Padmanabhanunni, 2017). Based on the above criticism, there is a clear call for a therapeutic intervention that offers lower attrition rates and sustainable therapeutic gains. When the focus of an intervention is shifted from a predominant focus on pathology toward developing the

strengths and adaptability of an individual, attrition rates decrease (Tse et al., 2016). In this regard, the strengths-based approach is a good starting point for making strides in this direction (Sullivan et al., 2018).

A widely used approach in South Africa is the University of Witwatersrand (WITS) trauma model, which integrates psychoanalytic principles and cognitive-behavioural interventions (Eagle, 1998; Eagle, 2000). This integration involves a cognitive intervention focusing on developing coping skills and identifying and correcting cognitive distortions and meaning attributions. Psychodynamic principles prevent repression as a defence mechanism by integrating the trauma (Eagle, 1998; Hajjiannis & Robertson, 2000; Sherman, 1998). This model consists of five components that can be introduced interchangeably, namely, i) telling/retelling the story; ii) normalising the symptoms; iii) addressing self-blame or survivor guilt (restoring self-respect), iv) encouraging mastery, and v) facilitating the creation of meaning. Hajjiannis and Robertson (2000) conducted a study investigating counsellors' appraisals of using this model. This study highlighted several strengths and limitations of the model. Strengths included that counsellors were familiar with the model and could use it successfully with uncomplicated trauma, that it was a practical and focused approach that is flexible, and it was useful with diverse groups and trauma types. Limitations included limited applicability to clients with special treatment needs (limited verbal ability), highly traumatised individuals and comorbid psychiatric disorders. Some MHPs suggested that the model should be adapted to facilitate the completion of developmental tasks associated with different age groups, noting that this model is not as effective with adolescents struggling with identity formation and sexuality, older Black men with traditional views and the elderly that experience profound despair and hopelessness. Additional limitations included inadequate introject resolution and dependency on the counsellor, traumatic bereavement, anger and somatic

complaints (Hajjiannis & Robertson, 2000). According to Hajjiannis and Robertson (2000), MHPs found the facilitation of the meaning component of this model the most problematic since they were concerned that clients often construct meaning in negative ways that contribute to increased levels of anger, hostility, fearfulness and violence. Accordingly, MHPs noted that the short-term nature of the model impedes a thorough review of the client's life history, which is essential in facilitating meaning.

Given these limitations, a guideline that places more emphasis on how to cultivate strengths-based facets like resilience and PTG could be particularly relevant. To develop a relevant and effective intervention, it is important to look at the current frameworks and approaches that inform practice within the strengths-based context.

2.3.2 The strengths-based approach

A strengths-based approach is defined as a wide range of practice principles that promote and draw out the resources of patients and their environments that initiate, boost and sustain change (Cummins et al., 2013). Strengths-oriented practitioners aid in the process of uncovering their patients' suppressed areas of potential or resilience (Saleebey, 2013) by emphasising the autonomy, assets and goals of the individual client and increasing their overall PWB (Tse et al., 2016). Joseph and Linley (2008a) elaborate on this idea by stating that PTG harnesses the core principles of positive psychology and PWB, such as strength, resilience, hope, gratitude, and forgiveness. These principles can be used in the therapeutic service of trauma survivors.

In essence, strengths-based interventions are designed to assist survivors in developing and growing post-trauma by recognising and developing core aspects of themselves, such as positive personal and interpersonal traits and existential and spiritual growth. These traits can be integrated into their self-view, resulting in long-term post-trauma behavioural changes (Clifton & Harter, 2003). Strategies within this approach

focus on modifying the use of strengths within the survivor's situational demands (Kaiser & Overfield, 2010). Within this approach, the trauma-informed mindfulness-based stress reduction (MBSR) interventions have shown some promise in clinically significant decreases in PTSD, depressive symptoms and anxious attachment in women who had experienced IPV (Kelly & Garland, 2016). These manualised interventions consist of guided meditations, gentle movement exercises, didactic lectures and group discussions aligned with the MBSR model (Crane et al., 2017). In contrast to the previously outlined deficit-focused interventions, the retention of participants in this type of intervention appears higher (Kelly & Garland, 2016). Another promising strengths-based approach is an integration of strengths-based components and CBT principles.

The CBT approach can be extended by integrating it with a strengths-based component in the form of strengths-based CBT. This therapeutic approach consists of a four-step model developed by Padesky and Mooney (2012) and is explicitly used to build and strengthen personal resilience. The client and therapist collaborate on a guided discovery through a search for strengths, constructing a personal model of resilience (PMR), applying the PMR to areas of life difficulty, and practising resilience. The practical aspects of this approach include i) reliance on observations of client experience as the source of detailed information regarding cognitive, behavioural, emotional, and physiological reactions; ii) therapist awareness of empirical data regarding resilience, and iii) functional testing of a personal model of resilience by using behavioural experiments to assess its utility in real-world situations.

Although this is a promising approach to research specifically related to utilising the strengths-based approach, it is lacking when working with FSASA in a South African context. Walker-Williams and Fouche (2017) conducted the only study of this sort. Their quasi-experimental study evaluates the benefits of a 'survivor to thriver' (S2T) strengths-

based group intervention programme that aims to facilitate PTG in women survivors of childhood sexual abuse. Their findings indicated that emotional awareness, decisive action, a post-trauma identity and a healing group context were enabling processes of PTG. The promotion of PWB is inherent in positive adaptation and transformation that we seek through strengths-based interventions and is echoed within the resilience and PTG approaches. Overall, assessing strengths places the evaluation in context by yielding a more holistic and balanced view of the client, identifies competencies and resources that can be monitored and built on in treatment development and outcome evaluations and in doing so provides clinicians with more direction in their interventions (Cowger, 1994; Epstein, 1999; Harniss et al., 1999; Tedeschi & Kilmer, 2005).

A meta-analysis of current resilience training programmes and interventions found a moderate positive effect of resilience interventions (0.44 [95% CI 0.23 to 0.64]) with subgroup analysis suggesting that CBT-based, mindfulness and mixed interventions were most effective (Joyce et al., 2018). Although some strengths-based interventions exist to assist sexual assault victims worldwide (Regehr et al., 2013), such interventions for sexual assault survivors in South Africa are lacking. In South Africa, most of the interventions aimed at adult female survivors are focused predominantly on psychoeducation on the impact of the trauma and are specifically aimed at increasing antiretroviral adherence (Cameron et al., 2014; Kim et al., 2009; Knettel et al., 2020; Roland et al., 2012). Sikkema et al. (2018) developed a brief coping intervention to address traumatic stress and HIV care engagement among South African women with sexual abuse histories. This intervention incorporated trauma-focused CBT and included both individual and group sessions with psychoeducation and focused on several treatment themes, including synergistic stress of sexual trauma and HIV; the impact of trauma on health behaviours; safety, intimacy, power, and self-esteem; stressor

identification and appraisal; adaptive versus maladaptive coping; social support, and reduction of shame and stigma. A more in-depth therapeutic focus was taken when Fouché and Walker-Williams (2016) developed a strength-based group intervention for women who experienced childhood sexual abuse. This intervention drew on South African-based empirical research exploring the coping behaviours, PTG, and PWB of a sample of women who had experienced childhood sexual abuse (Walker-Williams et al., 2012, 2013), a South African trauma treatment model, the WITS trauma model (Eagle, 1998), and traditional approaches and transformational strengths-based outcomes of PTG. Qualitative thematic analysis revealed several enabling resilience processes, namely the group as a healing vehicle of change; changing destructive to constructive rumination coping strengths and meaning-making.

2.3.3 Individual vs group therapy

Intervention treatment of sexual assault survivors cited in the literature is advocated by an individual or in a group context. Literature is scarce on differentiating between the effectiveness of individual versus group treatment. However, Kessler, White and Nelson's (2003) systematic review found group treatment to be the most effective treatment in the recovery of female sexual abuse survivors. Group therapy can have a significant effect on the isolation that accompanies the shame and self-blame often reported by sexual assault survivors (Heard & Walsh, 2021; Menon et al., 2020). In some cases, group interventions were created due to the need voiced by IPV survivors to have a safe space to share their experiences with other women with similar life journeys (Tutty & Rothery, 2002). Positive outcomes following group therapy include developing interpersonal relationships that enable participants to build trust and receive validation of experiences, as they are able to share in a context that reduces shame and stigma (Schwartz et al., 2019; Yalom & Leszcz, 2020). Chivers-Wilson (2006) explains that a group therapy

context can provide a safe space for survivors to share their experiences, focus on the present, and challenge myths that perpetuate shame and self-blame. In addition to these benefits, group therapy is cost-effective and time-sensitive (Heard & Walsh, 2021), characteristics that are especially crucial in resource-limited settings such as non-governmental organisations (NGOs).

Heard and Walsh (2021) conducted a scoping review of the group therapy interventions available to adult sexual assault survivors. Trauma-focused therapy interventions identified in their review included EMDR, cognitive processing, psychotherapy, exposure therapy, art and drama therapy and stress inoculation. Support and educational interventions identified in their review drew on CBT and psychoeducation. Given the scarcity of sexual assault therapeutic intervention resources in South Africa and the effectiveness of group treatment in reducing cost and stigmatisation in such survivors, it appears a dedicated intervention approach to employ in this study.

3. PROBLEM STATEMENT

High prevalence rates of sexual violence have been reported globally (Abrahams et al., 2014; Dworkin et al., 2021). The numerous accompanying devastating long-term outcomes for survivors of sexual violence are well documented (Dworkin et al., 2017). The WHO (2013) asserts that recovery from sexual trauma is possible when appropriate research-supported interventions are implemented. Historically research-supported interventions for this population emanate from a pathogenic or deficit-based approach, where working only from a trauma-informed perspective appeared beneficial (Sweeney et al., 2018). However, studies show that such interventions may fall short in terms of high attrition rates (Bradley et al., 2005), mental health challenges such as PTSD, depression, anxiety, suicidal ideation, drug/alcohol abuse, premature termination of

therapy (Gaston, 2018) and residual symptoms remaining after completion of treatment (Larsen et al., 2019). As such, these criticisms have created a call for professionals working in trauma recovery to shift their primary focus from a deficit approach to working within a salutary or strengths-based approach, incorporating resilience processes and PTG-enabling outcomes (Park & Ai, 2006).

A strengths-based approach within a mental health care context focuses on interpersonal processes that work with the individual's and their community's strengths to achieve client-defined goals and personal recovery (Slade, 2009; Smith-Merry et al., 2011). If not implemented appropriately, this approach may come across to clients as negating the impact of their traumatic experience. Therefore, the combination of TIC and strengths-based approaches ensures that the impact of the trauma can be fully acknowledged while at the same time, empowering clients by identifying and enhancing their strengths borne from their struggle to overcome the trauma. In seeking this balance, it is essential to look at evidence-based interventions that have proven effective for sexual assault survivors (Hagger & Luszczynska, 2014). Although several interventions are available for sexual assault survivors, the predominant amount cited is deficit-focused (Parcesepe et al., 2015). Whereas these interventions have shown efficacy, this approach focuses on removing or improving an underlying conflict or changing maladaptive thinking, behaviours and symptoms (Priebe et al., 2014). These treatments may have the unintended consequence of strengthening a negative image of clients and reducing their sense of control, thereby encouraging passivity (Maddux et al., 2004; Wright et al., 2021). The most widely used trauma intervention model in South Africa, the WITS trauma model, combines psychoanalytic principles with cognitive behavioural interventions (Eagle, 1998). Although this model touches on some aspects of strengths-based practice (mastery and creation of meaning), MHPs have found it particularly

challenging to facilitate positive meaning-making amongst survivors while utilising this model (Hajiyiannis & Robertson, 2000). Given the significant impact that sexual assault has on an individual's worldview, meaning-making is particularly important in alleviating PTSD. This indicates that spending additional time in recognising the strengths of the participants and cultivating empowering narratives may be particularly beneficial. Walker-Williams and Fouche (2017) developed a strengths-based intervention for South African women who experienced childhood sexual abuse. These authors found that their group-based intervention enabled PTG by facilitating emotional awareness, decisive action, a post-trauma identity and a healing group context. Although the findings of this study could offer a glimpse into processes that may be relevant to adult sexual assault survivors, it was not explicitly aimed at this population.

Although current trauma-informed guidelines highlight the importance of providing counselling services to survivors, these guidelines do not offer specific intervention components beyond medico-legal recommendations (WHO, 2003), identification of survivor needs, appropriate referral (Stefanidou et al., 2020), and/or psychoeducation about trauma responses (Jina et al., 2010). Shortage of staff, lack of specialisation, and lack of knowledge in managing PTSD related to sexual assault have all been found to contribute to ineffective treatment of survivors in NGOs (Abrahams & Gevers, 2017; García-Moreno et al., 2015; Greeson et al., 2016). Cost-effective and time-sensitive interventions are crucial in resource-limited settings such as NGOs in South Africa. When exploring treatment interventions for this population, traditional models advocate for individual treatment. However, in the emerging research, groups are cited as being more impactful than individual therapy. This attributes to stigma reduction and solidarity in the presence of peers while recovering. The benefits of group contexts are substantial (Heard & Walsh, 2021). In addition to benefits such as fostering healthy social connections and

reducing isolation (Menon et al., 2020), group therapy is cost-effective and time-sensitive (Heard & Walsh, 2021), while fostering healthy social connections and reducing participant isolation (Menon et al., 2020).

This study seeks to develop characteristics that are especially crucial in resource-limited settings such as NGOs in South Africa. As such, the study aims to inform a trauma-informed strengths-based group intervention guideline for FSASA for MHPs in South Africa. This is accomplished by synthesising scientific literature and best practice in existing evidence-based intervention models (rapid review) and hearing survivors' first-hand narratives of their trauma experiences (convergent mixed-method study). The rapid review enables the research team to identify functional elements of existing interventions. The convergent mixed-method study informs our understanding of how distress and PWB indicators are interrelated and assist in identifying facilitators and barriers in recovery treatment. With this understanding, we have designed an intervention guideline to equip MHPs to enhance resilience and PTG in sexual assault survivors. After a brief outline of the definition of sexual assault applied in this study, a literature overview is provided to contextualise the study.

4. THE FOCUS OF THE STUDY

This study has included adults in our sample as prior studies have shown that risk factors tend to accumulate during this stage of development (Van Vugt et al., 2014) and protective factors tend to be more effective (Bachmann et al., 2014). In addition to this, we are cognisant of the limited research concerning strengths-based studies for this population. Although this study focuses on women, this does not discount nor minimise the importance of developing such interventions for males or non-binary groups. The researcher aims to expand upon and includes males and/or non-binary groups once the intervention guideline has been evaluated and implemented upon completion of this PhD.

This intervention guideline is focused on a group intervention context. This context was decided upon based on the limited resources noted during the informal consultation with NGOs. In addition, shame has consistently been found to be a central factor in sexual assault survivor recovery. Thus, group counselling is effective in providing a voice for such marginalised populations (Griffith, 2014) by providing social support (Yalom & Leszcz, 2020), and teaching coping strategies (Meaney-Tavares & Hasking, 2013); where the group can be seen as a vehicle of healing (Walker-Williams & Fouché, 2017).

5. PURPOSE STATEMENT

This study focuses on designing a trauma-informed strengths-based group intervention guideline for FSASA. MHPs may apply such trauma-informed strengths-based group intervention guidelines in facilitating and enhancing resilience processes, PWB, and PTG outcomes in FSASA. By exploring and describing the objectives outlined below, the researcher will seek to formulate the guidelines that will assist in designing, developing, and evaluating an appropriate intervention. To reach the main objective, the following secondary research objectives will be addressed:

- **Research Objective 1:** To explore and describe interventions that promote recovery in FSASA reported in scientific literature (*rapid review*).
- **Research Objective 2:** To analyse the relationship between demographic variables, PTSD, PWB, resilience, and PTG of a group of FSASA residing in the Gauteng Province (*empirical research: convergent mixed-method; quantitative section*).
- **Research Objective 3:** To compare experiences of the upper (significant signs of recovery - referred to as SSR) and lower (few signs of recovery - referred to as FSR) FSASA scorers regarding attributing factors to their PWB, resilience and PTG in Gauteng, South Africa (*empirical research: convergent mixed-method; qualitative section*).

- **Research Objective 4:** To synthesise findings from the rapid review and convergent mixed-methods empirical study to inform the development of the trauma-informed strengths-based group intervention guideline for FSASA (*rapid review and empirical research*).

6. MAIN RESEARCH QUESTION

The main research question for this study, based on the objectives mentioned above, is *What components must be included in a trauma-informed strengths-based group intervention guideline designed for FSASA within the South African context?* To answer the research question, the following secondary research questions were formulated:

- **Research Question 1:** What interventions reported in scientific literature promote recovery in FSASA? (*Rapid review.*)
- **Research Question 2:** What is the relationship between demographic variables, PWB, resilience, and PTG of a group of FSASA residing in Gauteng Province? (*Empirical research: convergent mixed-methods study; quantitative section.*)
- **Research Questions 3:** What can we learn from the upper (SSR) and lower (FSR) FSASA scorers regarding attributing factors to their PWB, resilience and PTG in Gauteng, South Africa? (*Empirical research: convergent mixed-method; qualitative section.*)
- **Research Question 4:** What should be included in a trauma-informed strengths-based group intervention guideline for FSASA based on a rapid review and convergent mixed-methods empirical study? (*Rapid review and empirical research.*)

7. STUDY DESIGN MAP

A clarification of the different elements of this study must be provided. Therefore, a layout of the different manuscripts is provided below (Table 1).

Table 1: Study design map

	Manuscript 1: Phase Two: Information gathering using a rapid review (January 2022 – March 2022)	Manuscript 2: Phase Two: Information gathering employing a convergent mixed-methods study (April 2022 – November 2022)	Manuscript 3: Phase Three: Designing the trauma-informed strengths-based group intervention guideline (December 2022 – March 2023)
Secondary research questions	Research Question 1: What interventions reported in scientific literature promote recovery in FSASA?	Research Question 2: What is the relationship between demographic variables, PWB, resilience, and PTG of a group of FSASA residing in the Gauteng Province? Research Question 3: What can we learn from the upper (SSR) and lower (FSR) FSASA scorers regarding attributing factors to their PWB, resilience and PTG in Gauteng, South Africa? (<i>Empirical research: convergent mixed-method; qualitative section.</i>)	Research Question 4: What should be included in a trauma-informed strengths-based group intervention guideline for FSASA based on a rapid review and convergent mixed-methods empirical study?
Design method	Rapid review	Convergent mixed-method study	Integration of findings from informal consultations with managers at NGOs, the rapid

			review, and empirical convergent mixed-methods study.
Sampling, participants, and data collection method	A systematic review of 325 papers; 35 papers were quality-appraised; 17 studies were thematically analysed to extract content for a trauma-informed strengths-based group intervention guideline for FSASA.	Purposive and snowball sampling; online surveys that included psychometrically validated scales and open-ended questions.	N/A
Data analysis	Iterative data analysis; independent coding; consensus discussion.	<p><u>Quantitative:</u></p> <p>Exploratory factor analysis (EFA) to outline the relationships between the variables identified. Descriptive statistics and mean comparisons to identify different groups of survivors.</p> <p><u>Qualitative:</u></p> <p>Constant comparative analysis for responses of different scoring groups; independent coding; consensus discussions.</p>	Integrating findings from the rapid review and empirical convergent mixed-method study.

Outcome	First formulated the outline of group intervention guideline that highlights interventions currently available for FSASA.	<p><u>Quantitative:</u></p> <p>Correlations between PTSD, PWB, resilience and PTG amongst adult sexual assault survivors.</p> <p>Scoring profiles for the above-mentioned variables for South African FSASA.</p> <p><u>Qualitative:</u></p> <p>FSASA experiences barriers and facilitators to recovery.</p> <p>FSASA experiences PTSD, PWB resilience and PTG.</p> <p>Comparison between the experiences of sexual assault survivors that show SSR to those that show FSR.</p>	Trauma-informed strengths-based group intervention guideline for FSASA.
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8. RESEARCH METHODOLOGY

The researcher's knowledge of existing theoretical or conceptual frameworks, including models, theories, concepts, and definitions, is reflected in the theoretical assumptions (Ngulube et al., 2015). The theoretical assumptions of the researcher include the central theoretical argument, concepts relevant to the study and theoretical framework. These are outlined below.

8.1 Central Theoretical Argument

Cognisance of the trauma and the extent to which survivors experience the symptoms associated with the assault, as well as the resources they use in recovery are central to this study. The researcher gained a clearer understanding of the effects of sexual assault on the survivor through the literature review, the rapid review, and the convergent mixed-method study - with a strong emphasis on the experiences and narratives of the survivors throughout. Resilience research focuses on the interplay between the impact of trauma and how survivors use internal and external resources to function in their daily lives. These components also align with PTG as an outcome of a specific coping process to restructure a coherent post-trauma life narrative (Fouché & Walker-Williams, 2016). Therefore, this approach is well-suited as the framework for this intervention guideline which aims to enhance resilience processes and PTG-enabling outcomes without negating the genuine difficulties brought on by the trauma of sexual assault. By assessing PTSD, PWB, resilience, and PTG, the researcher can form a detailed picture of their current functioning. Integrating these profiles with their narratives outlines aspects that need to be considered in practice to increase the suitability and effectiveness of such interventions.

8.2 Conceptual Framework

This study is based on the assumptions of the strengths-based approach grounded in positive psychology. Within this perspective, several models are observed in practice, including resilience and the PTG model. The Resilience Portfolio model guided the variables that were measured in this study (Hamby et al., 2018). This model integrates theory and research on resilience, positive psychology, PTG, and adaptive coping, thereby providing a more comprehensive understanding of the health and thriving processes emanating in individuals exposed to adversity (Grych et al., 2015). Within this model, several factors contribute to an individual's recovery from a traumatic event. These include i) the individual's exposure to violence; ii) the resources and assets available to the individual; iii) their appraisal and coping behaviours, and iv) their overall psychological health (Hamby et al., 2018). The model proposes that an individual's psychological health after exposure to violence is determined by characteristics of the adversity, the assets, and resources available to them and their behavioural responses. Guided by the model as a framework, the participants' exposure to violence was highlighted (demographic questionnaire), and the resources and assets of the individuals (Adult Resilience Measure [ARM] and Posttraumatic Growth Inventory [PTGI]) alongside their psychological health, were measured (MHC-SF, PCL-5). Measuring and investigating the relationship between these variables indicated the characteristics present within the FSASA and enabled the researcher to group participants into different recovery profile groups.

8.3 Paradigmatic Perspective

The pragmatic paradigm informed this study as it enabled the researcher to combine methods that work for the aim of each section of the study (Creswell & Creswell, 2017; Onwuegbuzie & Leech, 2005; Patton, 2002). In keeping with the mixed-methods design, the researcher positioned themselves within both the positivistic and postmodern

paradigms. This positioning was guided by the study section, the quantitative section (positivist), and the qualitative section (constructivism). The positivism paradigm uses the hypothetical deductive method to verify hypotheses regarding the functional relationship between dependent and independent variables and values of researcher objectivity (Park et al., 2020). The quantitative section of the convergent mixed-method study was an enquiry into the relationships between PTSD, PWB, resilience and PTG in sexual assault survivors. An understanding of how these variables were related informed the researcher about which variable had to be focused on to yield the most benefits for sexual assault survivors in their recovery journey. In contrast, the constructivism paradigm focuses on understanding multiple participant meanings assigned to a phenomenon and highlights the importance of how the interpretation of findings is shaped by the researcher's own experiences and background (Creswell & Creswell, 2017). This positioning in the qualitative section of the study enabled the researcher to investigate how participants experienced PTSD, PWB, resilience and PTG, as well as the meaning they ascribed to their recovery experiences. Combining these paradigms in the different sections within the study offered information about the measurable aspects of reality and rich contextualised data based on survivor experiences.

8.4 Research Approach

This study aimed to design a trauma-informed strengths-based group intervention guideline for FSASA. This intervention study was guided by Rothman and Thomas's (2013) design and development model (D&D Model). Embedded within this approach are three main research components. These components include i) an informal needs analysis conducted with NGO managers working with FSASA; ii) a rapid review, and iii) a convergent mixed-methods study with FSASA.

The first phase involved accessing the appropriate gatekeepers and consulting with service providers who work with sexual assault survivors. This phase aimed to gain an informed opinion on the factors impacting the intervention's feasibility. In the second phase, a rapid review of existing scientific literature was conducted to ascertain an empirical baseline for the design of the intervention guideline. The third component was a convergent mixed-method study.

The quantitative component of this study consisted of sexual assault survivors completing the PTSD Checklist from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) (PCL-5), Mental Health Continuum-Short Form (MHC-SF), Resilience Research Centre's ARM, the PTGI, and a demographic questionnaire. These measures were used to assess PTSD, PWB, resilience, and PTG. The qualitative component was embedded within the demographic questionnaire and included a short list of open-ended questions where participants were asked about aspects of their recovery journey. In Phase Three, the intervention was developed based on integrating the results from Phases One and Two. On completion of this study, the researcher endeavours to continue and conduct a Delphi evaluation to expand on the guideline and complete the development thereof, alongside a pilot test of the intervention guideline.

8.5 Type of Research

This study focused on designing an intervention guideline within the South African context and can therefore be categorised as applied research. Applied research informs action, enhances decision-making on practical issues, and is not focused on generating theory and producing knowledge for its end (Tolley et al., 2016). Given this factor, it is essential to consider contextual factors in the research.

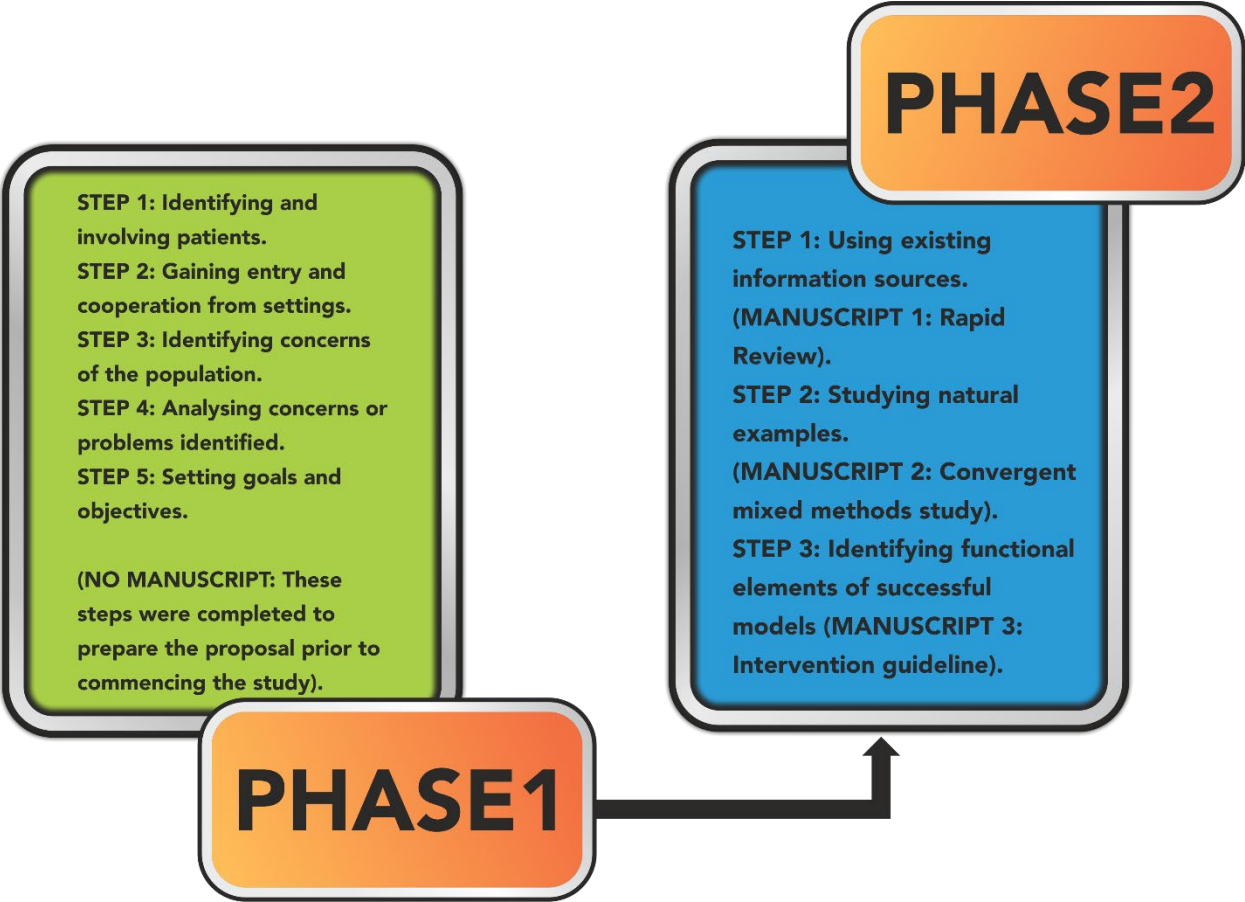
The researcher is a clinical psychologist interested in empowering trauma survivors, utilising a trauma-informed strengths-based approach in their therapeutic work. This

approach places the survivor's experiences and strengths at the centre of inquiry and the intervention to guide the professional in the therapeutic journey with the client. The researcher is currently in part-time private practice, and although they have worked in similar centres in the past in the Eastern Cape, they have not worked in any of the centres that were approached for this study. It is noted that the centres the researcher sampled from in this study also followed the strengths-based approach and offered guidance during the intervention design on what will work in their settings. The researcher was mindful of including as much diversity in participants as possible in the sampling process to implement the intervention as relevant to the diverse population in South Africa as possible.

8.6 Research Model

The D&D model was selected for this study. Kruger (2008) notes that the developers (Rothman & Thomas, 2013) of this model have been publishing in the intervention development field for over 25 years. This model has also been documented to have been used successfully within the South African context (Dunn, 2011; Hartzenberg, 2005; Hope & Van Wyk, 2018; Murray, 2009; Pierce & September, 2000). The D&D model comprises six phases (Roestenburg & Strydom, 2022), namely i) problem analysis and project planning; ii) information gathering and synthesis; iii) design; iv) early development and pilot testing; v) evaluation and advanced development, and vi) dissemination. This study focused on the first three phases, and the last three phases will be completed during post-doctoral studies. For illustrative purposes, the phases, their steps, and the manuscript in which they are discussed are outlined in Figure 3 below. Thereafter, two tables are divided into smaller sections (Tables 2 and 3) that illustrate how the steps in the model were carried out in the study, followed by a discussion of each.

Figure 3: Overview of Phases Relevant to the D&D Model



8.6.1 Phase One: Problem analysis and project planning

Roestenburg and Strydom (2022) explain that this phase focuses on defining the social problem and, consequently, involves significant role players that could benefit from the intervention. This phase is addressed within this chapter.

8.6.1.1 Step 1: Identify patients

The earlier problem statement reflected that the historical focus on trauma survivor recovery utilised the deficit-based formulation. However, numerous survivors appear to have exhibited resilience processes and PTG outcomes. These survivors appear to have been largely overlooked in the literature. Therefore, there is a clear need to examine the recovery processes and strengths within this population to create interventions informed

by survivors' experiences. This study focused on these processes to develop a trauma-informed strengths-based intervention guideline for FSASA.

8.6.1.2 Step 2: *Gaining entry and cooperation from relevant settings*

Survivors of sexual assault can be difficult to access. For this study, the researcher explored different ways of entering organisations that allow access to adult survivors of sexual assault. Involving local women's rights advocates or direct service groups, when it is safe to do so, is an excellent way to ensure that the proposed methodology is based on a sound understanding of the local context, is relevant and is appropriate for the setting (WHO, 2001). Therefore, the researcher-initiated contact by reaching out to professionals in organisations who work with FSASA to discuss the feasibility of the intended intervention guidelines. Discussions with professionals in this field also assisted the researcher in understanding the referral process FSASA undergo after a sexual assault in South Africa.

When individuals report a sexual assault case at a hospital or police station, they are referred to the nearest Rape Crisis Centre. At these centres, an investigating officer takes a police statement. First, responders provide psychological first aid, HIV testing and counselling, information packages on the impact of rape on a survivor and referral to a range of services, including shelters (where indicated) and longer-term counselling and support (Networking HIV & AIDS Community of Southern Africa [NACOSA], 2015). Even though some of these centres offer follow-up counselling sessions for patients with a social worker, their primary focus is on offering services in the acute stage. Therefore, survivors are referred, resulting in referrals to other organisations for longer-term interventions being common practice (Van Grijp, personal communication, August 3, 2020). This information enabled the researcher to focus recruitment efforts on the appropriate settings.

Since PTG is a process emerging in the later parts of or longer-term phase of recovery it is not necessarily prevalent in acute care, thus, the input from service users of organisations that offer longer-term follow-up is crucial to obtaining the relevant information for developing the intervention in this study. Initially, seven organisations that fit this description were contacted electronically and telephonically to participate in this research. The organisations that responded to the requests were visited on-site, and consultations were conducted with each site's directors and project managers. These organisations provided contact details for similar organisations, who were then contacted, and similar consultations were scheduled. The organisations that agreed to participate in this research included Family and Marriage Society of South Africa, Lifeline, South African Female Federation and the Transform Education About Rape and Sexual abuse (TEARS) Foundation. These organisations offer longer-term counselling services focusing on victim empowerment for women who have experienced gender-based violence (GBV). Some of these organisations advertised for recruitment at their facilities by placing posters at their organisations (during Phase Three, the convergent mixed-method study). However, due to staffing shortages and high workload, the organisations could not spare a recruitment person at their facility, and the organisations were not open to accepting an outside recruiter due to privacy concerns. As a result, this sampling strategy was not interactive and did not yield significant participant numbers (n=3). An alternative sampling strategy was employed that is described in the convergent mixed-methods section of this thesis.

8.6.1.3 Steps 3 and 4: Identifying and analysing concerns or problems identified

A collaborative partnership was established during consultations. This partnership guided the goals and objectives for the intervention and resulted in an agreement that recruitment could take place at the organisations. During these consultations, the researcher gained a clearer understanding of managers' concerns in these organisations

(Roestenburg & Strydom, 2022). These consultations focused on identifying different organisations involved in service delivery for FSASA, existing guidelines and procedures being followed, and the barriers to service delivery for FSASA. An analysis of the findings from these consultations offered interesting information. For example, existing guidelines that the organisations follow complement the following laws and policies that apply to sexual offences in South Africa:

- The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007;
- The Children's Act, 38 of 2005 (as amended);
- Older Person's Act, 13 of 2006;
- National Directives and Instructions on Conducting a Forensic Examination on Survivors of Sexual Offence Cases in Terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 (issued by the Department of Health);
- National Instruction 3/2008: Sexual offences (issued by the SAPS);
- Regulations on services for victims of sexual offences and compulsory HIV testing of alleged sex offenders (issued by the Department of Justice and Constitutional Development);
- National Instruction 2/2012: Victim Empowerment (issued by the SAPS); and
- Regulation 33076: Consolidated Regulations Pertaining to the Children's Act, 2005 (issued by the Department of Social Development) and the Victims' Charter.

The aim of these policies and regulations is focused on the roles and responsibilities of medical personnel and members of law enforcement. Although existing policies and guidelines note the importance of referring survivors to specialised mental health care services (social workers, psychologists, psychiatrists) to attend to the psychological impact of the assault, these policies do not outline specific psychological treatment modalities that need to be followed to assist survivors in recovery.

Two main barriers to service delivery were highlighted during stakeholder consultations. Due to financial constraints, most of these organisations do not have psychologists on staff in positions where they offer services directly to patients. As a result, social workers, registered counsellors, and auxiliary social workers offer counselling. In effect, the staff in these organisations are not always sufficiently trained to offer patients who require extensive psychosocial interventions adequate care. Stakeholders also reported that many patients do not return for follow-up services due to severe financial constraints. Having to choose between transport money for therapy and food for their families is a reality many patients contend with. Therefore, there are frequent disruptions in the psychosocial services provided, impacting recovery rates.

The intervention guideline designed in this study extends the guideline already being used within the organisations yet expands its focus and can therefore be integrated into the existing procedures being followed. The guideline currently being used in NACOSA outlines the scope and content of services and outlines the training and supervision needed to support first responders (NACOSA, 2015). This guideline is focused on acute care and outlines the guiding principles for services that are in line with the Victim Charter, explains the steps in psychological first aid and the legal duty to report, outlines services available at police stations and Thutuzela care centres (rape crisis centres) and highlights the need for supervision. As a result of the referral policies already in place, this intervention guideline will not go into detail about the referral channels before the implementation thereof. The diverse training needs of the MHPs offering psychosocial services to patients expressed by the professionals call for a guideline with delineated steps that would be easy to follow. The stakeholders also noted a need for staff capacity building. In response to this, once the development of the intervention is complete, the researcher intends to spend time training the staff in the intervention guideline to equip

them to implement it appropriately. Being mindful of the high rates of interruption of services due to financial constraints on the survivors, it is also important to note that if the interventions require several follow-up sessions, provision must be made for transportation services. Group-based interventions were also seen as favourable since they offer services to more than one individual that lives in the same setting at a time.

8.6.1.4 Step 5: Goals and objectives for the intervention

This intervention guideline was informed by the rapid review and empirical convergent mixed-method study and includes the needs identified by the managers of the professionals working with FSASA, as well as evidence-based interventions highlighted in the literature. The preliminary objectives for the intervention guideline include:

- Offer professionals guidance on the interventions, their formats, and related outcomes that have shown to work for this population (rapid review); and
- Offer psychoeducation about resilience, PTG, and PWB to assist professionals to help survivors in identifying and harnessing their strengths and resources to become more resilient in facing future challenges (convergent mixed-methods study).

8.6.2 Phase Two: Information gathering and synthesis

The next section outlines phase two of the larger study where information was gathered through a rapid review and convergent mixed-method study.

Table 2: Phase Two study overview

<p>PHASE TWO: INFORMATION GATHERING AND SYNTHESIS</p> <p>Phase Two focused on knowledge acquisition and synthesis. Knowledge acquisition involves identifying and selecting relevant types of knowledge and using and integrating appropriate sources of information (Roestenburg & Strydom, 2022). In this regard, Roestenburg and Strydom (2022) recommend studying existing information sources and natural examples. In line with this recommendation, this information-gathering phase followed two consecutive steps. These include a rapid review (Study 1) and a convergent mixed-method study (Study 2).</p>
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OBJECTIVE 1: To explore and describe interventions that promote recovery in FSASA outlined in scientific literature (rapid review).

OBJECTIVE 2: To analyse the relationship between demographic variables, PWB, resilience, and PTG of a group of FSASA residing in Gauteng Province (empirical research: convergent mixed-method; quantitative section).

OBJECTIVE 3: To compare experiences of the upper (SSR) and lower (FSR) FSASA scorers regarding attributing factors to their PWB, resilience and PTG in Gauteng, South Africa (empirical research: convergent mixed-method; qualitative section).

Steps in the D&D model	Steps in the proposed research
<ol style="list-style-type: none"> 1. Using existing information sources. 2. Studying natural examples. 3. Identifying functional elements of successful models. 	<p>Step 1: Rapid review.</p> <p>Conducted a rapid review of the treatments for FSASA to identify practices and functional elements of successful theories, models, programmes, interventions, and practices.</p> <p>Step 2: Convergent mixed-method study.</p> <p>Conducted a convergent mixed-method study to quantify the presence of PTSD, PWB, resilience and PTG within a sample of several sexual assault survivors. Looked at qualitative responses of the top 20 (SSR) and bottom 20 (FSR) scoring FSASA participants from the quantitative strand to explore the factors they experience as enhancing recovery.</p> <p>Step 3: Integrating Step 1 and Step 2 findings.</p> <p>The findings from the rapid review and the mixed-method study were integrated to identify functional elements of successful interventions for the population under study.</p>

This phase's outcome is comprised of a list of functional aspects that can be integrated into the design of the intervention. The steps in Phase Two are described in more detail below.

8.6.2.1 Step 1: Using existing information sources

In this step, empirical research examines reported practice and relevant identified interventions (Kruger, 2006). Selecting information sources should be relevant to the intervention and adequately address the researcher's requirements. To inform the development of the intervention for this study, it was crucial to clearly understand the current interventions used with this population in practice. A comprehensive understanding of the components inherent in previous evidence-based interventions guides the components required for the group intervention guideline.

To achieve this, a rapid review was conducted since it allowed the researcher to conduct a focused, systematic search of relevant interventions noted in the current literature. This methodology has emerged to fulfil the need for a rigorous yet timely literature review so policymakers, healthcare professionals and consumers can make research-supported recommendations on healthcare activities and decisions (Watt et al., 2008). A rapid review is a literature review methodology that addresses a research question and provides commentary on the strength of the evidence and its direction, consistency, generalisability, and applicability for the audience within a relatively short time frame due to the concessions to the breadth and depth of the process (Varker et al., 2015; Watt et al., 2008). The review guidelines of the Cochrane Institute were used to guide this study (Higgins et al., 2019) and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) reporting guideline was implemented (Liberati et al., 2009). After the PICO (population, intervention, control, and outcomes) framework was used to develop the research question (Methley et al., 2014), a protocol for this rapid review was designed, as outlined in the table below.

Table 3: Rapid review protocol

Research Question: What interventions reported in scientific literature promote recovery in FSASA?

Parameters: Databases, Search terms, Eligibility criteria

Databases that were searched included Ebscohost (Academic Search Premier, African-Wide Information, E-journals, ERIC, PsychINFO and SocIndex), Web of Science, Scopus and SA Journals, Cochrane CENTRAL and MEDLINE. The reference lists of the included articles and relevant systematic reviews were scanned for additional relevant articles for inclusion to compensate for any deficiency in the retrieval terms (Grayson & Gomersall, 2003; Papaioannou et al., 2010).

Search Terms: The PICO question framework was used to determine the search words for this review since it offers comprehensive results (Methley et al., 2014). The following search words were utilised:

- (P) “rape” OR “sexual assault” OR “sexual violence”
- (I) “interventions OR “strategies” OR “best practices” OR “treatment” OR “therapy” OR “program”.
- (C) Comparison was not specified to ensure that as many interventions as possible were included.
- (O) The outcome was not specified to ensure that as many interventions as possible were included.

Eligibility Criteria: Publications between 2012 and 2022 were included to review the most recent literature and build upon previous syntheses that were concluded in 2012. Only English peer-reviewed articles that outlined their ethical considerations were included. Further exclusion criteria used are outlined below, followed by a justification of each.

Bystander-focused interventions (n=8): Since this review focuses on interventions that assist survivors in recovering from sexual assault, interventions focused on prevention or bystander-focused interventions were excluded.

Interventions not evaluated: The emphasis on the evidence-based nature of the interventions highlighted in this study excluded articles where the interventions were introduced but not evaluated. These included protocols for interventions that were not empirically tested.

Focused on specialised population (military/ID) (n=41): Although these populations experience sexual assault, they are not the target group for the intervention guideline.

IPV interventions (n=31): Although the researcher acknowledges the overlap between these populations in practice, these studies were excluded since they did not specifically focus on sexual assault but included aspects such as care in shelters.

Interventions focused on prevention (n=30): The intervention guideline for this study is aimed at women who have already experienced sexual assault instead of prevention. These articles predominantly focus on governmental changes outside this study's scope.

Staff training in acute settings (n=23): This study is focused predominantly on the survivor's experience rather than the MHPs. Furthermore, these studies focused on the experiences of the staff implementing interventions and not on the interventions themselves, offering limited information on components required in constructing an intervention guideline for survivors.

Mixed trauma sample (n=23): Although the researcher acknowledges the overlap between these populations in practice, the intervention guideline is focused on sexual assault survivors specifically. Studies have also shown that sexual assault has the highest levels of PTSD among all the trauma samples.

Adolescent focus (n=8): These studies are outside of the scope of the intervention guideline target group, FAMAS.

Systematic reviews (n=21): Primary studies were reviewed for this study to decrease the chance of bias in the secondary reporting of findings. Although not included in the articles reviewed, the relevant systematic reviews were used to inform decision-making pertaining to the timespan searched and incorporated into the article's discussion section to contextualise the findings.

Executing search

There were two reviewers who independently assessed the titles and abstracts of all records identified through the searches based on the inclusion criteria, coding them as 'yes' (eligible), 'no' (not eligible) or 'maybe' (potentially eligible or unclear) using Rayyan (Qatar Computing Research Institute, 2022). Reasons for excluding ineligible studies were documented throughout. In the event of disagreements about inclusion, the review authors assessed and discussed the full article for relevance. If an agreement could not be reached through discussion, they consulted a third review author as a mediator. Final decisions were made by consensus.

Duplicate records were identified and removed. Multiple reports that related to the same study were evaluated in terms of the outcomes assessed. The selection process was recorded in sufficient detail to complete the four-phases (identification, screening, eligibility and included), the PRISMA flow diagram

was set out for reporting purposes (Liberati et al., 2009) and the 'Characteristics of excluded studies' section - as noted earlier in this table. Rayan was used as a platform to upload the included studies and extract data. Rayan allowed us to analyse the data and build the text, tables, and figures for presenting the review.

We piloted and refined the data collection table by using the first five studies included in the review. The review author extracted data on key characteristics, methods, and outcomes from each included study, and compared their results with an independent reviewer to identify differences. When further clarification or missing data were needed from the study authors, we made all reasonable attempts to contact the study authors and obtain the relevant information.

Quality appraisal: The appraisal tools developed by the Johanna Briggs Institute (JBI) were used to quality appraise the articles included in the review. This quality appraisal was conducted separately by the researcher and their supervisors and then the scores were collated. Articles that were of poor methodological quality were excluded from the review.

Evidence Synthesis

The data extracted from the included studies were put together on an Excel sheet with the following column headings: *Authors, Year of publication, Study design, Sample characteristics, Setting, Outcomes and assessment instruments, Time points assessed, Frequency and length of sessions, Style of delivery, JBI score, and Limitations*. The data was then viewed holistically, and inferences were made about the characteristics of the studies through colour coding the different aspects of each column in the findings in the table. (for example, outcomes and measures used for each outcome). Thereafter, Manuscript 1 was written to outline the findings of the synthesis.

Once information has been gathered, researchers analyse critical features of the programmes and practices that have previously addressed the problem (Roestenburg & Strydom, 2022). In this study, this analysis was addressed within the rapid review. By studying successful and unsuccessful interventions that have attempted to address the problem, potentially valuable elements of an intervention were identified (Bellg et al., 2004; Linnan & Steckler, 2002). In line with the recommendations given by Roestenburg

and Strydom (2022), during the analysis of the interventions identified in the rapid review, the factors in Figure 4 were identified in each study to guide the intervention design.

Figure 4: Questions answered in the rapid review

- Which interventions are available for this population?
- What outcomes are measured in existing interventions?
- Are there common aspects involved in successful interventions for this population?
- What are the limitations of these interventions?
- Which participant characteristics must be screened for before the interventions are administered?

This analysis enabled the researcher to design and develop activities that will be added to the intervention. Successful models and functional elements of the models are incorporated into the new strength-based trauma-informed intervention. After establishing a solid theoretical base, it was essential to understand the experiences of FSASA in South Africa to identify factors that may impede or enable success in practice. This next phase where the researcher studied natural examples through a convergent mixed-method study is discussed below.

8.6.2.2 Step 2: Studying natural examples

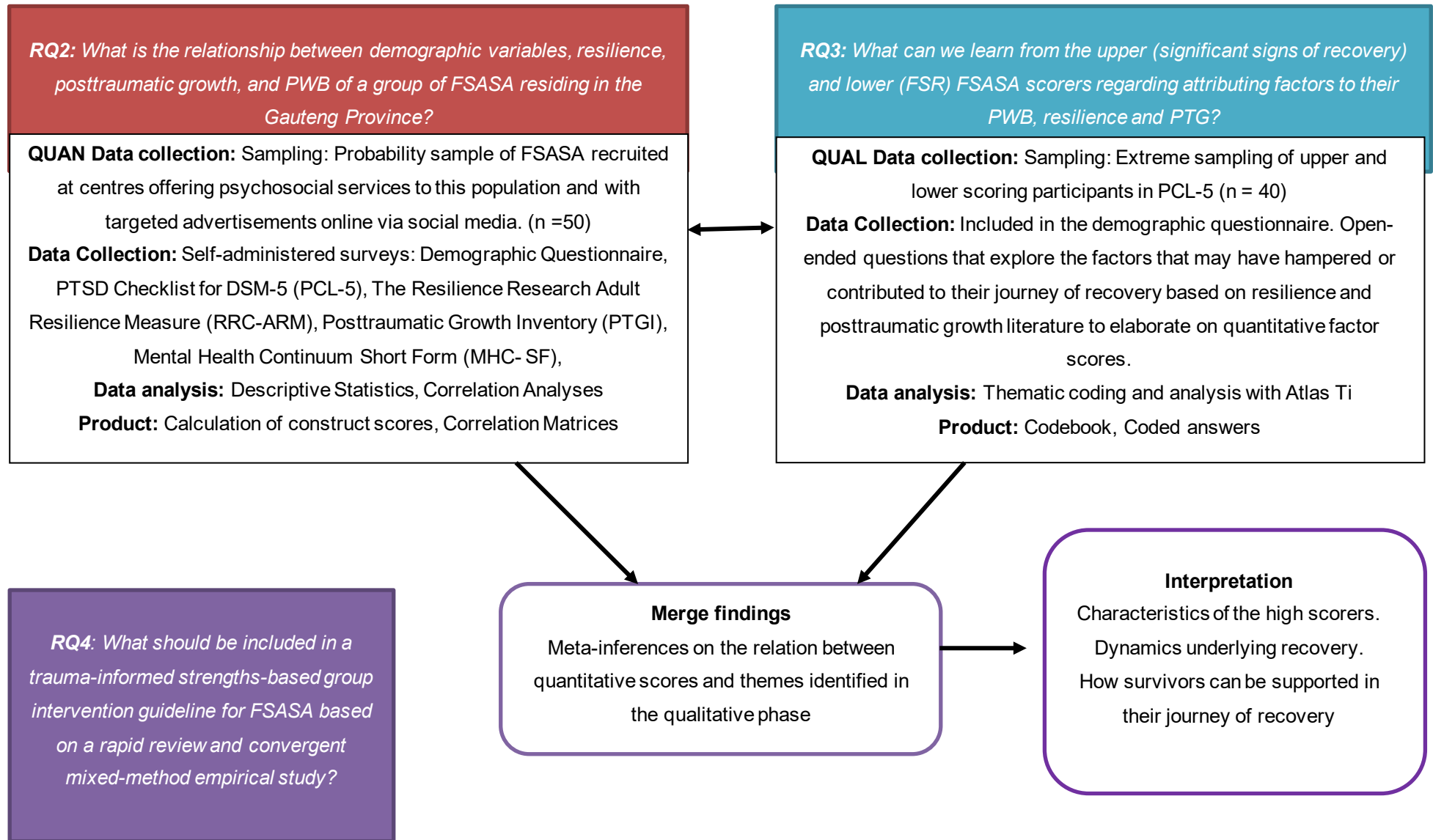
De Vos et al. (2011) note that interviews with people who have experienced the problem or know about it can provide insights into which interventions might or might not succeed and the variables that may affect success. A mixed-method study was incorporated to include the views and experiences of the FSASA for which this intervention was designed. This study section was aimed to assist in understanding the factors contributing to the survivor's recovery. It allowed for the incorporation of helpful factors in their treatment into the guideline, discarding any unhelpful components. This mixed-methods study identified trauma as well as strengths-based variables and experiences that needed to be considered when designing an intervention for FSASA in

South Africa. A convergent mixed-methods design was used; in this design, qualitative and quantitative data were collected in parallel, analysed separately, and then merged. In this study, psychometric measures that have been validated for use with this population were used to evaluate the extent to which survivors experience PTSD, resilience, PWB and PTG in South Africa. In addition, relationships between these variables were investigated to highlight the variable that should be focused on to develop the most impactful intervention guideline. The open-ended questions in the survey explored factors that were relevant to the journey of recovery for the sample of South African FSASA in Gauteng. The reason for collecting both quantitative and qualitative data was to gain a clearer understanding of the psychological health of FSASA and the factors that assist in and impede their recovery to inform a trauma-informed strengths-based group intervention guideline.

The core assumption of mixed-method studies is that by encompassing the rigorous methods (data collection, data analysis and interpretation) of both quantitative and qualitative approaches (Creswell & Creswell, 2017), additional insight beyond the information provided by either approach alone is obtained in response to the research question (Johnson et al., 2007). Within this design, quantitative data provides only a rough indicator of trends, and a follow-up with qualitative data can explore (in greater detail) why the trends might have occurred (Creswell & Zhang, 2009). The quantitative and qualitative data of the study were collected simultaneously via an online survey from an identical sample (Creswell & Clark, 2017). Quantitative data was analysed first to describe the characteristics of the sample, identify the relationships between variables and highlight the different scoring profiles of each participant. Quantitative data analysis included descriptive statistics (means, standard deviations, reliability coefficients and correlations).

After confirmatory factor analysis (CFA) indicated that the proposed factor structures did not fit, EFA was conducted. Thereafter, the participants were ranked according to their PCL-5 scores and the top 20 scorers were assigned to the SSR group and the bottom 20 scorers were assigned to the FSR group. The constant comparative method was then used to analyse the data. In this analysis, several themes were highlighted, and comparisons were made between the groups. With an understanding of the extent that participants experienced positive psychology variables (resilience, PWB and PTG), how these variables were related and how they were experienced by the participants, a trauma-informed strengths-based group intervention guideline-directed at MHPs working with this population was designed. To illustrate the complexity of this design, a schematic representation that depicts the details and flow of the research activities in this study is provided below (Figure 5), followed by a description of each research component within the proposed mixed-method study.

Figure 5: Convergent mixed method study



8.6.3 Participant recruitment for the convergent mixed-methods study

Participants recruited for this study were selected based on specific inclusion and exclusion criteria, therefore a combination of purposive and snowball sampling was used.

The inclusion of participants in the study was based on the following criteria:

- Females at or above the age of 18 that have experienced sexual assault during adulthood;
- Participants need to have disclosed the trauma, received some form of trauma counselling or debriefing, worked through the acute phase, and feel that they can contribute to the study; and
- Potential participants were excluded if they were involved in a criminal trial to prevent the research from interfering with their testimony as a survivor.

This study used identical samples (Plano Clark et al., 2008), in which the quantitative and qualitative data were collected from the same participants. Throughout the study, the participants remained anonymous as no identifying particulars were requested in the questionnaires. However, they needed to provide the researcher with a contact number and email address so that their reimbursement voucher could be sent to them. Participants were reimbursed for their data usage to the extent of R30 each.

This study incorporated several sampling strategies to maximise participant recruitment. The first sampling strategy involved asking the gatekeepers of the organisations to put posters in their centres and to identify fieldworkers within their organisations that did not have a power relationship with clients (administrative staff) to help recruit participants. These fieldworkers were to direct potential participants that met the inclusion criteria at the psychosocial support centre to the relevant poster and helped them to access the links to the informed consent and questionnaires on a dedicated device at the centre. The reason for incorporating this face-to-face sampling strategy was

based on feedback in the first phase of this study. Numerous NGO gatekeepers noted that financial need frequently impaired their client's ability to access online devices. This strategy was aimed at accessing individuals already at the centre for other services and was not intended to force participants to go to one of these centres simply for the study. The field workers were not required to assist with completing the questionnaires as there was an online chat box monitored by an independent person, where participants could receive responses for any questions they may have had about the process. This first strategy did not yield significant participant numbers (N=3). There were two main factors that influenced the success of this strategy. Firstly, the organisations were not able to spare their administrative staff to assist with recruitment due to high workload and staff shortages. The organisations were also not comfortable with giving an outside recruiter access to their clients due to privacy concerns; confidentiality clauses also inhibited the organisations to share patient details with recruiters. The absence of a study representative may have hampered participant recruitment since community collaboration could not be established and therefore trust with survivors could not be built (Logan et al., 2008).

The second sampling strategy involved posting advertisements for the study on social media (See Media Campaign Plan – Addendum C). These advertisements were paid for by the researcher and indicated the target population. When the user clicked on the advertisement, they were rerouted to the primary research website (<http://emthini.co.za/>) where more information on the study was available. The user could then decide if they wanted to participate. Once the participant clicked on the link to participate in the study, they were directed to an informed consent page. On the online informed consent page, they were given information about the study, how their privacy and confidentiality would be protected and how their data would be protected and stored. There was a chat box on

this page where the participant could ask questions they had about the study and the informed consent form that was answered in real-time by the independent person. At the end of this survey page, there was a list of the inclusion and exclusion criteria that they could click 'yes' or 'no' to. Once the potential participant submitted this informed consent page, they were redirected to the questionnaires. They were requested to complete a demographic questionnaire, the PCL-5, the ARM, the PGTI, and the MHC-SF. These assessments took approximately 40 minutes to complete. As mentioned, participants were reimbursed for their participation with an R30 data voucher. Upon completion of the survey, participants were encouraged to refer anyone they thought could contribute to the study by sharing the initial website link.

Participants had the opportunity to ask questions or indicate the need for counselling throughout and after completing the questionnaires. Communication with the researcher was facilitated by an online chat box on the site. A list of non-profit organisations they could contact for assistance appeared once they completed the questionnaires. The consulting psychologist was contacted in two circumstances. Firstly, if participants requested a session through the secure online chat box where they could leave their contact information. Secondly, if a participant who referred another survivor for inclusion noted that specific participants were high-risk (due to an especially brutal assault or psychological distress). In both circumstances, their contact information was sent to the consulting psychologist, who booked an appointment with them within 72 hours.

8.6.4 Data collection for the convergent mixed-method study

This was a convergent mixed-method study where the quantitative and qualitative data were collected simultaneously through online questionnaires, therefore identical sampling was used (Creswell & Clark, 2017). The quantitative aspect of a survey includes a strand in which measurements record and investigate aspects of reality using numerical data

(Creswell & Clark, 2017). The primary purpose of the quantitative part of this study was to empirically evaluate the extent to which FSASA experience PTSD, PWB, resilience, and PTG and look for correlations between these variables. This enabled the researcher to i) explore the relationships between the variables through EFA and ii) group the participants in two groups based on their profile scores. These groupings enabled the researcher to compare the qualitative data from the 20 highest and 20 lowest PTSD scorers.

Qualitative data sets include rich, detailed, and heavily contextualised descriptions of each source (Levitt et al., 2018). The participants answered open-ended questions in the demographic questionnaire that allowed them to tell their stories to relay their experiences related to recovery. The questions were set out in three different languages; English, Afrikaans and Sesotho, and the participant could answer them in their home language. A professional translator translated the questionnaires initially, as well as the answers when data collection was complete. In cases where a language other than English was used, forward and backward translations were utilised. The constant comparative method was used to identify themes in these participants' answers.

8.6.5 Data collection instruments

To explore the extent to which adult survivors of sexual assault experience PTSD, PWB, resilience, and PTG, several psychometric instruments were used. These include a demographic questionnaire; the PTSD checklist for the DSM-5 (PCL-5) (Blevins et al., 2015; Weathers et al., 2013); the ARM (Resilience Research Centre, 2018); the PTGI, and the MHC-SF (Perugini et al., 2017). Bearing in mind that assessments in research should be culturally sensitive and take cognisance of the cultural variations in symptom expression, whilst a diagnosis must also be ethical, all the psychometric instruments selected for this study have been validated within the South African context (Seedat et

al., 2004). These measures have been selected as they measure variables that are included within the theoretical framework used for this study (Resilience Portfolio model); their psychometric properties are outlined below. The survey is available as part of the questionnaire pack in Addendum 4.

8.6.5.1 Demographic questionnaire

A brief demographic questionnaire was included to gather demographic and background information on the participants. The questions included were based on the necessary biographical information for a meaningful sample description. Personal characteristics included age, ethnicity, gender, relationship status and occupation. Time frames in which the sexual assault occurred were added since time plays a role in acute stress symptomology (American Psychiatric Association, 2013b). In addition to these sections, the questionnaire asked open-ended questions about coping strategies, their experiences with disclosure to police services, social support, and counselling experiences. They were also encouraged to reflect on how they coped after the assault, the advice they would give other survivors, and how their view of themselves was changed by the experience.

8.6.5.2 Posttraumatic Stress Disorder Checklist for DSM-5

The PTSD Checklist for DSM-5 (PCL-5) is a 5-point Likert-type scale (1 = not at all; 5 = extremely), self-report, 20-item measure of PTSD symptoms experienced within the last month in line with the diagnostic criteria in the DSM-5 (Blevins et al., 2015). A diagnosis of PTSD is considered when the total score is above 33. The PCL-5 test scores demonstrated good internal consistency ($\alpha = .96$), test-retest reliability ($r = .84$), and convergent and discriminant validity (Bovin et al., 2016). This measure has been used in numerous studies conducted in South Africa (Booyesen, 2021; Kagee et al., 2022; Knettel et al., 2020; Makhubela, 2018) and, thus, is appropriate for this context.

8.6.5.3 Resilience Research Adult Resilience Measure

The ARM is a 5-point Likert-type scale (1 = not at all; 5 = a lot), self-report, 28-item measure of resilience-promoting resources and is based on a socioecological framework of resilience (Resilience Research Centre [RRC], 2018; Ungar & Liebenberg, 2011). This measure is comprised of Section A (demographic questions), Section B (optional community-site-specific questions) and Section C (the socioecological measure of resilience) (Ungar & Liebenberg, 2013). For this study, Section A will be replaced by the detailed demographic questionnaire noted above. Section B will be omitted since these aspects have already been discussed with stakeholders in Phase One of the study.

The RRC-ARM consists of eight clusters which represent three subscales of resilience resources, namely individual capabilities (personal skills, peer support, and social skills clusters); relationships with important individuals (physical and psychological caregiving clusters), and contextual factors that promote a sense of belonging (spiritual, educational, and cultural clusters). Higher scores indicate more resilience-enabling resources and, thus, greater potential for resilience. In a South African study conducted by Bemath et al. (2020), the internal consistency reliability of the total RRC-ARM was $\alpha = 0,88$, and for the subscales: individual resources = 0.79, relational resources = 0.83, contextual resources = 0,62. This measure was selected for this study due to its psychosocial focus on measuring resilience.

8.6.5.4 Posttraumatic growth inventory

The PTGI is a 21-item measure of positive life changes after trauma. The items are rated on a 5-point Likert scale ranging from 0 (I did not experience this change) to 5 (I experienced this change to a great degree). The PTGI yields a total score as well as five subscale scores. The subscale scores include new possibilities (five items), relating to others (seven items), personal strength (four items), spiritual change (two items) and

appreciation of life (three items). The PTGI has shown good reliability in previous South African studies of trauma survivors, with a total Cronbach's alpha ranging from 0.95 (Walker-Williams, 2012) to 0.76 (Mason, 2019).

8.6.5.5 Mental Health Continuum – Short Form

The MHC-SF consists of 14 items rated on a 5-point Likert scale ranging from 0 (never) to 5 (every day). The items encompass three sub-scales, specifically emotional well-being, personal PWB, and social well-being. Individuals who are displaying positive mental health on the scale are described as 'flourishing', individuals who are experiencing poor mental health are described as 'languishing' and individuals in the middle of the spectrum have moderate mental health. The MHCF-SF has shown excellent internal consistency (Cronbach's alpha 0.80) and discriminative validity, and the test-retest reliability estimates range from 0.57-0.82 for the full scale (Keyes, 2007). In studies utilising this scale conducted in South Africa, Cronbach's alpha scores for the total scale range from 0.74 (Keyes et al., 2008) to 0.95 (Walker-Williams, 2012).

8.6.6 Data analysis convergent mixed-method study

Although the initial sample size was N=70, a large portion of the surveys needed to be excluded from analysis since the assault reported by the participant occurred before the age of 18 and therefore, they did not meet the inclusion criteria for the study (n=20). When the researcher realised that the participants who did not meet the inclusion criteria were completing the surveys, the social media campaign messaging was adjusted to be more specific. The data that was collected via the online questionnaires were downloaded from Google Forms in a .xlsx file. Thereafter, the participant's cell phone numbers were replaced with participant numbers and data analysis commenced for the quantitative and qualitative data.

8.6.6.1 Quantitative data analysis

The quantitative data was analysed using the Statistical Package for the Social Sciences (SPSS 27) (IBM Corporation, 2021) and Mplus 8.6 (Muthén & Muthén, 1998-2022). The statistician and researcher completed this analysis. Descriptive statistics, including frequencies, means and standard deviations, are reported to describe the basic features of the sample and provide simple summaries of the measures (Choi et al., 2020). The data collected were evaluated for skewness and kurtosis before being analysed in more detail. Cronbach's alpha was calculated where applicable to address reliability for the quantitative component of this study. An alpha value is considered acceptable when it is above .70 (Cohen, 1988). The descriptive statistics, levels of skewness and kurtosis, and reliability coefficients were computed in SPSS 27 (IBM Corporation, 2021). Mplus 8.6 (Muthén & Muthén, 1998-2022) was used to evaluate the presence and strength of relationships between the concerned variables (PWB, resilience, PTG) by specifying a measurement model. The practical and statistical significance of the correlations is reported in Manuscript 2. The best-fitting measurement model was used as a basis for the structural model, where the proposed directions of the relationships were confirmed (regression of PTG on PWB and resilience), after which a model with indirect effects was tested (indirect effect of mental health on PTG through resilience). The statistics used to evaluate model fit include chi-square (χ^2 ; lower values indicate better fit) and degrees of freedom (df); Comparative Fit Index (CFI; acceptable > .90, excellent > .95); Tucker-Lewis Index (TLI; acceptable > .90, excellent > .95); Root Mean Square Error of Approximation (RMSEA; acceptable < .08); and Standardised Root Mean Square Residual (SRMR; acceptable < .08).

8.6.6.2 Qualitative data analysis

The researcher followed the stages outlined in Maykut and Morehouse's (2002) constant comparative method. These include i) inductive coding; ii) refinement of categories; iii) exploration of relationships and patterns across categories, and iv) integration of data, thus yielding an understanding of people and the setting being studied.

Stage One's Step One involves reading the data and identifying initial recurring themes and concepts, resulting in a tentative list of themes. The next step is to combine themes and ideas that could overlap and assign some provisional codes. In Stage Two, categories are refined by looking at the provisional list of codes and planning specific rules which will serve as the criteria to include or exclude themes from a code. This refinement is completed by grouping all the similar themes under one provisional category, rereading the data, and comparing and revising the provisional rules. The last step in this stage is to recheck whether the meaningful units of data fit in their assigned category. The division of the relevant quotes from the open-ended survey questions for this study can be seen in Addendum 10. In Stage Three of this analysis, the categories with common elements are grouped to make broader groups (Maykut & Morehouse, 2002). Memon et al. (2017) suggest that the ratio of occurrence of each unit of meaning in a code can also be quantified in this stage. Accordingly, this practice helps enable researchers to see the strength of the code by outlining the exact number of responses. Data integration takes place during the last stage (Maykut & Morehouse, 2002). Here, the relevant categories were clustered around the research question that it answered, thereby creating a complete understanding of the patterns of meaning. Intercoder reliability and consistent coding were ensured as the researcher and an independent coder followed each step parallel to one another and then discrepancies were addressed after each stage.

8.6.7 Phase Three: Designing the guideline

The next section outlines phase three of the larger study, in this phase functional elements of successful models were identified.

8.6.7.1 Step 1: Identifying functional elements of successful models

After the components of the interventions were identified (rapid review), as well as the factors that affect participants' experiences (convergent mixed-method study), functional elements for the intervention were outlined. The utilisation of knowledge, skills, and training for their acquisition, environmental change tactics, policy change or enforcement techniques, and reinforcement procedures are among the procedural aspects that make up the final output (Roestenburg & Strydom, 2022). This outline was guided by answering the question: *Which evidence-based components should be added to the intervention?*

The findings of Phase Two indicated the inherent procedural elements in current interventions and showed how the implementation of these elements could be improved in the intervention guideline designed for this thesis. The researcher and study leaders decided to make the intervention guideline group-focused as the benefits of a group intervention are particularly suitable for the needs of the resource-limited settings in which it will be implemented (Heard & Walsh, 2021). The findings from the convergent mixed-methods study allowed for the inclusion of contextually relevant factors that need to be considered by practitioners in their work with these survivors. Groups offer a unique opportunity to build interpersonal relationships and combat stigma, two intrapersonal facets that survivors often struggle with during recovery (Schwartz et al., 2019; Yalom & Leszcz, 2020). The rapid review was used to identify specific screening processes along with outcome measures that could inform effectiveness. The recommended group size is 6-10 participants and the groups should be closed to facilitate development of trust and logical progression of psychoeducational material throughout the process (Heard &

Walsh, 2021).

9. ETHICAL ASPECTS

To deliver trustworthy results that are credible, dependable, confirmable, and transferable, several ethical aspects needed to be considered for each phase of the study. Consensus discussions with the study leaders of this study were conducted to increase the trustworthiness of the findings of each phase of this research. In addition, independent coders were used when thematic analysis was conducted, and an audit trail was kept. For transferability considerations, a detailed description of the research topic and methodology was provided and the characteristics of the participants were outlined (Korstjens & Moser, 2018). Ethical considerations that were specific to the two different phases are outlined below.

9.1 Ethical Considerations for the Rapid Review

Before the commencement of the study, this proposal was sent for review by readers within the Optentia Scientific Committee of the North-West University (NWU) and ethical approval was obtained from NWU's Health Research Ethics Committee (NWU-00206-21-A1) (Addendum 1). Ethical practice in analysing the studies involved in the rapid review was focused on minimising threats to the internal and external validity and reliability of review findings (Carrig & Hoyle, 2011). To facilitate this, the researchers used a clear protocol wherein the search strategy, quality appraisal and analysis where all key constructs that were defined conceptually and operationally in behavioural terms, and the method of dissemination was outlined (Petticrew & Roberts, 2008). Ethical practice in the analysis of the qualitative studies involved in the rapid review was focused on constructing a holistic understanding of the phenomenon so that it authentically represented the subjective experiences of diverse groups in varied contexts (Suri, 2020). Constructing a holistic understanding was achieved by maintaining genuine engagement with diverse

viewpoints that could lead to understanding how individual accounts of a phenomenon reinforce, refute or augment each other (Jaye, 2002). To this end, the PICO framework was used to define the search terms in the study (Methley et al., 2014). Studies that did not receive ethical clearance or did not delineate how ethical practices were abided by during the study were not included. The PRISMA guidelines for reporting were employed to offer a transparent report on how articles were selected (Liberati et al., 2009).

9.2 Ethical Considerations for the Convergent Mixed-Methods Study

Selecting appropriate participants for the study was crucial to mitigate risks; thus, exclusion and inclusion criteria were highlighted in the advertisement. The informed consent that participants needed to agree to before completing the surveys highlighted voluntary participation. This informed consent procedure was highlighted above. It is also important to note that the focus of the psychometric measurements was not on the traumatic event itself but instead on the recovery process – therefore, the risk of the participant reliving their trauma while participating in the study was minimised. All the psychometric measures used in this study are reliable and valid in the South African context. All electronic data and information obtained in the study will be saved on the researcher's Google Drive and an encrypted external hard drive as a backup. The online questionnaire results were collected using Google Forms, and the results can only be accessed by the researcher using a secure password. The surveys and consent forms will be kept on two encrypted external drives in one of the supervisors' offices for the next five years.

Due to the content this study focused on, some distress or discomfort may have occurred during survey completion. The risk of discomfort in the initial stage, where the participant was approached to take part in the study by the recruiter, was mitigated by training the mediators appropriately for the task at hand, and the researcher was available

for online consultation should any problems arise. The questionnaires were completed in a private and safe space at the organisation where the participants receive treatment (if they completed them face-to-face). The motivation was that they were familiar with the space and that their counsellor could be nearby if they required debriefing after the session. This highlights another risk mitigation strategy inherent in this study. Sampling from the organisations that work with FSASA and utilise organisation staff as mediators, and sampling from support groups ensured that the sampling process was structured in such a way that the participants that were identified for the study already have therapeutic support in place before, and during and upon completion of their participation. For the participants who completed the questionnaires online, only a cell phone number and email address were collected for them to receive their vouchers.

The sampling strategies had some implications for the privacy of participants. The first implication was found in the snowball sampling that the recruiters utilised. While snowball sampling has been used in many studies, it is worth noting that due to the nature of the method, the anonymity of the participants cannot be guaranteed. While the researcher and their affiliates took all possible measures to ensure that the anonymity of the participants was kept, no guarantee could be given that participants would not communicate with one another about the study. Secondly, the use of social media for advertising a study also has implications for anonymity. As noted above, social media pages were created to advertise the study. It is important to note that not everyone who liked the page would be a participant in the study and that other Facebook users could see each other on the page. The page consisted of advertisements for the study and a link to the primary research website where the informed consent and the data collection occurred. Participants could also send a direct message to the page's Admin to find out more about the study or ask to participate. This advertised link could then be accessed

by users that decided to participate in the study and they were redirected to the primary website for the study where their identifying particulars were not available. Therefore, there was no distinction on the page between users that liked the page and participants. As an additional safeguard, to prevent users from identifying themselves as participants (for example, by asking how they could complete the questionnaires as a post), posts and comments were moderated by the page's admin. It is essential to note that data collection did not occur on social media platforms. The data collection remained grounded in the primary research website. As noted above, the participants completed the informed consent and the questionnaires online. During completion on this website, they could remain anonymous.

10. CONTRIBUTIONS OF THE STUDY

The contribution of this study is twofold. Firstly, it will be incorporated with existing literature to contribute to the existing body of knowledge on what should be included in a trauma-informed strengths-based group intervention guideline for FSASA and how much recovery manifests and is reported by South African FSASA. Secondly, the study will inform guidelines for MHPs to assist them in conducting trauma-informed strengths-based group interventions. The findings of this study will also highlight further research gaps that require exploration in this regard.

11. THE LAYOUT OF THE STUDY

The report is presented in article format. Four articles will come from this study, each focusing on an objective of the study, tentative titles are listed below. The articles will be submitted to the *South African Journal of Psychology* and the *Journal of Traumatic Stress* and will be written to meet the relevant requirements thereof. The layout of the study is presented in the table below.

Table 4: The layout of the study

Section A	Overview of the Study			
Section B	Study 1: Rapid Review	Study 2: Convergent mixed-method study		Phase Three: Design of intervention guideline
	<i>Manuscript 1</i>	<i>Manuscript 2</i>	<i>Manuscript 3</i>	<i>Manuscript 4</i>
	Interventions that promote recovery among FSASA: A rapid review.	The relationship between posttraumatic stress, PWB, resilience, and PTG in a South African sample of FSASA.	Using the narratives and statistics of sexual assault recovery to empower others: A comparative qualitative article	Designing a trauma-informed strengths-based group intervention guideline for FSASA.
Journal publication	<i>Violence against women</i>	<i>Journal of traumatic stress</i>	<i>Violence against women</i>	N/A
Section C	Conclusions, limitations, recommendations, and combined reference list			
Addenda	<ul style="list-style-type: none"> • Ethics approval letter • Consent forms • Independent psychologist debriefing agreement • Independent coder confidentiality agreement • Questionnaires • Recruitment posters • Social media campaign screenshots • Rapid review table • Quantitative group division • Qualitative data outline • Constant comparative method findings outline 			

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SECTION B - STUDY 1
(Rapid Review)

MANUSCRIPT 1: INTERVENTIONS THAT PROMOTE RECOVERY AMONG FEMALE ADULT SEXUAL ASSAULT SURVIVORS: A RAPID REVIEW.

PREFACE

The manuscript forms part of a larger study, which comprises four phases:

- Phase One – Rapid review (Manuscript 1);
- Phase Two – Convergent mixed-method study quantitative (Manuscript 2);
– Convergent mixed-method study qualitative (Manuscript 3); and
- Phase Three – Intervention guideline design (Manuscript 4).

The manuscript that follows, reports on Phase One and seeks to meet Research Objective 1, namely “To explore and describe interventions that promote recovery in FSASA reported in scientific literature”. A secondary research question drove this part of the study, namely *What interventions reported in scientific literature promote recovery in FSASA?*

The manuscript is intended for publication, possibly in *Violence against Women*. The specifications as set out by the journals were considered, however for uniformity in the research report, the manuscript/article was written in the following format: Arial 12, justified, 2.0 spacing and with APA referencing.

INTERVENTIONS THAT PROMOTE RECOVERY AMONG FEMALE ADULT SEXUAL ASSAULT SURVIVORS: A RAPID REVIEW

ABSTRACT

This rapid review synthesised the literature on evidence-based therapeutic interventions for adult sexual assault. Several academic databases were searched (Ebscohost, Web of Science, Scopus, SA Journals, Cochrane CENTRAL and MEDLINE) for peer-reviewed articles in English published between 2012 and 2023. The quality of evidence was analysed using the JBI appraisal tools. A total of 18 papers were included. Findings suggest that most studies were conducted in specialised clinic settings in the United States of America (USA). Intervention types included CBT, CPT, image rehearsal therapy (IRT), brief exposure therapy, neurological integration-based interventions (EMDR, Modified Lifespan Integration [MLI]) and mindfulness-based interventions (yoga and physical exercise). Standard components across interventions included psychoeducation, exposure techniques, and skills training. These findings build upon findings of other reviews by including strengths-based interventions.

INTRODUCTION

The high prevalence rate of sexual violence against women is a particularly concerning public health burden (Jewkes & Abrahams, 2002; Shen et al., 2022). Globally, up to one in three women have experienced physical or sexual violence at least once (WHO, 2021b). Numerous studies have shown that sexual assault may lead to an increase in overall health problems (Golding et al., 1998; Jina & Thomas, 2013); sexual difficulties (Deliramich & Gray, 2008; Littleton et al., 2013); psychiatric disorders (Dworkin et al., 2017), and intra- and interpersonal difficulties (Olatunji et al., 2010; Salim et al., 2021). Given the significant impact that these forms of assault can have on the health of survivors (Campbell et al., 2009; Dworkin et al., 2017; Haskell & Randall, 2019; Petrak, 2002;

Vanzile-Tamsen et al., 2005), it is crucial to have a comprehensive understanding of the interventions that are available for this population.

A considerable amount of research focuses on identifying effective psychological therapies for this population (Lomax & Meyrick, 2022). However, systematic reviews synthesising the literature on sexual assault focus predominantly on preventative or early interventions (Dworkin & Schumacher, 2018; Lomax & Meyrick, 2022). Early interventions typically occur within 24-72 hours of the assault and focus on alleviating immediate distress and preventing long-term problems (Campbell & Wasco, 2005). These interventions are typically administered within the emergency services contexts after the forensic examination of the survivor has been completed, do not typically include long-term treatments, and are administered before a diagnosis of PTSD can be allocated to the survivor.

Dworkin and Schumacher (2018) explored the role of early intervention (within one month of the assault) experiences in developing PTSD after sexual assault. Their review found that responder contact alone is not typically associated with significant differences in posttraumatic stress. Still, the service quality and perceptions of interactions with certain responders appear to impact symptomology. Short et al. (2020) offered an update and expansion on this review to include interventions that were implemented within 90 days of the assault. They discovered no statistically significant moderating impact of any of the following: pharmacological versus psychological intervention, the timing of intervention delivery, the modality of treatment delivery, and universal versus targeted approach in the treatment of sexual assault survivors. Lomax and Meyrick (2022) looked at the effect of psychosocial interventions on well-being outcomes for adolescent or adult victims/survivors of sexual assault in studies conducted before April 2019. Their review found inconclusive evidence for the effectiveness of psychosocial interventions with

people who have experienced a recent sexual assault (three months ago). Although these studies offer valuable insights into the interventions relevant to sexual assault survivors, they have not highlighted interventions offered to survivors after the acute phases of the trauma.

Intervention studies investigating long-term interventions predominantly outline the efficacy of exposure-based approaches such as CPT, PET and EMDR (Parcesepe et al., 2015). These studies have indicated that exposure-based approaches significantly reduce symptoms of PTSD and depression by assisting survivors in processing dissociation and feelings of guilt and anxiety. Parcesepe et al. (2015) reviewed the effectiveness of mental health interventions for FSASA, synthesising findings of articles published between 1985 and 2012. They outlined the available interventions and compared their reported efficacy. Their systematic review found that the seven treatments (assertion training, clinician-assisted emotional disclosure, CPT, EMDR, PET, SIT, and supportive psychotherapy) were similarly effective but differed in the delivery style, length and mental health outcomes assessed. Numerous developments have been indicated in the literature since 2012, denoting a need for an update on this review. Furthermore, little is documented about a collaborative approach, integrating a traditional approach with strengths-based interventions.

AIM OF THE REVIEW

This rapid review aims to identify, organise, and synthesise scientific literature published between 2012 and 2023 reporting on evidence-based therapeutic interventions for FSASA. The review findings will inform the design and development of an intervention guideline for FSASA. The research question driving this study is *What interventions reported in scientific literature promote recovery in FSASA?*

METHODOLOGY

Scientific and ethical approval was obtained from the Optentia Research Unit and the NWU's Health Research Ethics Committee (NWU-00206-21-A1) before the commencement of the study. Rapid reviews aim to answer a focused question by systematically searching for and identifying relevant studies, assessing their risk of bias, and summarising and interpreting all the studies (Higgins et al., 2019). Rapid reviews follow similar rigorous processes as systematic reviews at an accelerated rate by delimiting the search period and researchers involved in the process (Garritty et al., 2021). This rapid review aims to inform decision-making on a policy and practice level promptly. For trustworthiness and reliability, the evidence-informed guidance offered by the Cochrane Rapid Reviews Methods group was followed throughout this study (Garritty et al., 2021) and the PRIMSA reporting guideline was used for reporting results (Liberati et al., 2009).

Setting the Review Questions

An updated overview of the current evidence-based interventions available to adult sexual assault survivors will enable the researcher to develop a comprehensive intervention guideline for practitioners. An outline of the current literature will enable practitioners to be more intentional in their decision-making when working with this population. The research question that guided this study was *What interventions reported in scientific literature promote recovery in FSASA?*

Setting Eligibility Criteria

The PICO question framework was used to determine the search words for this review since it offers comprehensive results (Methley et al., 2014). The following search words were utilised for the search: (P) "rape" OR "sexual assault" OR "sexual violence" (I) "interventions OR "strategies" OR "best practices" OR "treatment" OR "therapy" OR

“program”. Comparison and outcome were not specified to ensure that as many interventions as possible were included. Publications between 2012 and 2022 were included to review the most recent literature and build upon previous syntheses that were concluded in 2012. Only English peer-reviewed articles that outlined their ethical considerations were included. Since this review focuses on interventions that assist survivors in recovering from sexual assault, interventions focused on prevention or bystander-focused interventions were excluded. The emphasis on the evidence-based nature of the interventions highlighted in this study excluded articles where the interventions were introduced but not evaluated.

Searching

Databases that were searched included Ebscohost (Academic Search Premier, African-Wide Information, E-journals, ERIC, PsychINFO and SocIndex), Web of Science, Scopus and SA Journals, Cochrane CENTRAL and MEDLINE. To compensate for any deficiency in the retrieval terms, the reference lists of the included articles and relevant systematic reviews were scanned for additional relevant articles for inclusion (Grayson & Gomersall, 2003; Papaioannou et al., 2010).

Study Selection and Risk of Bias

Firstly, titles and abstracts were screened by the researcher for inclusion. Articles were excluded if they focused on perpetrators, bystanders, or clinicians in training since we were investigating interventions that were directly implemented on survivors. Studies whose sample included women who experienced childhood sexual abuse or domestic violence were included if the focus of the intervention was on the sexual assault they experienced as adults. Studies that included participants under the age of 18 were excluded. The included articles were then exported to Endnote, and the duplicates were removed. Thereafter, the researcher discussed the screening criteria for the articles with

their supervisors. Another round of screening was conducted, during which articles that focused on military populations and preventative interventions were excluded. This decision was made to delineate the focus of the review. Afterwards, eligible articles were exported to Rayann and screened by the researcher and one of the supervisors. During this round of screening, it became evident that several articles highlighted interventions that were not evaluated (n=123) and were marked for exclusion. The second supervisor screened the articles on which the researcher and first supervisor disagreed regarding inclusion, thus offering a consensus vote. Fourthly, the included articles were exported from Rayann back to Endnote, and full texts were obtained and imported.

The included articles were categorised in folders labelled by the type of study (quasi-experimental, randomised control trial [RCT], mixed-method), uploaded to Google Drive, and shared with the supervisors. The included articles were then quality appraised using an Excel sheet outlining the criteria for each JBI quality appraisal tool (JBI, n.d) and charting the relevant studies accordingly. An additional Excel sheet was uploaded for the supervisors to conduct their quality appraisals of the articles, and the results were collated. The studies charted in the data-charting form are thus the studies that were included after the quality appraisal. The PRISMA guidelines provided an outline of the article exclusion process, as shown in Figure 6.

Data Extraction and Synthesis

The 18 eligible articles were prepared for data extraction manually by highlighting the relevant aspects of each in different colours. The researcher prepared an Excel sheet outlining the relevant components of each study. Several items were included in the Excel sheet, including author, year of publication, title, journal, country, methodology, the outcomes measured, the measurement tools used, and the interventions' components. A single supervisor checked the extracted data's correctness and completeness, and the

researcher incorporated relevant changes. After the extracted data was finalised in the Excel sheet, qualitative content analysis was employed. Thematic analysis is a method for identifying, analysing, and reporting patterns within data by organising, describing, and interpreting different aspects of the findings (Braun & Clarke, 2006). Following Braun and Clarke (2006), a number of steps were followed. In Phase One, the researcher familiarised themselves with the data by reading all the articles that were included, thereby obtaining an initial understanding of the articles and possible themes. In Phase Two, the researcher highlighted several common elements within the study and gave them code names. These codes included common elements throughout the articles, such as 'type of intervention' and 'outcomes' and were tabled in an Excel sheet as noted above. After that, in Phase Three, the researcher searched for the relevant codes within the data set and created more defined themes to analyse the data on a broader level. In Phase Four, the researcher reviewed the themes by tabling them in an Excel sheet and sharing the table with the supervisors who conducted independent coding. Thereafter, a consensus discussion clarified the descriptions of each theme. During this phase, it became apparent that the interventions often measured secondary outcomes, and an additional column entitled 'other outcomes' was added for outcomes that were unique to specific studies. An additional column was also added to highlight the measurement instruments used to clarify that different measurement instruments often measure similar constructs. In Phase Five, we defined and named the themes for the write-up to clarify how we would set out our analysis in Phase Six.

FINDINGS

A total of 919 articles were screened, 325 full-text documents were reviewed, and 18 articles were included for analysis after quality appraisal. The included articles were published between 2012 and 2023, with most articles (n=8) published after 2017. The

table in Addendum 7 presents the 18 articles that met the study inclusion criteria. Figure 6 provides a summary of the review findings.

Figure 6: Summary of rapid review findings

Countries of origin	Settings of interventions	Screening participants	Intervention types	Common components
<ul style="list-style-type: none"> •United States of America (n=6) •Democratic Republic of the Congo (n=4) •Australia (n=2) •France (n=1) •Denmark (n=1) •Sweden (n=1) •South Korea (n=1) •Iran (n=1) •Canada (n=1) 	<ul style="list-style-type: none"> •Specialised clinics (n=6) •Rural villages (n=3) •Minimum security prison (n=3) •Online (n=3) •Research unit at a university (n=2) 	<ul style="list-style-type: none"> •Trauma history •PTSD •Axis I disorders •Subjective distress •Rape related fears •Disruptive nocturnal behaviours •Depression related constructs (shame, guilt, self-worth, suicidality) •Impact of sexual violence on functioning 	<ul style="list-style-type: none"> •Cognitive behaviour therapy •Cognitive processing therapy •IRT •Brief exposure group intervention •Neurological integration-based interventions •Mindfulness-based interventions 	<ul style="list-style-type: none"> •Psycho-education •Exposure techniques •Skills training (relaxation)

A total of eight of the 18 articles included were quasi-experimental, five studies were RCTs, two were pilot studies, one was a follow-up study, and two were mixed-method studies. The sample sizes ranged from 14 to 405 and incorporated female participants aged from 18 years upwards. The studies were conducted in eight countries, namely six in the USA, four in the Democratic Republic of Congo (DRC), two in Australia, one in France and one in Sweden, South Korea, Iran and Canada, respectively. Furthermore, six studies were conducted in a specialised clinic or community centre, three in rural villages, three in a minimum-security prison, three online and two in a research unit at a university. All the interventions administered included pre-and post-treatment outcomes. Follow-up assessments ranged from directly after the interventions to 10 years later.

Regarding the format of the interventions, seventeen took place face-to-face, seven were delivered individually, seven were in a group format, and three interventions were a mixture of individual and group sessions. Only one intervention was individual and online. The duration of treatment varied from a single session to the most extended, 20 sessions.

Outcomes Measured

Several outcomes were assessed during the implementation of these interventions, in addition to PTSD symptomology. These included trauma history, PTSD, Axis I disorders and functional impairment. Some studies measured trauma history (n=5). All the primary studies measured PTSD (n=15), and some studies (n= 2) utilised more than one scale to measure PTSD. Studies that utilised EMDR (Allon, 2015; Tarquinio, Brennstuhl, et al., 2012; Tarquinio, Schmitt, et al., 2012) utilised the Impact of Events Scale (IES) and subjective distress units to measure participants' trauma-related symptoms. Rape-related fears were measured in one study (Littleton et al., 2012) and disruptive nocturnal behaviours associated with PTSD symptoms in another (Belleville et al., 2018). Axis I disorders such as depression and anxiety were measured in most (n=10) studies. Only four studies measured specific facets of depression, such as shame and guilt (n=1), suicidal ideation (n=1), self-worth (n=1) and rumination related to depression (n=1). Global functional impairment was measured based on general distress (n=1), the impact of sexual violence (n=1) and quality of life (n=1).

The Initial Screening and Participant Characteristics

Most interventions included an initial screening of participants before inclusion (Bass et al., 2013; Belleville et al., 2018; Goodarzi et al., 2020; Littleton et al., 2012; Littleton et al., 2016; Louison Vang et al., 2020; Nixon, 2012; Nixon et al., 2016; Rajan et al., 2020; Shors et al., 2018; Tarquinio, Brennstuhl, et al., 2012; Tarquinio, Schmitt, et al., 2012). Exclusion criteria were predominantly based on severe psychopathology, including

psychosis, bipolar mood disorder, active suicidality, personality disorders and substance-related disorders. Only five assessed and reported on the trauma history of the participants included in the interventions (Allon, 2015; Bass et al., 2013; Littleton et al., 2012; Littleton et al., 2016; Resick et al., 2012); specifically, the studies conducted in the DRC evidenced war-related trauma in addition to the assault that appeared to have had a significant impact on PTSD scores before and after the interventions (Allon, 2015; Bass et al., 2013).

Intervention Types

The 18 included studies reported on the evaluation of seven different types of interventions, namely CBT (n=2), CPT (n=3), IRT (n=1), exposure therapies (n=4), neurological-based integration therapies (EMDR and LI) (n=4), and yoga and mindfulness meditation (n=3). All the interventions included a psychoeducation component, with some including exposure techniques in various forms (n = 7) and others incorporating relaxation techniques (n = 8). These evidence-based interventions will be discussed next.

Cognitive behavioural therapy

Two studies evaluated the S2T program, an online therapist-facilitated program for rape-related PTSD, with two groups of college women (Littleton et al., 2012; Littleton et al., 2016). This program utilises cognitive behavioural strategies to address issues commonly faced by survivors of rape and is built on a combination of psychoeducation and clinician-facilitated Socratic dialogue. The psychoeducational elements of this program are focused on the impact of the trauma, relaxation and grounding techniques, coping strategies, and CBT principles (automatic thoughts, negative cognitions, posttraumatic beliefs) (Littleton et al., 2012; Littleton et al., 2016). The first study did not have a comparison group (Littleton et al., 2012); however, the second study (Littleton et al., 2016) compared groups where the participants took part in an interactive program or

a self-help website with the same content, incurring similar findings across groups. Both studies found a significant decrease in PTSD symptomology related to cognitions and moderate to large-size reductions for general depressive and anxiety symptoms. Littleton et al. (2016) found that these reductions were maintained upon a 3-month follow-up.

Image rehearsal therapy

IRT is a cognitive behavioural treatment that targets nightmares associated with PTSD by letting patients rehearse a modified dream script during the daytime to alter the conditioned association between nightmares and sleep (Aurora et al., 2010). IRT is particularly effective for chronic nightmares, improves sleep quality, and decreases PTSD symptom severity (Krakow et al., 2001). Belleville et al. (2018) compared a CBT intervention with an adjunct component of IRT to a CBT intervention alone. The findings of this article indicated that both treatment groups showed a significant improvement in PTSD symptoms; however, combining IRT and CBT did not yield superior results to CBT on its own. The authors noted several limitations in this study, including a sample of predominantly students, the inability to differentiate between idiopathic and posttraumatic nightmares and poor reliability of the PSQI (Pittsburgh Sleep Quality Index) with measures of disruptive nocturnal behaviours associated with PTSD symptoms.

Cognitive processing therapy

Three articles included studies utilising CPT (Bass et al., 2013; Galovski et al., 2012; Gutner et al., 2013; Nixon, 2012; Resick et al., 2012). CPT is based on an information-processing theory of PTSD and includes education, exposure and cognitive components (Resick & Schnicke, 1992). The first article reported different aspects of a study conducted in conflict-affected low-income rural villages in the DRC, where the cognitive-only model of CPT was used (Bass et al., 2013). Bass et al. (2013) reported on the impact of the intervention on PTSD, depression, and anxiety symptoms. This study found that

improvements in anxiety, depression, PTSD, and functional impairment were more significant in the therapy group than in the individual-support group and were maintained six months after treatment ended (Bass et al., 2013). The authors noted that baseline differences in symptom severity between symptom groups, differences in group and individual administration, and supervision of facilitators limit comparability between groups.

The second article reported on randomised controlled trials where CPT was administered and individually compared to supportive counselling (Nixon, 2012; Nixon et al., 2016). The study included one male and 45 females who self-referred and were diagnosed with acute stress disorder. They completed five to seven weekly sessions of 90 minutes each, individually. Results indicated that more CPT participants reached good end-state functioning at the 12-month follow-up than in the supportive counselling group. Limitations of this study included modest sample size and large confidence intervals, no control group, limited retention of follow-ups and unclear influence of comorbidity on treatment success.

The third article described a long-term follow-up of a previous study (Resick et al., 2002) where CPT was compared to prolonged exposure and a minimal attention condition (Resick et al., 2012). The CPT intervention consisted of cognitive therapy and exposure in the form of writing and reading about the traumatic event and consisted of 12 sessions (Resick & Schnicke, 1993). The PET intervention included education-rationale, breathing retraining, behavioural exposures and imaginal exposures; it consisted of nine sessions with additional homework sessions (Foa et al., 1994). Resick et al. (2012) found no statistical differences between the treatment groups, both evidencing significant decreases in symptoms of PTSD and depression reported in the original study that was maintained five to 10 years after the initial study.

Brief exposure group intervention

Exposure-based therapy modalities have an exposure component aimed at integrating the memory of the assault and are based on the emotional processing theory. Accordingly, individuals must emotionally activate fear memories in situations where fear-incompatible information is also available to change the pathological fear networks associated with PTSD and other anxiety disorders (Foa & Kozak, 1986).

The first study explored the efficacy of a group-based intervention previously delimited to adolescent survivors of sexual assault on adults (Louison Vang et al., 2020). Although this study sample included adolescents (aged 13-18) and adults (aged 19-37), a clear distinction is evident in the findings between the different age groups; therefore, this article was included. The STEPS program is a step-by-step approach to identifying problems after sexual assault and pursuing new goals (Bicanic et al., 2014). This program consists of five components, namely psychoeducation, sensu exposure to sexual assault, cognitive restructuring of the experience, in vivo exposure by confronting reminders of the trauma and relapse prevention (Louison Vang et al., 2020). This intervention showed a statistically significant decrease in PTSD sustained after 12 months when administered to a group of FSASA in a Danish rape centre. This study did not include a control group, and participants received individual supportive sessions in addition to the STEPS program; these factors could have contributed to the decrease in participants' symptoms.

There were three quasi-experimental studies that investigated a brief exposure group-based intervention in the context of minimum-security prisons in the USA (Karlsson et al., 2014; Karlsson et al., 2020; Karlsson et al., 2021). The therapy was conducted over eight 90-minute sessions. These sessions included psychoeducation, imaginal exposure, challenging trauma-related cognitions, and relapse prevention. The first study (Karlsson et al., 2014) was a pilot study conducted with 14 female prisoners, participant trauma

history was not formally assessed, and follow-up assessments were not completed. The second study (Karlsson et al., 2020) reported on six separate groups that were conducted with 32 women. The third study (Karlsson et al., 2021) examined data from 57 incarcerated women who completed SHARE and provided follow-up data while still incarcerated. In all three studies, participants showed significant decreases in depression and generalised anxiety disorder symptoms post-treatment (Karlsson et al., 2014; Karlsson et al., 2020; Karlsson et al., 2021). This reduction was maintained during the three-month follow-up period (Karlsson et al., 2021). For all three studies, the authors reported that the sample was homogenous, no control groups were used and that findings could not necessarily be generalised to other facilities owing to differences in facility characteristics.

Neurological integration-based interventions

There are two interventions that require specialised training in protocol administration: EMDR and MLI. The first, EMDR, is a therapeutic approach based on the adaptive information processing (AIP) model (Solomon & Shapiro, 2008). EMDR uses standardised protocols to access information that has been stored in a dysfunctional manner to stimulate the innate processing system and facilitate dynamic linkages to adaptive memory networks, thereby allowing the characteristics of the memory to change as it transmutes to an adaptive resolution (Shapiro & Maxfield, 2002; Solomon & Shapiro, 2008). There were three studies using EMDR with sexual assault survivors that were included in this study (Allon, 2015; Tarquinio, Brennstuhl, et al., 2012; Tarquinio, Schmitt, et al., 2012).

The first article (Tarquinio, Schmitt, et al., 2012) evaluated the use of the standard EMDR protocol on a group of six women who experienced sexual assault perpetrated by an intimate partner. Their findings indicated a significant and gradual decrease in PTSD,

depression, anxiety, and perceived disturbance as treatment progressed. This study was limited in its generalisability due to its small sample size and exclusion of participants who experienced other traumas that could lead to elevations in Axis I disorders.

The second article combined several EMDR protocols and psychological debriefing into a single session administered in an emergency room on women who were assaulted within 24 to 76 hours before the presentation (Tarquinio, Brennstuhl, et al., 2012). Posttraumatic stress state scores measured by the IES decreased and remained stable at the four-week and six-month follow-up intervals. This study did not include a control group. In contrast to previous studies that used the standard protocol, the subjective distress score did not reduce to zero. The authors indicated the importance of integrating debriefing for more vulnerable targeted victims or including a debriefing component in the group treatment. In addition, problems with sexual intimacy were maintained, indicating a need for additional sexual-therapeutic treatment in conjunction with this approach.

The third article compared a standard EMDR protocol administered individually and an EMDR Integrative Group Treatment Protocol (EMDR-IGTP) (Allon, 2015). Although both protocols decreased posttraumatic stress state scores, findings suggested that the standard EMDR protocol was the most effective. The authors noted that the results could have been influenced by characteristics prevalent in the EMDR-IGTP group, including the severity of the trauma experienced, unstandardised measurement of subjective units of distress, and limited screening practices. There was also no control group in this study.

MLI is a similar intervention requiring specialised accreditation. This intervention uses a specific protocol to transform the index trauma into an episodic memory in the traumatised individual's chronological timeline so that the limbic system stops perceiving it as a potential threat (Pace, 2003). As opposed to EMDR, this memory integration is focused on unintegrated ego states in the self-system (Hu, 2014). Rajan et al. (2020)

evaluated the effect of a single-session treatment of this approach on Swedish women who experienced a single sexual assault. Their study found that there was a PTSD symptom reduction at the three-week follow-up that remained stable at the six-month follow-up and a moderate decrease in the general psychological distress of participants in the treatment group. This study only included participants who experienced a single sexual assault, differing significantly from previous studies that assessed interventions on participants with multiple traumas. In addition, no demographic variable data was collected to contextualise the findings. Lastly, a waiting list with a very short follow-up period was used, which could have exaggerated the efficacy of the intervention.

Mindfulness-based interventions

Based on the research, there are three interventions that incorporated a more body-centred approach, combining meditation, body scanning and/or mindfulness exercises. According to Szoke and Hazlett-Stevens (2019), mindfulness may assist survivors in decreasing the avoidance, hyperarousal, and occurrence of negative thoughts associated with PTSD by increasing attitudes of acceptance of the present moment and self-compassion. A total of three articles included in this review can be categorised as mindfulness-based.

Lee and Cha (2021) developed a virtual reality-based intervention incorporating mindfulness meditation and reflective writing delivered through smartphones. Their sample included females aged 19 to 24 who experienced sexual violence (rape, sexual abuse, or sexual harassment). The experimental group completed the intervention, and the control group practised audio-guided mindfulness meditation. Significant improvements in perceived social support, negative impact from sexual violence and suicidal ideation scores were evident in both groups. Analysis of the reflective writing indicated that several themes emerged in participant experiences. Accordingly, the

participants were able to objectify sexual violence, realise that they were able to heal by engaging in the process of confronting issues and relinquishing emotions and felt consoled by realising that others had similar experiences to their own. The small sample size inhibits the generalisability of the findings of the study. In addition, no control group was used, and intervention engagement was measured through self-report.

Shors et al. (2018) compared four groups of women by offering them mental and physical (MAP) training, focused attention meditation alone, aerobic exercises or no training. Findings indicate the MAP training led to a significant increase in self-worth scores and significant decreases in trauma-related cognitions and ruminative thoughts evident in women who experienced sexual violence. These findings indicate that combining MAP training is more effective than either component alone. The authors did not report attrition rates and did not assess mindfulness as an outcome.

Goodarzi et al. (2020) evaluated an eight-week intervention program that combined mindfulness and artmaking with 16 FSASA in Iran aged 20-49. This intervention was based on a modified mindfulness-based art therapy protocol (Monti et al., 2012), with sessions comprised of teaching and practising the foundations of mindfulness and an art activity related to the mindfulness content discussed in the session. A significant decrease in depression, anxiety and shame scores was evident in the experimental group at the post-test and follow-up. This study included participants with moderate symptom severity, which may not apply to participants with more severe symptoms. The IES-R used to measure PTSD does not fully cover the PTSD definition as noted in the newest Diagnostic Statistical Manual (American Psychiatric Association, 2013a). The strength of this evidence was limited since the study had a small sample size, gave no description of the control group treatment and did not allow sufficient information to be replicated.

DISCUSSION

The review identified 18 studies that met the eligibility criteria. The studies included various interventions administered in different arrangements and contexts, offering a holistic view of options available for survivors. Similar to Lomax and Meyrick (2022) overall, most studies were subject to a high risk of bias, resulting in poor internal and external validity, reflecting common limitations in their design. Not all the studies reported on the demographic variables of their samples, those that did showed homogenous samples that were predominantly Caucasian, except those conducted in the DRC.

PTSD was used as the primary outcome that was measured to determine the efficacy of the interventions for sexual assault survivors. Although most of the interventions assessed PTSD, this outcome was not measured by the same psychometric measures throughout. Therefore, equivalent comparisons of intervention effectiveness were not possible. This review was not limited to interventions solely focused on PTSD (Dworkin & Schumacher, 2018; Oosterbaan et al., 2019) and, similar to previous reviews, incorporated articles that looked at several mental health outcomes (Heard & Walsh, 2021; Lomax & Meyrick, 2022; Short et al., 2020). Most of the studies included an initial screening of participants before inclusion, and exclusion from intervention participation was predominantly based on severe psychopathology. In total, seven different intervention types were identified in this review.

Several differences and similarities emerge when comparing this review with previous evidence syntheses on this topic. Time passed since the assault was not an exclusion criterion for article inclusion, expanding findings beyond previous early intervention syntheses (Dworkin & Schumacher, 2018; Lomax & Meyrick, 2022). Although the time frame used in this study overlaps with those included in previous reviews (Dworkin & Schumacher, 2018; Heard & Walsh, 2021; Lomax & Meyrick, 2022; Oosterbaan et al.,

2019; Short et al., 2020), this review extends beyond the last search date of 2019 to include articles that span until 2022. This inclusion of more recent articles added a group-based CBT intervention (Louison Vang et al., 2020), a brief exposure group intervention (Karlsson et al., 2020; Karlsson et al., 2021), an MLI intervention (Rajan et al., 2020) and three mindfulness-based interventions (Goodarzi et al., 2020; Lee & Cha, 2021; Shors et al., 2018) that were not included in the previous reviews. The absence of mindfulness-based interventions in the previous reviews suggests that this is a relatively new type of intervention available to survivors. Intervention types included in previous reviews but not found in articles that met the inclusion criteria of the current review are art and drama therapy, SIT (Heard & Walsh, 2021), and progressive muscle relaxation (Lomax & Meyrick, 2022). This review's results align with previous evidence showing that most intervention evaluations are CPT-based (Lomax & Meyrick, 2022). Common components across the interventions were a psychoeducation component, with some including exposure techniques in various forms and others incorporating relaxation techniques.

The absence of studies conducted in the South African context is glaring and motivates further investigation. The South African studies initially found in the database search stage of this review were all case studies that were excluded based on the inclusion criteria. There is, therefore, a clear need for more robust evidence-based investigations in the form of RCTs within this context to inform practice.

LIMITATIONS

This study identifies an important knowledge gap in the literature concerning interventions for sexual assault survivors but has several limitations. This review was limited to English peer-reviewed articles that excluded participants under 18 years of age. The timeframe limitations may have excluded several interventions that have been noted in earlier reviews. No meta-analysis was included in this rapid review that could indicate

how the interventions compare in terms of efficacy. Interventions focused on IPV, and multiple types of traumas were excluded from this review. Consequently, participants may not be representative of the clinical and social complexity most patients' psychotherapists see in their practices. In addition, several interventions were found in the initial search of the databases but were excluded since they were not formally evaluated. Case studies were excluded from this review due to their poor evidence quality - this had the unintended effect that South African articles were excluded from the review.

RECOMMENDATIONS

This review expands on the intervention synthesis literature by including mindfulness-based interventions, indicating a promising new avenue for future research. More randomised control and quasi-experimental studies evaluating interventions are required within the South African context. The researcher is aware of two interventions used in practice that could not be included in this review due to a lack of empirical studies published on these. These interventions include Brain Working Recursive Therapy and the WITS trauma model. It is, therefore, recommended that clinicians focus on formally evaluating these interventions to expand on the evidence-based interventions available to this population.

This review highlighted several components crucial to successful interventions, namely psychoeducation, exposure, and skills development. The importance of screening participants before inclusion, assessment tools used to assess outcomes, timing and duration of interventions and delivery methods were also outlined. These components should be considered in future intervention development for this population. Studies investigating the prevalence of participant strengths may open new avenues of exploration for intervention development for this population that is strengths-based and not deficit focused. Furthermore, studies focused on participant experiences of these

interventions that go beyond measurable outcomes could highlight additional factors that may affect efficacy and attrition rates.

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SECTION B - STUDY 2 (CONVERGENT MIXED METHOD STUDY- QUANTITATIVE SECTION)

In Manuscript 1, the intervention components that are crucial to alleviating sexual assault survivor distress were identified. The concerns regarding the transferability of these interventions to the South African context noted in the literature review opened a new avenue of exploration that the researchers aimed to address. For a clearer understanding of the survivors' perspectives, it was crucial to investigate their experiences of what contributed to their recovery. From this perspective, the next step in this dissertation was to conduct a convergent mixed-method study.

In this study, we recruited online participants to complete questionnaires that included scales and open-ended questions. The quantitative section enabled the researchers to evaluate the relationships between the relevant variables (PTSD, resilience, PTG and PWB) and divide the participants based on their scoring profiles. The second manuscript describes the relationships between the different variables focusing on the findings from the EFA. Understanding how these variables are related enabled the researcher to highlight which variables would offer survivors the most effective intervention for recovery.

MANUSCRIPT 2: THE RELATIONSHIP BETWEEN POSTTRAUMATIC STRESS, PSYCHOLOGICAL WELL-BEING, RESILIENCE AND POSTTRAUMATIC GROWTH IN A SOUTH AFRICAN SAMPLE OF ADULT SEXUAL ASSAULT SURVIVORS.

PREFACE

The manuscript forms part of a larger study, which comprises three phases:

- Phase One – Rapid review (Manuscript 1);
- Phase Two – Convergent mixed-method study quantitative (Manuscript 2);
– Convergent mixed-method study qualitative (Manuscript 3); and
- Phase Three – Intervention guideline design (Manuscript 4).

The manuscript that follows reports on Research Objective 2: “To analyse the relationship between demographic variables, PWB, resilience, and PTG of a group of FSASA residing in the Gauteng Province”. The following secondary research questions drove this part of the study: *What is the relationship between demographic variables, PWB, resilience, and PTG of a group of FSASA residing in Gauteng Province? (Empirical research: Quantitative data from convergent mixed-method).*

This manuscript reports on the quantitative findings of a convergent mixed-method study, using descriptive statistics to describe the sample and their scores and EFA to highlight the relationships between different variables (PTSD, PTG, resilience, PWB) prevalent in the sample obtained through assessment with validated psychometric measures. The manuscript is intended for publication, possibly in *Violence Against Women*. The specifications as set out by the journals were considered, however for uniformity in the research report, the manuscript/article was written in the following format: Arial 12, justified, 2.0 spacing and with APA referencing.

ABSTRACT

Limited research has focused on the prevalence of strengths-based trauma responses following sexual assault in South African women. This article reports on the quantitative

findings from a convergent mixed-method study that was conducted to investigate the recovery experiences of FSASA in South Africa. Quantitative data was collected to assess demographic variables, PTSD, PWB, resilience, and PTG in a group of 50 self-referred FSASA. Participants were recruited through posters placed at NGOs and a targeted social media campaign that incorporated purposive sampling. These participants completed an online survey anonymously. Descriptive statistics, including means and standard deviations, reliability coefficients, and correlations, were calculated with SPSS.

Despite 68% of the participants scoring above the threshold for PTSD, the participants seemed to be doing well overall, with high means for PWB, average resilience levels and high scores for PTG. Correlations between latent and demographic variables indicated that the passage of time lowered PTSD and increased PWB, and time spent in therapy affected PWB positively. Given the small sample size that led to poor reliability indices in some measures, findings should be interpreted with caution.

Keywords: Sexual assault, Mental health seeking, South Africa, mixed-methods

INTRODUCTION

Most research focuses on pathological (PTSD) rather than strengths-based (PWB, resilience and PTG) responses to sexual assault. Numerous studies over decades have consistently shown that the impact of sexual assault on the mental health of individuals is one of the most severe of all traumas, causing multiple, long-term adverse outcomes (Boyd, 2011; Briere & Jordan, 2004; Broman-Fulks et al., 2007; Campbell et al., 2009; Chivers-Wilson, 2006; Kilpatrick & Acierno, 2003; Krakow et al., 2001; Tamuli et al., 2013; Temple et al., 2007). Although numerous scholars have written about the harmful effects of sexual assault on mental health, the possibility of alternative mental health trajectories has recently been investigated (Bonanno, 2013; Steenkamp, 2011; Steenkamp et al., 2012). Some international studies have reported the high prevalence rates of PTG in

sexual assault survivors (Cole & Lynn, 2010; Gwynn, 2008; Kunst, 2011). In a South African study with childhood sexual abuse survivors, 60% of the participants manifested PTG and 42% manifested PWB (Walker-Williams et al., 2012).

Studies investigating the interrelation between pathological and strengths-based trauma responses offer conflicting results due to inconsistencies in the definition of the variables measured (Bensimon, 2012; Bonanno, 2013; Elderton et al., 2017; Steenkamp, 2011). This study has utilised the most prevalent definitions of each variable to shed light on this interaction. In addition, there is a gap in the literature pertaining to how these variables manifest and relate to one another in the South African population. The research question driving this study was *What is the relationship between demographic variables, PWB, resilience, and PTG of a group of FSASA residing in the Gauteng Province?* To contextualise the discussion on the prevalence and interrelation of- and the relationships between the variables measured in this study successfully, the definitions used for each variable must be clarified. As such, each variable is defined below, followed by a brief literature description denoting the prevalence amongst relevant sample groups.

Posttraumatic Stress in Sexual Assault Survivors

The behavioural, somatic and psychological reactions associated with rape are closely related to PTSD symptomology (Padmanabhanunni & Edwards, 2016). Therefore, it is not surprising that rape is associated with the highest frequency of PTSD when compared to other traumatic events (Dinan et al., 2004; Foa & Rothbaum, 2001; Kaminer et al., 2008; Padmanabhanunni & Edwards, 2013). PTSD is a psychological response to a traumatic event comprising 17 symptoms grouped in three clusters; re-experiencing the event, avoidance, and numbing and hyperarousal (American Psychiatric Association & Association, 2013). Women who experience behaviours typical of freeze response are more likely to have a greater degree of PTSD symptomology after the assault (Bovin et

al., 2008; Rizvi et al., 2008). From the psychosocial framework, PTSD is not seen as a separate outcome but rather as a process indicating a need for cognitive and emotional processing of the new trauma-related information (Joseph & Linley, 2008b). During this process, survivors can experience a deficit in their PWB.

Psychological Well-being in Sexual Assault Survivors

PWB is a multidimensional concept encompassing emotional, mental and social well-being that involves different aspects of the self, such as affect, cognition and behaviour (Wissing & Van Eeden, 2002). The MHC model considers positive mental health as flourishing, not only by the absence of psychopathology (Keyes, 2005). The MHC model has six dimensions (self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth) and focuses on the individuals' evaluations of their public and social lives in terms of emotional-, social- and PWB (Keyes, 2005). South African communities can be high-risk environments where inequality and its associated psychosocial problems prevail, and citizens are predisposed to multiple and continuous trauma, which tends to have a cumulative negative effect on their psychological health (Atwoli, 2015; Joubert et al., 2022; Peltzer et al., 2007). Thus, an individual's overall functioning is impacted by how resilient they are in the face of life stressors and traumatic events.

Resilience in Sexual Assault Survivors

Most definitions of resilience include a concept of healthy, adaptive or integrated positive functioning over time in the aftermath of adversity (Southwick et al., 2014). Measuring resilience is significantly influenced by whether it is seen as a trait grounded in personal characteristics (Connor & Davidson, 2003) or a psychosocial concept (Ungar, 2018). Ungar (2018) explains that resilience encompasses the capacity to navigate the psychological, social, cultural, and physical resources that sustain our well-being and

negotiate for these resources to be provided in meaningful ways. Therefore, rather than being a static outcome, resilience is promoted by an interplay between protective factors within the individual and environmental factors that facilitate better outcomes (Liebenberg & Moore, 2018; Masten, 2014). Ponce-Garcia et al. (2015) reported that social and cognitive factors such as social support, social skills, prioritising and planning behaviours, and goal efficacy determine resilience. According to Steenkamp (2011), sexual assault survivors experience recovery instead of resilience to the trauma. There were four distinct recovery trajectories that were identified following sexual assault, namely high chronic, moderate chronic, moderate recovery and marked recovery. Accordingly, most sexual assault survivors will see a gradual decline in symptoms even if highly distressed in the immediate weeks post-assault; however, clinical intervention may be necessary for those who experience a chronic trajectory.

Posttraumatic Growth in Sexual Assault Survivors

In contrast to resilience, PTG refers to the positive psychological change in people that goes beyond an ability to resist and not be damaged by highly stressful circumstances, involving a movement beyond pre-trauma levels of adaptation (Tedeschi & Calhoun, 2004). This growth occurs through the cognitive restructuring of the trauma survivor's assumptive world when their pre-trauma assumptive beliefs are challenged and forced to appraise and derive new meaning from the traumatic experience (Calhoun et al., 2010). Specifically, PTG can be seen in the success with which individuals coping with the aftermath of trauma reconstruct or strengthen their perceptions of self, others, and the philosophy of life (Tedeschi & Calhoun, 1996a). When compared to motor vehicle accident and bereavement victims, sexual assault survivors reported lower levels of psychological growth (Shakespeare-Finch & Armstrong, 2010).

PTG in IPV survivors have been measured in both quantitative and qualitative studies. Interestingly, quantitative studies utilising the PTGI showed that some IPV survivors report changes in all the domains of PTG (improved relationships with others, personal strength, spiritual growth, new possibilities and appreciation for life) (Elderton et al., 2017). Accordingly, the appreciation of life domain was most consistently affected (Cobb et al., 2006; Grubaugh & Resick, 2007; Kleim & Ehlers, 2009), followed by the personal strength domain (Grubaugh & Resick, 2007; Kleim & Ehlers, 2009). Qualitative studies have also found themes related to the PTGI domains in the narratives of interpersonal survivors. These included growth in terms of behavioural components that built personal strength (Senter & Caldwell, 2002; Taylor, 2004), improved relationships with others (Hou et al., 2013; Senter & Caldwell, 2002; Taylor, 2004) and the appreciation for life (Hou et al., 2013; Senter & Caldwell, 2002). Elderton et al. (2017) identified several pre-trauma, peri-trauma and post-trauma variables that influenced whether an IPV survivor would experience PTG in their systematic review. Pre-trauma variables included age (Grubaugh & Resick, 2007), ethnicity (Frazier et al., 2004; Kleim & Ehlers, 2009), education level (Grubaugh & Resick, 2007) and prior sexual victimisation (negatively correlated with growth) (Cole & Lynn, 2010). Regarding peri-trauma variables, some studies found that the severity of the assault seemed to lead to positive change (Cobb et al., 2006; Song, 2012), whereas others did not (Kennedy et al., 1998). Regarding post-trauma variables, initial trauma-related distress and optimistic expectancies directly influenced perceived growth following adversity (Updegraff & Marshall, 2005).

Interrelations Between Posttraumatic Stress Disorder, Personal Well-being, Resilience and Posttraumatic Growth

The Resilience Portfolio model guided the variables measured in this study (Hamby et al., 2018). This model integrates theory and research on resilience, positive psychology,

PTG, and coping, providing a more comprehensive understanding of the health and thriving processes in individuals exposed to adversity (Grych et al., 2015). The model proposes that an individual's psychological health after exposure to violence is determined by the characteristics of the adversity, the assets and resources available to them, as well as their behavioural responses (Grych et al., 2015). In line with this model, some studies have examined how these strengths-based variables intersect.

Conceptual coherence has been found between measures of constructive coping, PTG, and psychological wellness (Walker-Williams et al., 2012). Women who scored high on PTG showed more PWB than those who did not, notably in the dimensions of life purpose and environmental mastery (Ruini et al., 2013). PTG facilitates new wisdom, leading to better PWB and greater life satisfaction (Calhoun et al., 2010; Triplett et al., 2012). PWB and PTG both encompass elements of spirituality; thus, an increase or decrease in spirituality can lead to changes in both variables (Kennedy et al., 1998). Resilience-enabling behaviours such as acceptance coping and utilisation of support networks are positively associated with perceived growth and negatively associated with adverse stress reactions (PTSD) (Cole & Lynn, 2010).

Conversely, studies defining resilience as resistance to PTSD following adversity instead of a process of recovery (Bonanno, 2004; Bonanno et al., 2006; Levine et al., 2009), found an inverse relationship between PTG and resilience. Levine et al. (2009) offer two explanations for this finding. Firstly, trauma survivors with characteristics that make them less vulnerable to PTSD are not as challenged by the meaning-making process inherent in PTG and will therefore display fewer indications of growth. Secondly, if PTG is seen as unrealistic optimism, individuals who have high levels of resilience are less likely to resort to reporting this outcome since they have a reduced need for wishful thinking (Levine et al., 2009). Therefore, findings from studies investigating the

relationship between PTG and PTSD have offered conflicting results. Whereas five studies reported no significant relationship between these variables (Borja et al., 2006; Cobb et al., 2006; Grubaugh & Resick, 2007; Kunst, 2010; Kunst, 2011), three studies found a negative correlation between growth and distress (Cole & Lynn, 2010; Frazier et al., 2001; Frazier et al., 2004) and one study found a curvilinear relationship between these variables (Kleim & Ehlers, 2009).

AIM OF THE STUDY

The present study was conducted to examine whether the life outcomes of sexual assault survivors are generally only deficit-based or whether strengths-based variables are prevalent. This study focused on PTSD, PWB, resilience and PTG in a sample of South African FSASA. The research question guiding this study was *What is the relationship between demographic variables, PTSD, PWB, resilience and PTG?*

METHOD

Study Procedure

Before the commencement of the study, this proposal was sent for review by readers within the Optentia Scientific Committee of the NWU and ethical approval was obtained from the NWU Health Research Ethics Committee (NWU-00206-21-A1) (Addendum 1). Participants were recruited via a targeted social media campaign (Addendum 6) that asked participants to complete online surveys anonymously on a website specifically developed for the study. Participants were also asked to refer a friend upon completing the survey, if they could. The sample included 50 adults (18 years and older) and South African women residing in the Gauteng Province. Women were included if they experienced a sexual assault more than three months prior to disclosing the trauma, received some form of trauma counselling or debriefing, and felt they could contribute to

the study. Potential participants were excluded if the assault did not occur in adulthood (they were younger than 18), only experienced sexual assault during childhood, and were involved in a criminal trial during data collection. After providing informed consent, participants completed the online surveys that included a demographic questionnaire and four standardised questionnaires and were reimbursed with an R30 data voucher. Throughout the online completion, the participants had access to a real-time chat box to ask questions and request a referral for additional services. The researcher's contact details and a list of free referral services were visible on each site page.

Participants and Setting

A description of the sample is outlined below (with percentages kept to the first decimal point for clarity). A more detailed table is available in Addendum 8. Women ranged in age from 18 to 60 at the time of the survey ($M = 29.48$, $SD = 10.01$). In terms of ethnicity, the sample included Black (68%), White (26%) and (6%) mixed-race women. When asked about relationship status, 42% were in a relationship, 40% were single, 10% were married, 4% were separated and 4% were divorced. The sample was well educated (58% completed school until matric and 12% finished post-graduate studies). The sample experienced high levels of trauma, with 64% experiencing more than one assault varying from two (18%) or three times (18%) to more than four times (10%). The time since the last assault was between less than a year (37.5%) and more than 20 years (4.2%). In this sample, 72% of the participants knew the perpetrator, with the relationship varying in closeness. Less than half (40%) of the participants reported the assault to the police, and of these, 26.5% found the police unhelpful, and only 12.2% saw them as helpful. Whereas 26% of participants did not disclose the assault, 54% disclosed it to a person they trusted (including a friend, a family member, or a partner), and 12% spoke to a professional person. Even though 36% of participants reported that they did not receive support, some

sources of support included informal support (friends, family, and partners) (44%) and formal support (NGOs and therapists) (6%). In terms of help-seeking behaviour, 52.2% of participants went for therapy. The time they waited to attend therapy ranged from a month to after more than 5 years. Sites of delivery for therapy included free services (NGOs, churches, government services; 36.3%), private therapists (20.5%), and numerous providers (2.3%). The duration of therapy ranged from only attending one session (10%) to a few years of attending therapy (10%). Therapy was deemed very helpful by 32%, somewhat helpful by 16%, and not at all helpful by 8% of the participants.

Quantitative Measures

Guided by the Resilience Portfolio model as a framework, the participant's exposure to violence was highlighted (demographic questionnaire), and the resources and assets of the individual (ARM and PTGI), as well as their psychological health, were measured (MHC-SF, PCL-5). The measures assessed demographic characteristics, PTSD, MWB, resilience and PTG. All the measures used in this study have been validated for use with the South African population. The questions were set out in three different languages; English, Afrikaans and Sesotho, and the participant could answer them in their home language. A professional translator translated the questionnaires initially, alongside the answers when data collection was complete. In cases where a language other than English was used, forward and backward translations were utilised.

The demographic questionnaire gathered demographic and background information on the participants. The questions were based on the necessary biographical information for a meaningful sample description. Personal characteristics included age, ethnicity, gender, relationship status and occupation. Questions on sexual assault history, relationship to the perpetrator, as well as access to mental health services and informal support were included. Time frames in which the sexual assault occurred were added

since time plays a role in acute stress symptomology (American Psychiatric Association, 2013b). Questions outlining reporting to the police were also included.

The *PTSD Checklist for DSM-5* (PCL-5; Weathers et al., 2013) was used to assess posttraumatic stress symptoms experienced within the last month in line with DSM-5 diagnostic criteria. The 20 items evaluate four subscales, namely re-experiencing, avoidance, negative alterations in cognition and mood, and hyper-arousal. All items start by asking, "In the past month, how much were you bothered by...", and some examples of completed questions are "...repeated, disturbing dreams of the stressful experience?", "...feeling very upset when something reminded you of the stressful experience?", "...blaming yourself or someone else for the stressful experience or what happened after it?" and "...having difficulty concentrating?". This questionnaire has shown good reliability within South African studies ($\alpha = 0.95$) (Makhubela, 2018) ($\alpha = 0.97$) (Kagee et al., 2022).

The participant's mental health was evaluated utilising the MHC-SF (Keyes, 2005, 2009). The 14 elements on this scale range from never (coded as 1) to every day (coded as 6) and are measured on an ordinal scale. Participants are asked to rate how often each of the descriptions, such as "engaged in life," "that people are generally decent," and "confident to think or express your views and opinions," they experienced during the preceding month. In total, three items measure emotional well-being, six measure PWB, and five measure social well-being. The MHC-SF has demonstrated excellent internal consistency (> 0.80) and discriminant validity, among other countries, in the USA, the Netherlands, and South Africa (Keyes, 2005, 2007, 2009b; Lamers et al., 2011).

The *Revised Adult Resilience Measure* (ARM-R) (Resilience Research Centre, 2018) is a 5-point Likert-type scale (1 = not at all; 5 = a lot), self-report, 28-item measure of resilience-promoting resources and is based on a socioecological framework of resilience (Ungar, 2018). Higher scores indicate more resilience-enabling resources and, thus,

greater potential for resilience. The ARM consists of eight clusters which represent three subscales of resilience resources: i) individual capabilities (personal skills, peer support, and social skills clusters); ii) relationships with important individuals (physical and psychological caregiving clusters), and iii) contextual factors that promote a sense of belonging (spiritual, educational, and cultural clusters). In a South African study conducted by Bemath et al. (2020), the internal consistency reliability of the total ARM-R was $\alpha = 0,88$, and for the subscales, individual resources = 0.79, relational resources = 0.83, contextual resources = 0,62.

The *PTGI* (Tedeschi & Calhoun, 1996b) is a 21-item measure of positive life changes after trauma. The items are rated on a 5-point Likert scale ranging from 0 (I did not experience this change) to 5 (I experienced this change to a great degree). The PTGI yields a total score as well as five subscale scores. The 21 items were summed to assess the extent of PTG. The subscale scores include appreciation of life (three items); new possibilities (five items); personal strength (four items); spiritual change (two items), and relating to others (seven items). The PTGI has shown good reliability in previous South African studies of trauma survivors, with a total Cronbach's alpha ranging from 0.95 (Walker-Williams, 2012) to 0.76 (Mason, 2019).

Data Analysis

Descriptive statistics, including means and standard deviations, reliability coefficients, and correlations were calculated with SPSS 27 (IBM Corporation, 2021). CFA could not be performed due to the small sample size. A decision was made to perform an EFA in SPSS 27 (IBM corporation, 2021) for the questionnaires to find any possible underlying factors or combinations of items not identified in previous samples. An EFA in SPSS consists of two steps that are repeated until all included items have been allocated to a specific factor. The first step is Principal Component Analysis (PCA), to identify the

possible number of underlying factors according to Eigenvalues > 1.00. In the second step, Principal Axis Factoring (PAF), each item is assigned to one of the possible identified factors according to its highest loading. If all items show acceptable factor loadings (> .30), the EFA is complete. If not, the items with low loadings are removed from the analysis and the two steps (PCA and PAF) are repeated. The cut-off value is set at .30 because the exploration of factors should not be so strict that important, collected information is lost.

RESULTS

The following section provides the quantitative results of the study. The table below presents the descriptive and reliability statistics.

Table 5: Descriptive statistics and reliability coefficients

Variable	M	SD	α	Ω
1. Posttraumatic stress (1-100)	66.31	19.50	0.95	0.96
a. Re-experiencing (1-5)	3.35	1.15	0.95	0.95
b. Avoiding (1-5)	3.76	1.04	0.80	0.82
c. Negative cognitions (1-5)	3.84	1.17	0.87	-
2. Mental well-being (1-6)	3.68	1.19	0.94	0.94
a. Emotional well-being	3.77	1.35	0.82	0.85
b. Social well-being	2.97	1.37	0.87	0.87
c. PWB	4.22	1.22	0.88	0.89
3. Resilience (1-5)	3.29	0.90	0.89	0.90
a. Personal	3.70	1.01	0.79	0.80
b. Relational	3.09	1.18	0.88	0.88
c. Contextual	3.16	1.11	0.80	0.80
4. Posttraumatic growth (1-5)	3.64	1.05	0.94	0.95
a. Personal strength	3.96	1.02	0.61	-
b. New possibilities	3.59	1.33	0.91	0.92
c. Improved relationships	3.97	1.11	0.89	0.89
d. Spiritual growth	3.09	1.36	0.83	0.83
e. Appreciation for life	3.51	1.46	0.80	-

M = Mean; SD = Standard deviation; α = Cronbach's alpha; Ω = Omega reliability coefficient

The acceptable cut-off value for both reported reliability coefficients is .70 (Cohen, 1988; Hayes & Coutts, 2020); thus, all included measures showed acceptable reliability.

The only exception was the variable *personal strength* (a first-level variable of PTG), which showed a Cronbach's alpha of .61. Omega could not be calculated for this variable, as it only consisted of two items.

Each questionnaire's results should be interpreted according to the measuring scale used, namely the PCL-5, and ARM-R (with a scale of 1 to 5), the PTGI (0 to 5) and the MHC-SF (1 to 6). Originally, the PCL-5 was measured on a 0 to 4 scale, with total scores ≥ 33.00 indicating a possible diagnosis of PTSD. The scale of 1 to 5 used in this study meant that the threshold for a possible PTSD diagnosis needed to be adapted to ≥ 41.25 for this specific sample. The PCL-5 overall mean was calculated at 66.31, much higher than the proposed threshold, with a standard deviation of 19.50, giving a range of 46.81 to 85.81 for about 68% of the participants, indicating a highly symptomatic sample.

The participants seemed to be doing well mentally ($M = 3.68$, $SD = 1.19$), with quite a high mean for *PWB* ($M = 4.22$, $SD = 1.22$) on the measurement scale of 1 to 6. However, the mean score for *social well-being* fell below the median of 3.50 at 2.97 with a high SD of 1.37. These scores should be evaluated with caution, as the respective SD-values all fell outside the acceptable range of -1.00 to +1.00, indicating that the scores were more widely distributed around the mean than preferable.

According to the ARM-R's overall mean, the participants showed average levels of resilience ($M = 3.29$, $SD = 0.90$). According to the authors, the 17-item scale consists of two subscales, personal and relational resilience (Resilience Research Centre, 2018). However, a third subscale emerged throughout the statistical analysis of this sample's data. Upon investigation, it was identified as *contextual resilience*, a subscale originally proposed in the ARM 28-item questionnaire, and therefore accepted as part of this model. The participants showed the highest level of *personal resilience* with the closest acceptable SD ($M = 3.70$, $SD = 1.01$). *Relational resilience* measured the lowest of the

three subscales with a slightly higher distribution around the mean but was still above the median ($M = 3.09$, $SD = 1.18$). All three subscales, as well as the overall resilience score, were shown to be reliable, with all Cronbach's alpha and omega coefficients being well above the .70 cut-off score.

Although the overall reliability of the PTGI and that of four of its factors were excellent, the first factor (*personal strength*) showed poor reliability ($\alpha = 0.61$). The factor *improved relationships* measured quite high with a distribution only somewhat wider than acceptable ($M = 3.97$, $SD = 1.11$). *Personal strength* was nearly on par ($M = 3.96$, $SD = 1.02$) but should be evaluated cautiously due to its low-reliability coefficient. Spiritual growth had the lowest score with the second-widest distribution ($M = 3.09$, $SD = 1.36$), while *new possibilities* and *appreciation for life* measured close to each other with means of 3.59 ($SD = 1.33$) and 3.51 ($SD = 1.46$), respectively. It should be noted that none of the five factors of PTG, nor overall PTG, indicated acceptable standard deviations.

Correlations Between Latent and Demographic Variables

Three biographical variables were identified as possibly exhibiting correlations with the overall variables. These relationships were calculated and results are reported below.

Table 6: Correlations between latent and demographic variables

	Posttraumatic stress	Mental well-being	Resilience	PTG
Time since assault	-0.29*	0.29*	0.12	0.19
Relationship to predator	-0.11	0.18	-0.11	0.03
Times assaulted	-0.08	-0.09	-0.14	0.06
Time in therapy	-0.10	0.35†*	0.01	0.25

* $p < 0.05$

** $p < 0.01$

† $r > 0.30$

There were three significant relationships that were identified. Posttraumatic stress had a significant negative relationship with time since the assault, with a small to medium effect ($r = -.29^*$). Mental well-being was found to have significant positive relationships

with two biographical variables: time passed since the assault ($r = .29^*$, small to medium effect) and length of time spent in therapy ($r = .35^*$, medium effect). The more time that has passed since the assault was found to be an indicator of lower posttraumatic stress and better PWB, even though the effect was mainly close to medium. The length of time spent in therapy could be taken as an implication of better or worse PWB; the more a participant had spent in therapy, the better their PWB was, and vice versa.

Confirmatory Factor Analysis

CFAs were attempted in Mplus (Muthén & Muthén, 1998-2021) for each of the questionnaires, according to their originally proposed factor structures, as well as factor structures found in other studies. Makhubela (2018) found that, except for its original four-factor structure, the PCL-5 could also consist of a differently grouped four-factor structure, a five-factor structure, two different six-factor structures or a seven-factor structure. Otto (2019) identified a possible three-factor structure solution for the PTGI, in addition to the original five-factor structure. Neither the authors' proposed factor structures nor the additionally identified factor structures fit the data. Only the MHC-SF achieved normal termination, however, its fit statistics did not reach the acceptable cut-off points for a good fit. The other tested models indicated problems that included non-positive definite first-order derivative products, residual covariances, and/or latent variable covariance matrices, leading to non-trustworthy results.

Exploratory Factor Analysis

A decision was made to perform an EFA in SPSS 27 (IBM Corporation, 2021) for the questionnaires to find any possible underlying factors or combinations of items not identified in previous samples. The PCL-5 was found to consist of three possible factors, namely Factor 1 containing Items 1, 2, 3, 9, 10, 11, 12, 13, 14, 15, 16, 18, and 19; Factor 2 containing Items 6, 7, and 8; Factor 3 containing Items 4, 5, 17, and 20. Only Item 21

did not load satisfactorily on any possible factor. The MHC-SF consisted of only two factors in this sample, specifically Factor 1 which contained Items 2, 3, 4, 5, 9, 10, 11, 12, 13, and 14; and Factor 2, containing Items 1, 6, 7, and 8. No item was removed. The ARM-R displayed three possible factors: Factor 1 consisted of Items 4, 5, 8, 10, 11, 15, and 17; Factor 2 consisted of Items 1, 2, 3, 14, and 16; Factor 3 consisted of Items 6, 7, 9, 12, and 13. No item was removed. The PTGI consisted of five possible factors, Factor 1 containing Items 2, 4, 5, 11, 14, 17, and 18; Factor 2 containing Items 6, 8, 20, and 21; Factor 3 containing Items 9 and 12; Factor 4 containing Items 1 and 7; Factor 5 containing Items 3, 10, 13, 15, 16, and 19. No item was removed.

These factor structures could not be confirmed due to the size of the sample ($n = 50$): for a possible factor structure from an EFA to be confirmed, a separate data set or a data set that is large enough to be split in two is needed to perform a CFA. Therefore, these subscales were applied as is for further analysis, including the calculation of reliability coefficients and Spearman's correlation coefficients. The next step was to assess the model for any indirect effects. The table below contains the correlation coefficients between the latent variables.

Table 7: Correlations

Variable	1	1a	1b	1c	2	2a	2b	2c	3	3a	3b	3c	4	4a	4b	4c	4d
1 Posttraumatic stress (1-5)	-																
a Re-experiencing	0.98† **	-															
b Avoiding	0.83† **	0.75† **	-														
c Negative cognitions	0.57† **	0.46† **	0.56† **	-													
2 Mental well-being (1-6)	-	-	-	-	-												
a Emotional well-being	0.48† **	0.46† **	0.39† **	0.38† **	-												
b Social well-being	-	-	-	-	0.84 †**	-											
c PWB	0.44† **	0.43† **	0.34† *	0.37† **	0.90 †**	0.70 †**	-										
3 Resilience (1-5)	-	-	-	-	0.95 †**	0.71 †**	0.78 †**	-									
a Personal	-0.30* †**	-0.29* †**	-0.28 †**	-0.27 †**	0.52 †**	0.40 †**	0.42 †**	0.54 †**	-								
b Relational	-0.07 †**	-0.06 †**	-0.02 †**	-0.07 †**	0.43 †**	0.20 †**	0.38 †**	0.48 †**	0.66 †**	-							
c Contextual	0.38† **	0.39† **	0.34† *	0.36† *	0.38 †**	0.32 †*	0.28* †**	0.41 †**	0.85 †**	0.36 †**	-						
4 Posttraumatic growth (0-5)	-0.16 †**	-0.15 †**	-0.22 †**	-0.16 †**	-0.16 †**	0.43 †**	0.40 †**	0.45 †**	0.81 †**	0.45 †**	0.52 †**	-					
a Personal strength	-0.15 †**	-0.16 †**	-0.01 †**	-0.13 †**	0.70 †**	0.48 †**	0.64 †**	0.74 †**	0.63 †**	0.61 †**	0.47 †**	0.52 †**	-				
b New possibilities	0.04 †**	-0.02 †**	0.18 †**	-0.28 †**	0.37 †**	0.26 †*	0.31 †**	0.38 †**	0.16 †**	0.29* †**	0.08 †**	0.15 †**	0.60 †**	-			
	-0.16 †**	-0.17 †**	-0.02 †**	-0.18 †**	0.57 †**	0.46 †**	0.51 †**	0.55 †**	0.55 †**	0.45 †**	0.43 †**	0.47 †**	0.87 †**	0.57 †**	-		

c	Improved relationships	-0.08	-0.11	0.15	-0.03	0.63 ‡**	0.36 †*	0.56 ‡**	0.70 ‡**	0.52 ‡**	0.57 ‡**	0.34 †*	0.37 †**	0.86 ‡**	0.55 ‡**	0.73 ‡**	-	
d	Spiritual growth	-0.19	-0.19	-0.09	-0.08	0.60 ‡**	0.36 †*	0.55 ‡**	0.64 ‡**	0.68 ‡**	0.60 ‡**	0.53 ‡**	0.55 ‡**	0.82 ‡**	0.35 †*	0.57 ‡**	0.61 ‡**	-
e	Appreciation for life	-0.14	-0.14	-0.09	-0.21	0.64 ‡**	0.49 †**	0.56 ‡**	0.65 ‡**	0.47 †**	0.39 †**	0.36 †*	0.50 †**	0.72 ‡**	0.37 †**	0.53 ‡**	0.55 ‡**	0.55 ‡**

* p < 0.05

** p < 0.01

† r > 0.30

‡ r > 0.50

The data were found to be non-normally distributed, thus Spearman's correlation coefficients were used to determine the presence and strength of relationships between the latent variables. As expected, the subscales of each questionnaire were found to correlate quite highly with one another. The correlations between the second-order factors PTSD, PWB, resilience, and PTG, were generally highly significant ($p < .01$) with large effects ($r > .50$). However, no relationship was found between PTSD and PTG ($r = -.15$), and although significant, the relationship between PTSD and resilience ($r = -.30^*$) only had a small to medium effect, however, the relationship between PTSD and PWB ($r = -.48^*$) had a medium to large effect, and relational resilience was found to exhibit significant relationships with medium to large effects with all other variables, except with personal strength (from PTGI; $r = .08$).

Indirect Effects

The second-order factors were used to determine if posttraumatic stress and PWB, respectively, had indirect effects through resilience on PTG. The results are reported in the table below.

Table 8: Indirect effects of posttraumatic stress and mental well-being on PTG

Variable	Resilience	
	Est.	95% CI
Post-traumatic stress	-0.20*	[-0.47, -0.07]
Mental well-being	0.20*	[0.07, 0.37]

CI = Confidence Interval

PTSD was found to influence PTG growth indirectly through its effect on resilience ($ab = -0.20^*$, 95% CI -0.47: -0.07). Participants reporting higher PTSD also reported lower resilience ($a = -0.27$), with greater resilience associated with higher PTG ($b = 0.72$). There was no definitive evidence that posttraumatic stress directly influenced PTG independent of the resilience process ($c' = -0.00$, $p = 0.98$, 95% CI -0.26: 0.25).

PWB was found to influence PTG indirectly through its effect on resilience ($ab = 0.20^*$, 95% CI 0.07: 0.37). Participants reporting higher PWB also reported higher resilience ($a = 0.39$) with greater resilience associated with higher PTG ($b = 0.44$). There was also evidence that PWB directly influenced PTG independent of the resilience process ($c' = 0.42^*$, $p = 0.00$, 95% CI 0.22: 0.63).

DISCUSSION

The present study explored the prevalence of PTSD, PWB, resilience and PTG and the correlations between latent and biographical variables in a sample of FSASA. Findings indicated that the sample experienced high levels of trauma, with most experiencing more than one sexual assault. This finding is consistent with previous studies conducted within the South African context (Dunkle et al., 2004; Jewkes & Abrahams, 2002; Kaminer & Eagle, 2010; King et al., 2004).

Participants that disclosed the assault received both formal and informal support and more than half attended psychotherapy. In terms of help-seeking behaviour, more participants reported disclosing the assault to their informal support network than reported in previous South African studies (Joubert et al., 2022). The higher levels of education and younger age reflected in the characteristics of this sample have been identified as enabling factors for disclosure and mental health service-seeking behaviour among sexual assault survivors (Smith et al., 2010). Similar to earlier studies among South African trauma survivors, the participants that did disclose the sexual assault relied predominantly on friends, family and their partners (Joubert et al., 2022; Walker-Williams, 2012). Resource deficiencies (De Kock & Pillay, 2017) and a lack of awareness of and negative attitudes towards government-based mental health services (Kaminer & Eagle, 2010; Schneider et al., 2016) have been reported to have inhibited access to mental health care services in South Africa. Despite this, more than half of the participants in the

sample could access MHPs in the context of private practice, NGOs, hospitals, and churches and found these services helpful. This finding could have been influenced by the online method of recruitment used for the study. Participants with access to online social media platforms receive more information about mental health services and supportive contexts available to them and therefore have more expansive resources to choose from that fit their needs.

The highly symptomatic nature of the sample was evident in the 68% of participants that scored above the diagnostic threshold for PTSD. This was significantly higher than the means reported in studies with other South African studies, including mortuary workers (Makhubela, 2018), HIV patients (Kagee et al., 2022), and university students (Padmanabhanunni & Wiid, 2022). The high scores reported in this study are reminiscent of baseline PCL-5 scores of South African sexual assault survivors whose scores improved dramatically after intervention (Knettel et al., 2020). This indicates that the survivors within this sample could benefit from clinical interventions to decrease their PTSD scores.

High mean scores for PWB indicated that the participants viewed themselves as doing well mentally. These mean scores were higher than reported in an earlier study of South African childhood sexual assault survivors (Walker-Williams et al., 2012). In line with previous studies, this study found that most sexual assault survivors reported at least some positive changes following the assault (Cole & Lynn, 2010; Frazier et al., 2004; Kleim & Ehlers, 2009; Updegraff & Marshall, 2005). Average levels of resilience were observed, with the highest domain being *personal resilience* and the lowest being *relational resilience*, indicating a tendency to be somewhat more reliant on personal strengths than environmental resources. A similar trend was noted in a sample of emerging adults in South Africa (Bemath et al., 2020). However, the mean scores for both

domains were significantly lower for this sample than in the other study. In line with previous studies, the participants reported changes in all the PTG domains (Elderton et al., 2017). Specifically, *the improved relationships with others* domain was the most elevated in the sample, similar to what was reported in other studies (Hou et al., 2013; Senter & Caldwell, 2002; Taylor, 2004).

Correlations between the latent and demographic variables indicated that PTSD decreased, and PWB increased as time passed. This finding is consistent with longitudinal studies investigating survivor recovery (Dworkin et al., 2018; Kline et al., 2021; Peleg & Shalev, 2006). As indicated in previous studies, the duration of therapy was correlated with better mental health (Campbell et al., 1999; Sullivan, 2018).

This study contributed towards the limited literature regarding the prevalence of strengths-based variables among sexual assault survivors in the South African context. It also highlighted the help-seeking behaviours amongst this population and identified the need for therapeutic interventions that may facilitate effective coping and recovery.

LIMITATIONS

Despite the potentially valuable findings of the study, some limitations exist. Firstly, the study was based on a relatively small sample, limiting the findings' generalisability. Secondly, data were collected via self-report questionnaires, which yielded subjective results. The inclusion criteria for this study limits the generalisability of the findings to female adult sexual assault survivors that disclosed the trauma and were not involved in criminal cases at the time of recruitment and those that felt that they could offer guidance to other survivors. Therefore, participants may not be representative of sexual assault survivors who have not received treatment.

RECOMMENDATIONS

An important focus for future research should be replicating the current study with a larger community sample. Replication of this study will enable researchers to investigate correlations between the variables and confirm the model of fit for the different measures in a bigger sample. This manuscript offered a clearer understanding of the dynamics of how PTSD, PWB, resilience and PTG relate to each other on a statistical level. Scoring profiles in this study indicate that resilience and PTG can co-exist with PTSD and lead to better-informed interventions. Measuring strengths-based variables within survivors that present with symptoms indicative of high PTSD may enable clinicians to become aware of internal resources which could be overlooked when they do not take a strengths-based approach to client interventions. However, little is known about how survivors experience these variables during their journey of recovery. Therefore, future studies should focus on survivor experiences related to these variables during recovery. Such an understanding would enable clinicians to operationalise these constructs during interventions.

These findings indicate that both PTSD and strengths-based variables are prevalent in survivors of adult sexual assault. This highlights the importance of addressing both during interventions with survivors to offer holistic treatment. The EFA highlighted the important role that resilience plays in survivor recovery, therefore indicating that a focus on resilience is crucial in strengths-based interventions for this population.

To expand on our understanding of how survivor experiences relate to their recovery, the next step in this phase was to investigate the qualitative data of the convergent mixed-methods study. The quantitative data analysed above, as well as the qualitative data, were collected simultaneously. The qualitative data was the result of open-ended questions that were included in the demographic questionnaire. These questions sought

to understand the facilitators and barriers to accessing services, experiences in psychotherapy, resources, and coping strategies (resilience and PWB), and how their views changed following the assault (PTSD and PTG). To understand the qualitative results, the participants were grouped into two groups (FSR and SSR) to compare the narratives between participants that scored the highest and lowest in the PCL-5 (PTSD). Manuscript 3 hereafter offers a description of this process and its consequential results.

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MANUSCRIPT 3: USING THE STORIES AND STATISTICS OF SEXUAL ASSAULT RECOVERY TO EMPOWER OTHERS: A COMPARATIVE QUALITATIVE ARTICLE

PREFACE

The manuscript forms part of a larger study, which comprises three phases:

- Phase One – Rapid review (Manuscript 1);
- Phase Two – Convergent mixed-method study quantitative (Manuscript 2);
– Convergent mixed-method study qualitative (Manuscript 3); and
- Phase Three – Intervention guideline design (Manuscript 4).

The manuscript that follows reports on Research Objective 3: “To compare experiences of the upper (significant signs of recovery - referred to as SSR) and lower (few signs of recovery - referred to as FSR) FSASA scorers regarding attributing factors to their PWB, resilience and PTG in Gauteng”. The following secondary research question drove this part of the study: *What can we learn from the upper (SSR) and lower (FSR) FSASA scorers regarding attributing factors to their PWB, resilience, and PTG in Gauteng, South Africa?*

This manuscript reports on the qualitative findings of a convergent mixed-method study, using the constant comparative method to highlight themes identified in the experiences of a sample of South African FSASA. The manuscript is intended for publication, possibly in *Violence Against Women*. The specifications as set out by the journals were considered, however for uniformity in the research report, the manuscript/article was written in the following format: Arial 12, justified, 2.0 spacing and with APA referencing.

USING THE STORIES AND STATISTICS OF SEXUAL ASSAULT RECOVERY TO EMPOWER OTHERS: A COMPARATIVE QUALITATIVE ARTICLE

ABSTRACT

Sparse research appears available focusing on the recovery journey from sexual assault and experiences of therapy in South African women. In response, a convergent mixed-method study was conducted to investigate the journey of recovery of FSASA in Gauteng, South Africa. Collecting both quantitative and qualitative data from the same participants enabled the researchers to compare participant narratives that exhibited different levels of recovery. An online survey that included psychometric questionnaires and open-ended questions was completed by a group of 50 FSASA. Quantitative data was collected to understand to what extent survivors experienced PTSD, PWB, resilience, and PTG. Open-ended questions explored informal support, therapeutic experiences, and aspects related to PTSD, PWB, resilience, and PTG. Both databases were analysed separately, and qualitative data were grouped by assigning participants to one of two groups based on their mean scores obtained for PTSD; namely the 20 lowest-scoring participants (SSR group) and the 20 highest-scoring participants (FSR group). The constant comparative method was used to analyse the two groups' open-ended survey answers and identify themes related to FSASAs' recovery experiences, to compare the findings between the groups. Barriers to accessing support included apprehension and distrust of self and others, lack of resources and informal support. Informal support included emotional validation and active support. More positive counselling experiences were reported by women in the SSR group than in the FSR group. Experiences and symptoms related to PTSD, resilience and PTG were reported in both groups. Implications for research and clinical practice with this population are provided.

Keywords: Sexual assault, Psychological well-being, Posttraumatic growth, Resilience, South Africa, Mixed-methods

INTRODUCTION

Numerous studies have reported on the adverse outcomes of sexual assault (Boyd, 2011; Briere & Jordan, 2004; Broman-Fulks et al., 2007; Campbell et al., 2009; Chivers-Wilson, 2006; Kilpatrick & Acierno, 2003). However, few studies have investigated strengths-based (strength or wellness-focused) variables such as PWB, resilience, and PTG in this population.

Abrahams et al. (2014) found that worldwide, 7.2% of women aged 15 years or older had experienced non-partner sexual violence. In 2018, the WHO reported that this number changed to 6% (WHO, 2021a). South Africa has one of the highest rates of sexual violence globally (Abrahams et al., 2014). An increase of 10.35% was noted for reported sexual offences between the years 2015 to 2017 (AfricaCheck, 2019; StatsSA, 2018), during which 70 813 sexual offences were committed (StatsSA, 2018), translating to 1 in every 500 individuals experiencing a sexual offence in South Africa during that period.

Whereas numerous studies have reported on prevalence rates (Borumandnia et al., 2020; Dworkin et al., 2021; Shen et al., 2022), as well as factors that contribute to the epidemic and the adverse effects thereof (Campbell et al., 2009), little is known about the strengths-based recovery experiences in this population. Some studies have explored aspects of PWB in sexual assault survivors, such as positive emotions (Kumar et al., 2022; Li et al., 2022); self-acceptance (Kline et al., 2021; Miller et al., 2010; Sigurvinsdottir & Ullman, 2015; Walker-Williams et al., 2013); social connections (Ahrens & Aldana, 2012); environmental mastery (Strauss Swanson & Szymanski, 2021) and personal growth (McFarland & Alvaro, 2000). However, no studies have measured this variable in sexual assault survivors. Other studies have indicated that resilience is prevalent among

survivors and that environmental resources had a significant impact on the presentation thereof (Cole & Lynn, 2010; Kuo et al., 2022; LoVette et al., 2022; Steenkamp et al., 2012). Additionally, whilst several studies have investigated PTG in sexual assault survivors, little is known about PTG in the South African cohort of this population.

Psychological Well-being in Sexual Assault Survivors

PWB is a multidimensional concept that involves different aspects of the self, such as affect, cognition and behaviour (Wissing & Van Eeden, 2002). The MHC highlights three indicators of positive mental health, namely emotional, social, and PWB (Keyes, 2002). More studies have accumulated that show that survivors are at the lower end of the PWB spectrum, which runs from languishing to flourishing. Sexual assault has the highest associated frequency of PTSD among survivors of a traumatic experience (Dinan et al., 2004; Foa & Rothbaum, 2001; Kaminer et al., 2008; Padmanabhanunni & Edwards, 2013). Survivors that engage in behavioural and characterological self-blame are more likely to experience early symptoms of PTSD, and symptom severity predicts subsequent behavioural self-blame (Kline et al., 2021). These cognitive factors have been found to contribute to the onset and maintenance of PTSD by generating a sense of ongoing threat or motivating cognitive and behavioural strategies that prevent recovery (Dunmore et al., 1999; Ehlers & Clark, 2000). The effect of these cognitive factors can be compounded by negative reactions from informal supporters. Negative reactions upon disclosure have been found to lead to increased self-blame and withdrawal whilst unsupportive acknowledgement has been associated with maladaptive coping (Relyea & Ullman, 2015).

Conversely, survivors who engage in self-compassion exhibit higher levels of social connectedness, life satisfaction, adaptive coping mechanisms, self-determination and self-concept accuracy (Neff et al., 2007). Environmental mastery can be significantly

negatively impacted by sexual assault (Ehlers, Clark, et al., 1998), however anti-sexual assault activism (Strauss Swanson & Szymanski, 2020) and self-defence (Beaujolaïs, 2023) have been found to increase self-efficacy and community connection. Thus, the extent to which a survivor experiences PWB is related to their resilience.

Resilience in Sexual Assault

Ungar (2018) defines resilience as the ability to navigate the psychological, social, cultural, and physical resources that support well-being and the useful provision of such assets. According to Ponce-Garcia et al. (2015), resilience is influenced by social and cognitive variables such as social support, social skills, prioritising and planning behaviours, and goal efficacy. However, literature investigating resilience in sexual assault survivors specifically is sparse.

Bonanno (2004) found that most sexual assault survivors show indications of an adaptive recovery trajectory in the first four months, in addition, survivors who show less PTSD symptoms in the first two months continued to improve (Steenkamp, 2011). The course of symptoms after a sexual assault seems to be most influenced by peri-traumatic dissociation, attributions regarding the sexual attack, and unfavourable cognitions connected to trauma (Steenkamp, 2011). Coping mechanisms that foster cognitive and emotional processing are particularly adaptive (Cole & Lynn, 2010). Studies conducted in South Africa have revealed a few elements that affect the resilience of women who have experienced various types of IPV. The development of resilience in this group is mostly influenced by more equitable gender norms (Kuo et al., 2022) and other social support measures such as social connectivity, greater network ties, and perceived supportive communities (LoVette et al., 2022; Machisa et al., 2018). Conversely, elements such as recent, severe IPV and negative disclosure reactions were linked to lower levels of resilience (Machisa et al., 2018).

Posttraumatic Growth in Sexual Assault

In contrast to resilience, PTG refers to a change or transformation in survivors that go beyond the ability to resist and not be damaged by highly stressful circumstances; this involves a movement beyond pre-trauma levels of adaptation (Tedeschi & Calhoun, 2004) resulting in positive psychological changes in one or more areas of functioning. Reviewing studies on PTG in sexual assault survivors reveals that this population's PTG differs from other populations (Ulloa et al., 2016). Most of the findings revealed that people's relationships with others have improved in terms of quality and satisfaction because of support after disclosure and growing empathy (Borja et al., 2006; Burt & Katz, 1987; Draucker et al., 2009; Frazier et al., 2001; Frazier et al., 2004; Guerette & Caron, 2007). There have also been reports of increased respect for life (Frazier & Burnett, 1994); spiritual growth (Frazier et al., 2006; Kennedy et al., 1998); personal resiliency (Burt & Katz, 1987; Draucker et al., 2009; Frazier et al., 2004), and support for other survivors (Burt & Katz, 1987; Draucker et al., 2009). Yet, South African studies exploring this phenomenon are sparse. When Peltzer (2000) looked at trauma symptoms caused by violent crime in an urban South African neighbourhood, they discovered poor PTG scores. When investigating PTG amongst female survivors of childhood sexual abuse, Walker-Williams (2012) found high rates of constructive coping, and PTG, as well as PWB, with higher levels of PTG, reported in previous studies. Importantly, a factor that can have a significant impact on the resilience and PTG that survivors display is the extent of the support that they receive. In addition, several factors may impact whether a survivor will have access to mental health services in South Africa.

Accessing Mental Health Services in South Africa

Characteristics of the survivor, the assault and their context appear to impact the likelihood of sexual assault survivors seeking mental health services (Ullman, 2007).

Historically, minority groups with low levels of education were less likely to access services (Campbell & Martin, 2001; Ullman & Brecklin, 2002a, 2002b). A lack of financial and social support (Bach et al., 2021) and poor service availability (Kessler et al., 1995) (Leibbrandt et al., 2010; Marais & Petersen, 2015; Petersen & Lund, 2011) compounds the likelihood that mental health services will not be accessed. Furthermore, how the survivor interprets the dynamics surrounding the assault itself may also influence reporting and assistance-seeking. As such, shame and self-blame are well-documented long-term adverse effects of sexual assault that can inhibit treatment-seeking (Sigurvinsdottir & Ullman, 2015; Ullman & Filipas, 2001). Some survivors are hesitant to define their experience as rape if they knew the perpetrator or were intoxicated at the time of the assault (Millar et al., 2002). Miller et al. (2010) found that survivors tend to experience more self-blame based on the number of previous assaults by history, the peritraumatic distress surrounding the assault, and the posttraumatic symptoms and negative self- and world beliefs and cognitions which they experience after the assault. As such, self-blame and negative social reactions to disclosure are strong deterrents for initiating and remaining engaged in counselling or recovery processes (Miller et al., 2010; Sigurvinsdottir & Ullman, 2015; Ullman & Brecklin, 2002a). Informal supporters, such as friends, families or partners, can offer emotional and tangible support to survivors. Leech and Littlefield (2011) define emotional support as showing care or concern whereas tangible support is seen as the provision of information or resources to assist survivors in navigating their traumatic situation and/or recovery. The therapeutic skills and characteristics that are crucial for successful therapy with this population are in line with those reported in other studies (Van Rooyen, 2018).

AIM OF THE STUDY

The present study was conducted to describe the PWB of South African FSASA. This was done with an understanding of i) to what extent participants experienced strengths-based/strengths-focused variables (resilience, PWB and PTG); ii) how participants experienced them, and iii) the comparison between participants that showed SSR and FSR. Recommendations are made for professionals working with this population.

METHODS

This study reports on the qualitative findings of a convergent mixed-method study. For the convergent mixed-method study, the quantitative and qualitative data were collected simultaneously through online questionnaires (Creswell & Clark, 2017). The primary purpose of the quantitative part of this study was to empirically evaluate the relationship between demographic variables, PTSD, PWB, resilience, and PTG. This enabled the researchers to first explore the extent to which participants experienced the analysis of the variables and look at which variables would be most beneficial to focus on during interventions (reported on in Manuscript 2). Secondly, this enabled the researchers to group the participants into different recovery groups based on their PTSD scores. The participants answered open-ended questions allowing them to tell their stories and relay their recovery-related experiences.

After the groups were identified, the qualitative data of each group were analysed through the constant comparative method to expand on our understanding of the different themes that were pertinent in both groups (Glaser, 1965). For this analysis, the stages outlined in Maykut and Morehouse (2002) were followed. These include i) inductive coding; ii) refinement of categories; iii) exploration of relationships and patterns across categories, and iv) integration of data yielding an understanding of people and the setting being studied. The questions were set out in three different languages; English, Afrikaans

and Sesotho, and the participants could answer them in their home language. A professional translator translated the questionnaires initially, as well as the answers when data collection was complete. In cases where a language other than English was used, forward and backward translations were utilised.

Sampling and Recruitment

This study used identical samples (Plano Clark et al., 2008), in which the quantitative and qualitative data were collected from the same participants. Participants were a volunteer sample of 50 South African, adult (18 years and older) women residing in the Gauteng Province. Participants were recruited in a targeted social media campaign (Addendum 6) and completed an online survey anonymously. Women were included if they experienced a sexual assault more than three months prior, disclosed the trauma and received some form of trauma counselling or debriefing, and felt that they could contribute to the study. Potential participants were excluded if the assault did not occur in adulthood (younger than 18 years of age), and if they were involved in a criminal trial during data collection.

Sample description

In the total sample ($n=50$) descriptive statistics indicated that women ranged in age from 18 to 60 at the time of the survey ($M = 29.5$, $SD = 9.9$). In terms of ethnicity, the sample included Black (68%), White (26%) and (6%) mixed-race women. When asked about relationship status, 42% were in a relationship, 40% were single, 10% were married, 4% were separated, and 4% were divorced. Overall, the sample was well-educated (58% completed Standard 10 to Matric and 42% finished post-graduate studies). The sample experienced high levels of trauma, with 64% experiencing more than one assault, varying from twice (18%), three times (18%), unsure of how many times but more than once (12%), more than four times (10%), and four times (6%). The time

since the last assault was categorised as less than a year (37.5%), between 1-3 years (14.5%), to more than 3 years (48%). In this sample, 72% of the participants knew the perpetrator with the relationship varying in closeness (19.2% partner, 17% friend, 6.4% family or 21.3% acquaintance). Only 40.7% of the participants reported the assault to the police; of these, 26.5% found the police unhelpful, and 14.2% saw them as helpful. Whereas 26% of participants did not disclose the assault, 54% disclosed to a person they trusted (friend, family member, partner) and 20% told a professional first (psychologist, counsellor). Although 36% of participants reported that they did not receive support due to non-disclosure, other sources of support included informal support (friends, family, and church) (34%) and formal support (NGOs and therapists) (30%). In terms of help-seeking behaviour, 54% of participants went for therapy. The time they waited to attend therapy ranged from a month to after more than 5 years. Sites of delivery included free services (NGOs, church, government services) (28%) and private psychologists (12%) and numerous providers (8%) and (6%) unspecified. Duration of therapy ranged from brief (1-2 months) (24%) to long-term (few months to a few years) (20%) therapy. Therapy was deemed very helpful by 32%, somewhat helpful by 14%, and not at all helpful by 8% of the participants.

Data Collection

Quantitative and qualitative data were collected simultaneously via a secure online survey that could be accessed via a website developed for the study. This survey included validated psychometric measures and open-ended questions. A description of each is outlined below.

PTSD. Posttraumatic stress symptoms experienced within the last month in line with the diagnostic criteria in the DSM-5 were assessed with the clinician rating scale for PTSD (PCL-5) (Weathers et al., 2013). The 20 items evaluate four subscales: re-experiencing,

avoidance, negative alterations in cognition and mood, and hyper-arousal. All items start by asking, “In the past month, how much were you bothered by...”, and some examples of completed questions are “...repeated, disturbing dreams of the stressful experience?”, “...feeling very upset when something reminded you of the stressful experience?”, “...blaming yourself or someone else for the stressful experience or what happened after it?” and “...having difficulty concentrating?”. This questionnaire has shown good reliability within South African studies ($\alpha = 0.95$) (Makhubela, 2018) ($\alpha = 0.97$) (Kagee et al., 2022). The cut-off score indicating a PTSD diagnosis for this scale is 33 (Bovin et al., 2016).

Mental Well-being. The MHC-SF consists of 14 items rated on a 5-point Likert scale ranging from 0 (never) to 5 (every day). Participants were asked to rate how often each of the descriptions, such as "engaged in life," "that people are generally decent," and "confident to think or express your views and opinions," they experienced during the preceding month. The items encompass three sub-scales, namely emotional well-being, PWB, and social well-being. Individuals displaying positive mental health on the scale are described as “flourishing”, individuals experiencing poor mental health are described as “languishing” and individuals in the middle of the spectrum have moderate mental health. The MHC-SF has demonstrated excellent internal consistency (> 0.80) and discriminant validity among countries such as the USA, the Netherlands, and South Africa (Keyes, 2005, 2007, 2009b; Lamers et al., 2011).

Resilience. The ARM is a 5-point Likert-type scale (1 = not at all; 5 = a lot) self-report 28-item measure of resilience-promoting resources and is based on a socioecological framework of resilience (Resilience Research Centre, 2018). Higher scores indicate more resilience-enabling resources and, thus, greater potential for resilience. The ARM consists of eight clusters which represent three subscales of resilience resources; individual capabilities (personal skills, peer support, and social skills clusters),

relationships with important individuals (physical and psychological caregiving clusters), and contextual factors that promote a sense of belonging (spiritual, educational, and cultural clusters). In a South African study conducted by Bemath et al. (2020), the internal consistency reliability of the total RRC-ARM was $\alpha = 0,88$, and for the subscales, individual resources = 0.79, relational resources = 0.83, contextual resources = 0,62.

PTGI. The PTGI is a 21-item measure of positive life changes after trauma. The items are rated on a 5-point Likert scale ranging from 0 (I did not experience this change) to 5 (I experienced this change to a great degree). The PTGI yields a total score as well as five subscale scores. The 21 items were summed to assess the extent of PTG. The subscale scores include new possibilities, relating to others, personal strength (4 items) spiritual change (2 items) and appreciation of life (3 items). The PTGI has shown good reliability in previous South African studies of trauma survivors, with a total Cronbach's alpha ranging from 0.95 (Walker-Williams, 2012) to 0.76 (Mason, 2019).

Qualitative measure. The open-ended questions included in the online survey questions focused on the participants' recovery journey. Questions highlighted barriers inhibiting participants from accessing therapy, their therapeutic experiences, how they coped with the assault, and how the assault affected their views of themselves and others. Additionally, participants were asked if they had any advice for professionals and other survivors on the road to recovery.

Data Analysis

The quantitative and qualitative data were collected simultaneously and both data sets were analysed separately. The quantitative data analysis included descriptive statistics, reliability coefficients and correlations (reported in detail in Manuscript 2). Although the initial sample size was N=70, a large portion of the surveys needed to be excluded from analysis since the assault reported by the participant occurred before the age of 18 and

therefore, they did not meet the inclusion criteria for the study (N=20). Therefore, in total, 50 survey responses were analysed in the convergent mixed-method study. The participant data were divided into high and low-scoring groups based on their PCL-5 scores. This article reports on a comparison of the themes found in the qualitative data in the highest (*FSR group, N=20*) and lowest (*SSR group, N=20*) scoring groups in the data set. Only two participants in each group appeared to be outliers that either scored high or low on all the measures. As reported elsewhere (Manuscript 2), the threshold for a potential PTSD diagnosis had to be adjusted to 41.25 for this sample due to the 1–5 scale that was used in the study. With a standard deviation of 19.50 and a range of 46.81 to 85.81 for roughly 68% of the participants, the PCL-5 overall mean was calculated to be 66.31, which is significantly higher than the suggested threshold and suggests a highly symptomatic population.

Comparison Analysis

For the qualitative data, participant answers were coded using constant comparative analysis (Glaser, 1965). Initially, the whole data set was coded to look at themes within the categories applicable to all the survivors. Thereafter, the two groups were analysed separately, and the data were compared. This involved four stages, namely inductive coding, category refinement, exploration of relationships and patterns, and data integration (Maykut & Morehouse, 2002). In Stage 1, initial themes were identified, and provisional codes were assigned. In Stage 2, categories were refined by establishing specific inclusion and exclusion criteria and grouping similar themes. These stages were completed by the researcher and an independent coder and were reviewed by a second co-coder (study supervisor). Finally, the data was reviewed to ensure meaningful units were correctly assigned to their respective category. Themes that were similar across

groups and divergent themes were noted to compare narratives between the two groups. The themes and quotes that offer explanations for the differences are outlined below.

RESULTS

The following section provides the qualitative results of the study. The qualitative findings of survivors’ recovery experiences were made by comparing the themes evident in both SSR and FSR groups. Throughout our discussion of the qualitative themes, we have reported on interesting scoring profiles where relevant, to explain peculiar findings.

Qualitative Themes

Four main factors played a significant role in the participant’s recovery journey. These were i) accessibility of support; ii) therapeutic experiences; iii) actions taken in recovery efforts, and iv) changes in cognitions that occurred after the assault. Each theme is described below, with a table outlining quotes from each group. A comparison of the responses of both groups is offered for each theme.

Accessing support

Participants noted several factors that influenced their willingness and ability to access psychotherapy. These factors included apprehension and distrust of self and others, lack of resources and the informal support that was at their disposal. Quotes from each subtheme are outlined in the table below, followed by a comparison between the two groups.

Table 9: Quotes related to accessing support with SSR and FSR group

Apprehension and distrust of self and others as a barrier to accessing mental health services	
SSR group	<p><i>The hospital not having female psychologist for rape victims. Always finding male psychologists in the public hospitals made it difficult for me to open up about the assault [P7]</i></p> <p><i>“I stayed quiet for years because people always saw me as a liar. I was able to accept help recently from people that I trust.” (P48)</i></p>

FSR group	<p><i>"I feared talking about it after the negative response from those I have already told." (P38)</i></p> <p><i>"I was angry at myself for getting myself into that position," (P26)</i></p> <p><i>"I felt embarrassed, dirty and I'm a private person. I felt like I was going to be speaking to someone who doesn't understand." (P37)</i></p>
Lack of resources as a barrier to accessing mental health services	
FSR group	<p><i>I don't have money to pay for therapy [P18]</i></p> <p><i>I was ready but I am still on a waiting list [P36]</i></p> <p><i>The therapist that I am comfortable is 70km away from me [P47]</i></p> <p><i>I can access it but I think I am ok [P50]</i></p>

Both groups noted that shame and fear were barriers to accessing therapy and they both had experienced not being believed when they disclosed, which led them to distrust the process (SSR; 38%, FSR; 50%). The participant in the SSR group that reported a negative reaction to her disclosure, reported that she was eventually able to find people that supported and accepted her. This support led to scores above the sample mean in resilience, PTG and mental health. There were two participants that reported negative responses to disclosure in the FSR group. Similar to the SSR participant, she highlighted a negative response from the first person she told, however, she did not report subsequent support and scored high on resilience and PTG but not on mental health. The second participant in the FSR group wrote about a fear of repeated negative responses, she scored low on resilience and mental health but scored above the sample mean for PTG. Participants in both groups reported that they found it difficult to open up due to factors associated with the services they could access. These included not trusting the therapist due to their gender (male) and proximity to the perpetrator. Participants in the FSR group denoted that they were not ready to face what had happened and displayed strong feelings of self-blame that were not as evident in the SSR group. Interestingly, two participants in the SSR group stated that they simply did not think of going to therapy.

When considering their scoring profiles, one of them scored high on resilience whereas the other did not.

Regarding the lack of resources, participants from both groups highlighted financial constraints, however, this appeared to be more relevant to the FSR group participants (SSR; 6% FSR; 25%). Only one participant in the FSR group reported that she was still on a waiting list for a therapist. This participant scored above the mean for resilience and PTG but below the mean for mental health. More participants in the SSR group reported that they did not have difficulties with accessing services than those in the FSR group (SSR; 38% FSR 24%). Another participant in the FSR group reported that she could access psychotherapy but that she did not think she needed it [P50]. Upon exploration of her quantitative scores, it became apparent that she scored above the mean on PTSD, resilience, PTG and PWB. This participant was a 45-year-old Black woman. The assault included physical scarring that reminds her of what happened, and she had a negative experience with mental health services and police when reporting her assault. The police refused to open a case and her therapist did not follow up with her. Despite this, she still advised younger survivors to go to counselling, since it helped her to know that she was not alone. She reported a strong support network that could explain her high scores on the strengths-based variables. Accessing mental health services was therefore highly influenced by an interplay between having access to the necessary resources and overcoming personal apprehension in this sample. Thus, the availability of resources and the amount of stigma a person experiences are influenced by their informal support network to a large extent.

Informal support

Next, we looked at the differences in informal support between the two groups. There was a marginal difference between disclosure rates between the two groups (SSR; N=2

FSR; N=6). However, three participants in the FSR group stated that they had no support despite disclosure. Informal supporters provided both emotional validation and reassurance and active support. These themes related to informal support and their related quotes are outlined in the table below.

Table 10: Quotes related to informal support in SSR and FSR groups

Emotional validation and reassurance by informal supporters	
SSR group	<p><i>My sister made sure I stayed calm and try to seek counselling [P8]</i></p> <p><i>My friends and family always gave me the space to be upset and talk, they are remarkably patient with me and so loving I truly am so blessed [P4]</i></p> <p><i>Very understanding about my emotions [P21]</i></p> <p><i>Helping me deal with my emotions when I'm not in therapy. [P7]</i></p>
FSR group	<p><i>Friends and family let me know that whatever I decide they'll support me [P9]</i></p> <p><i>Friends and family were constantly by my side and dealt with every trauma I had [P38]</i></p> <p><i>Every day they call and come to my place and my kids they are supportive even if this is hard for them [P50]</i></p>
Providing active support as a vehicle for recovery	
SSR group	<p><i>Going to therapy with me. Knowing and limiting inviting me to places that trigger me. [P4]</i></p> <p><i>Prayed with me. [P19]</i></p> <p><i>They offered to take me to therapy [P12]</i></p>
FSR group	<p><i>Checking with police if the case has gone through and sitting down and reassuring me [P11]</i></p>

Participants in both groups reported the availability of emotional reassurance (SSR; N=6 FSR N=5) and instrumental support (SSR; N=5 FSR N=4) that facilitated their recovery. However, there was a stronger tendency in the SSR group to have friends and family members that took an active role in encouraging them to seek counselling and actively cope with their emotions.

Experiences in counselling

Attending counselling appeared to have a significant impact on the participants in this study. In terms of attendance, 31.2% of the participants in the SSR group attended counselling compared to 5% of the participants in the FSR group. The participants that

attended counselling highlighted both positive and negative experiences. However, the participants from the SSR group reported more positive experiences related to counselling. The table below outlines the different subthemes and quotes for this theme.

Table 11: Quotes related to experiences in counselling reported in SSR and FSR groups

Empowering survivors with skills	
SSR group	<p><i>I was held accountable for not allowing my feelings to consume me [P4]</i></p> <p><i>Getting advice on how to deal with my emotions after the assaults helped [P7]</i></p> <p><i>Give out tips about self-care [P15]</i></p> <p><i>DBT was one of the most valuable skills for me since it helped me recognise my emotions and manage them in a healthier manner. EMDR helped a lot with the flashbacks. Helped me feel less isolated [P13]</i></p>
Therapist provided a safe space that aided in destigmatising survivor	
SSR group	<p><i>Safe space, without judgement or pity [P17]</i></p> <p><i>Patience, understanding of guilt feelings even if irrational [P17]</i></p> <p><i>Be gentle. And please don't give up on victims if they don't open up or not want to talk during the first session. It's difficult to know whom to trust or not and at times we need to be comfortable with your presence to be able to trust and talk to you. [P7]</i></p> <p><i>To always be patient and try to understand the sexual assault survivors because it is not easy for them to tell their story. [P8]</i></p> <p><i>They must let you cry to keep out the anger [P34]</i></p> <p><i>Healing start with letting out all your anger and pain. [P8]</i></p> <p><i>Talk about it even if it's extremely hard and never feel ashamed [P21]</i></p> <p><i>Not to speak over survivors - allow them to fully express all negative emotions before exploring the rationality of those emotions [P12]</i></p>
FSR group	<p><i>Be gentle – For me it was something serious that still has a physical and emotional impact on me today. Sometimes unknowingly words hurt more than it heals us. [P45]</i></p> <p><i>Have patience [P9]</i></p> <p><i>Be easy on survivors and give them some time. Just be patient with us. It is already very hard trying to talk about it [P11]</i></p> <p><i>That they should be patient with us and again let them not try to force us to talk when we not ready [P42]</i></p> <p><i>They should understand that opening up is not easy [P2]</i></p> <p><i>Also, please exercise patience to your victims. Especially for those who are denying what has happened to them [P32]</i></p>
Therapist helped with reframing the experience and normalising survivor reactions	

SSR group	<p><i>Therapy led to acceptance that it was not my fault [P19]</i></p> <p><i>Try to coach them to let go of any and all shame because none of it is inherently theirs to hold onto. [P4]</i></p> <p><i>Validating the experience is the most helpful thing and helps so much with the self-doubt and guilt and self-blame. It's hard enough losing trust in other people, never mind completely losing trust in myself so reinforcing any trust I have in myself helps ground me. Having a professional tell me it wasn't my fault, especially despite the number of occurrences was my lifetime [P13]</i></p>
FSR group	<p><i>She helped me understand that I did things to please people and now I should be looking out for me [P26]</i></p> <p><i>Yes, clarity because I blamed nobody but me [P14]</i></p> <p><i>I realised that I am insecure. I look for the love I was robbed of from people who actually don't care about me. [P43]</i></p>
Unhelpful therapeutic experiences related to therapist being ineffective or harmful	
SSR group	<p><i>Some issues were made about the assault which I didn't feel was accurate [P17]</i></p> <p><i>"Yes the therapist became the client and I the therapist [P33]</i></p> <p><i>Never say "I know how you feel" or "I can imagine how you feel" [P21]</i></p> <p><i>Do not be patronising or say it will get easier [P33]</i></p> <p><i>My first therapist tried to work through the traumatic events via talk therapy which resulted in a massive breakdown involving weeks of isolation and self-harm with no support structure in place. I saw a couple's therapist with a partner for help since I was having panic attacks during intimacy - his solution was that I should just let my partner "fuck me with the lights off". That was incredibly invalidating and the guilt I felt around the panic attacks worsened and I spiralled. [P13]</i></p>
FSR group	<p><i>They kept mentioning I should move on, but I always asked how [P26].</i></p> <p><i>Dive deeper into the survivors' emotions they're struggling to control that, emotions are overwhelming [P26]</i></p> <p><i>Nothing at all apart from the looks of pity from support staff at the offices there. I guess they knew why the clients that came there are for what type of abuse [P32]</i></p> <p><i>Counsellors should have the emotional intelligence to not bring your issues to your cases. You're dealing with people not numbers. fact that it's just quota for you and not really about the healing of the victim [P32]</i></p> <p><i>She made me felt as if it was my fault. [p45]</i></p> <p><i>I felt like I didn't open up too much to the therapist I keep some of the things [P42].</i></p>

The importance of providing access to resources to help survivors understand their symptoms and teaching specific skills to help survivors cope with their emotions was highlighted by several participants (SSR; N=10). Some (N=5) participants in the SSR

group felt empowered by the skills they learned in therapy centred around emotional regulation and self-care. Only one participant in the SSR group found therapy ineffective because she felt that the therapist did not display accurate empathic understanding. Interestingly, two participants in the SSR group warned therapists against using patronising statements that could lead to emotional invalidation. Another participant in the SSR group [P33] and one participant in the FSR group [P32] felt that the therapist did not have appropriate boundaries, in the sense that they brought their problems into the therapy session. The participant in the SSR group [P33] had a mental health training background as a social worker that could have offered a buffering effect against this experience. In addition to reporting poor boundaries on the part of the therapist, the participant in the FSR group [P32] reported that she felt pity at the crisis centre by support staff and that she was not taken seriously and treated as part of a meeting a quota. This participant's quantitative scores show elevations above the mean for all the measures. She is a mixed-race 31-year-old female that reported enduring a court case to prosecute her perpetrator. She received counselling from an NGO as well as a private therapist. She reported that she was being patient with herself in the healing journey and still slept with the lights on. She stated that her father was a significant support to her during the proceedings and claimed that she found that she was able to take her power back by owning the case. These factors could explain her high scores on the strengths-based variables.

An SSR participant's [P13] statement illustrates the importance of containment and appropriate assessment in the treatment of sexual assault survivors. Upon exploration of this participant's scores, it became evident that she scored below the mean for all the measures indicating that although she had low PTSD, she also showed low levels of the strengths-based factors. She is a 24-year-old White woman who experienced multiple

sexual assaults during adulthood by different perpetrators including one that she was in a long-term romantic relationship with. She attended psychotherapy for multiple years and reported symptoms indicative of borderline personality disorder (history of self-harming, suicidality, binge drinking, and manipulative behaviours). She reported invalidating experiences in therapy but that she eventually found that dialectical behaviour therapy was most effective for her.

Participants in both groups reported on the importance of therapist characteristics that provided a safe space and aided in alleviating feelings of stigmatisation. Both groups reported on the importance of patience and being non-judgemental on the part of the therapist to facilitate building a connection (SSR; N=3, FSR; N=5). Participants in the SSR group explained that it takes time for a survivor to tell their stories and that they should be given the space to do so. Another helpful aspect of therapy highlighted in both groups was the opportunity to reframe the experience and normalise the survivor's reactions. Whereas the participants in the FSR group reported they learned more about themselves, three participants in the SSR group reported that therapy enabled them to let go of shame and self-blame.

Whilst most of the participants in the SSR group emphasised the importance of emotional expression, contradicting narratives related to this theme were evident in the FSR group. For example, one participant in the FSR group stated that; "counsellors should not try to force us to talk when we are not ready" [P42] and the other stated; "dive deeper into the survivor's emotions, they're struggling to control that, emotions are overwhelming [P26]. The five participants in the FSR group that felt therapy was ineffective, stated that therapists did not offer enough psychoeducation and did not equip them with skills to manage their emotions. This indicates that they may not be advocating for emotional expression because they still experienced their emotions as too

overwhelming to confront. Concerning this theme, several participants wrote about how the assault affected their view of themselves and others.

Changes in view of self and others

An increase in negative perceptions of themselves and others after the assault were noted by several participants. These included lower self-esteem, mistrust of others and a higher likelihood of engaging in avoidance behaviours. The table below outlines these themes and their related quotes in each group.

Table 12: Changes in view of self and others

Stronger feelings related to how survivors view themselves.	
SSR group	<i>For a very long time I've been insecure about my body. [P7]</i> <i>I don't feel good about myself anymore. Especially the way that I look. People can tell me I am beautiful, but I don't just accept it. [P48]</i>
FSR group	<i>I hate myself [P10]</i> <i>Yes, I no longer feel like a woman [P26]</i>
Mistrust and environmental mastery	
SSR group	<i>I tend to conduct my life as if everybody is a bad person until proven otherwise when even though I know and understand it's the other way around. [P4]</i> <i>I hardly trust strangers/new people in my life [P7]</i> <i>Yes, because I feel like everyone is capable of assaulting someone and I have fear that history might repeat itself [P15]</i>
FSR group	No quotes related to this theme
Increased scepticism of men	
SSR group	<i>Trust in men will never be the same. I get a weird feeling about some men- may be wrong but the feeling hasn't been wrong in keeping me safe. A sixth sense if you will, I know in a way if someone is capable of abuse, silly as it may seem. [P17]</i> <i>I have a negative view of men. There is only a handful that I trust. [P48]</i>
FSR group	<i>I find myself behaving differently around males and I feel as if all I am good for is sex rather than looking at the awesome person I used to be and still can be [P43]</i> <i>I despise men [P26]</i>
Engaging in avoidance behaviours	
SSR group	<i>At first very toxic ways, I drank heavily and used marijuana and the occasional stronger drug. [P17]</i>
FSR group	<i>I didn't speak about it much, I didn't want to think about it, so I just distracted myself and acted as if nothing happened [P37]</i>

	<i>I deleted some of my social media platform [P25]</i> <i>I isolated myself [P14]</i> <i>Nothing. I moved on with my life [P38]</i> <i>Drank and smoked weed (cannabis) [P26]</i>
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Participants in both groups reported negative changes in their body image following the assault (SSR N=2; FSR N=3). Interestingly, no statements in the FSR group directly indicated that the participants developed general mistrust of others. In contrast, three of the participants in the SSR group reported a general distrust of others. This reported distrust appeared to be accompanied by a need for mastery in interpersonal relations instead of powerlessness. Both groups reported significant scepticism in their view of men (SSR: N=4; FSR: N=4). Whereas the participants in the FSR group gave statements indicating a generalised view of all men being bad, the SSR participants could trust specific men who hadn't harmed them. This contrast indicates that a part of recovery is to be able to take action to distinguish between safe and unsafe men. More avoidance behaviours were reported in the FSR group than in the SSR group (SSR N=2; FSR N=5). This included denial, substance use and self-isolation. As their views of themselves and others changed, there was a strong contrast between the actions that the SSR group and the FSR group took on their recovery journey.

Aspects of resilience

Considering their own experience, participants from both groups gave recommendations to other survivors for their road to recovery, indicating aspects of resilience and PTG. Under this theme, the researchers looked at actions indicative of resilient coping in both groups. These included activities that helped with emotional regulation, interpersonal support, and therapy. The table below outlines these themes and their related quotes.

Table 13: Quotes related to resilience reported in SSR and FSR group

Engaging in activities to help cope with the feelings associated with the assault	
SSR group	<p><i>Trying different hobbies until I found the one that helped me keep calm [P7]</i></p> <p><i>I was active in sports [P34]</i></p> <p><i>I confided in God [P8]</i></p> <p><i>I prayed to God to help me heal [P49]</i></p>
Engaging in interpersonal support	
SSR group	<p><i>Helping others [P4]</i></p> <p><i>Always try to help others who have been through the worst. [P8]</i></p> <p><i>Talked about the rape to my family [P19]</i></p> <p><i>At least have someone to talk to [P29]</i></p> <p><i>Being around people that cared and loved me [P21]</i></p> <p><i>Went for my sessions with my social worker. [P8]</i></p> <p><i>Don't hide when you are in pain [P38]</i></p>
FSR group	<p><i>I am going to look for help because I realise now that it has affected me in more ways than one [P43]</i></p> <p><i>Tell someone you know will listen and help you, just talk [P26]</i></p>
Engaging in therapy	
SSR group	<p><i>You need therapy, whether you think your sexual assault is not that bad or you don't want to deal with it because of other things in your life [P7]</i></p> <p><i>Accepting, and know that you are not alone, there is help for healing. [P19]</i></p> <p><i>Make sure you go for counselling and if you can't talk about it write in your diary so that social worker can read and understand your pain. [P49]</i></p> <p><i>Go to the hospital. Keep talking until someone believes you and [P33]</i></p>

The SSR group reported more resilience-related behaviours than the FSR group. Activities that enabled them to cope with their emotional reactions included engaging in different hobbies, praying, and accessing different support networks. Some participants in the SSR group were able to share their stories with people they trusted and helped other survivors. Some (N=4) of the SSR participants highlighted the importance of therapy for survivors and one participant encouraged survivors to write about it if talking was too difficult. Only two participants in the FSR group reported that they saw the importance of seeking support and one indicated her intention of doing so in the future. By engaging in

resilience-enabling practices, several participants were able to report experiencing some aspects of PTG.

Aspects of PTG

Several participants in both groups highlighted changes in the way they saw themselves after the assault that was indicative of PTG. Themes related to this were that the assault did not define them and empowering self-talk. The table below outlines these themes and their related quotes.

Table 14: Quotes related to PTG reported in SSR and FSR group

The assault does not define you	
SSR group	<p><i>You are not your assault it was an awful thing that happened to you, but it does not have to become you [P4]</i></p> <p><i>You need therapy to get the trauma out of your body before the trauma becomes your new norm [P7]</i></p> <p><i>Don't turn towards substances to try and torture yourself. You did not deserve this nor bring it on yourself. [P17]</i></p>
FSR group	<p><i>Don't blame yourself. Forgive yourself. Understand that you are not responsible for their actions and love yourself enough not to let people hurt you like that again [P43]</i></p> <p><i>I found my strength in talking about it and I took my power back from the perpetrator by owning my rape case. And I made it a part of my past and not something that defines me [P32]</i></p>
Empowering thoughts and self-talk	
SSR group	<p><i>Overcoming this helped me regain my self-confidence [P8]</i></p> <p><i>Most importantly as tough as it as soon as you are ready don't shackle yourself you can't and don't have to live your life tip toeing around something as fragile as a penis. [P4]</i></p> <p><i>Lastly through it all just remember you between the two of you your perpetrator is the weak one not you don't allow yourself to be broken by somebody so weak. [P4]</i></p> <p><i>They must think like winners. They are not a victim anymore. Trust fully in God. They do not have to fear anything or anyone if they trust in God. [P48]</i></p>
FSR group	<p><i>Be you no matter how hard it is to be you, take accountability and find resolutions for those in the future. [P14]</i></p>

Most participants highlighted that the survivor is not defined by their assault and noted several empowering mindsets that help during recovery. These included having a survivor

mentality or narrative, putting the assault in perspective, and trusting God. Positively, two participants in the SSR group highlighted the importance of taking a broader view in not letting the assault define them. Closely related to this were the responses from a participant from the SSR and FSR groups that highlighted the importance of self-forgiveness. Another two participants in the SSR group embraced a narrative that focuses on taking on empowering narratives that enabled them to take on the future with courage. This mindset was rooted in their ability to find their strength in overcoming the experience. This theme highlighted the importance of seeing the perpetrator as the weak one and not buying into the victim's narrative. Only one participant from the FSR group highlighted the importance of taking responsibility for change. Her PTG score was above the sample mean and her resilience and PWB scores were just below the sample mean. She experienced three assaults during adulthood and had received only one therapy session thus far. This could indicate that she has been able to make sense of the experience to some extent but could benefit from counselling.

Outliers Within the Groups

Dividing the data into three groups and analysing the high and low groups resulted in two participants in the FSR group and three participants in the SSR group being included which appeared to be outliers. In the SSR group, these participants scored above the sample mean on all the variables (PTSD, PTG, resilience and PWB). In the FSR group, these participants scored below the mean on all the measures. Where relevant, the quotes by these participants are contextualised above. These participants had several demographic variables in common. All three participants in the SSR group that scored below the mean for all the measures reported a history of multiple sexual assaults by acquaintances. These women delayed attending psychotherapy and one of them did not attend at all; two of them engaged in self-destructive coping and all three reported

external locus of control. These symptoms may indicate the presence of complex PTSD in these participants.

The two participants in the FSR group that scored above the mean for all the measures were both Black females who reported multiple assaults that were reported to the police, but only P32's case was prosecuted. Both received counselling from NGOs but P50 only went once, whereas P32 was in counselling for years. Both reported invalidating experiences in therapy where they were not adequately followed up on. They both reported strong support in their informal networks but reported that they were still struggling to heal and recover the identities they had before the assault. Both highlighted the importance of letting your story be heard and accepting what happened.

DISCUSSION

This study reports on the differences between two groups of FSASA. Several commonalities and some differences were evident among the groups. This study offers potentially valuable indications of factors that differentiate survivors who show SSR from ones that are still in the early stages of recovery and/or acutely symptomatic.

Scores on the PCL-5 were elevated for all the participants in this study. As with other studies, avoidance behaviours and trauma-related beliefs surrounding safety and mistrust of others were particularly prominent within this sample (Dunmore et al., 1997, 1999, 2001). In addition, perceived negative responses from others were also prevalent in the sample and harmed their PWB (Campbell et al., 2001; Littleton, 2010). Consistent with previous studies, apprehension, distrust, and self-blame were noted as barriers to seeking mental health services and garnering informal support (Sigurvinsdottir & Ullman, 2015). The findings of this study indicated factors that could facilitate the process of accessing mental health services. In line with Christofides et al. (2006), participants valued having a sensitive healthcare provider that could offer counselling. However,

resource constraints reported by the participants are indicative of the gaps in mental health service delivery that are still prevalent in South Africa (Leibbrandt et al., 2010; Marais & Petersen, 2015; Petersen & Lund, 2011).

In terms of therapeutic interventions, survivors benefited more from courageous therapists that could offer a safe space where clients could express their emotions fully and help them address cognitions related to self-blame. The most effective therapists took an active role in offering skills and resources that equipped survivors to regulate their emotions and process the trauma they endured. The therapeutic skills and characteristics that are crucial for successful therapy with this population are in line with those reported in other studies (Van Rooyen, 2018).

Resilience-enabling actions highlighted in the findings of this study, such as reaching out to others, engaging in therapy, and expressing emotions, echo previous findings. Kirkner et al. (2021) found that survivors encouraged each other to talk about their trauma and reach out to others whom they trust and feel comfortable with. Whereas women in both groups experienced negative reactions, only participants in the FSR group experienced unsupportive acknowledgement from informal supporters. This finding coincides with Relyea and Ullman (2015) that found that negative reactions were associated with increased self-blame and social withdrawal, whereas unsupportive acknowledgement led to maladaptive coping. Findings from this study indicate that survivors benefitted from informal supporters that offer emotional reassurance and instrumental support. However, active support that facilitates access to mental health services and that encourages survivors to actively engage in the recovery process instead of facilitating avoidance appears to be more impactful. Outliers in this sample that scored above or below the mean on all measures indicate that experiencing multiple sexual assaults can affect whether survivors experience strengths-related variables. The effect

of invalidating experiences in therapy may have lasting effects on survivors' PTSD scores despite strong informal support.

Indicators of PTG in this sample were closely related to themes reported in other studies. The theme “the assault does not define you” is closely related to the personal strength domain in the PTGI that has been reported in other sexual assault survivor studies (Burt & Katz, 1987; Draucker et al., 2009; Frazier et al., 2004; Grubaugh & Resick, 2007; Guerette & Caron, 2007; Kleim & Ehlers, 2009). The “engaging in empowering self-talk” theme is closely related to the *appreciation of life domain* of the PTGI also reported in other studies with this population (Hou et al., 2013; Senter & Caldwell, 2002). Participants in this study that were part of the FSR group yet still showed high levels of PTG reported significant support in their informal networks. This finding is explained by other studies that found that sexual assault survivors experienced PTG as a result of deeper connections with their friends and family and advocating for other survivors (Borja et al., 2006; Burt & Katz, 1987; Draucker et al., 2009; Frazier et al., 2001; Frazier et al., 2004; Frazier & Burnett, 1994; Guerette & Caron, 2007; Hou et al., 2013).

LIMITATIONS

Although this study offers potentially valuable indicators, several limitations were noted. Firstly, the small sample size made the data particularly vulnerable to the impact of outliers that influenced the themes reported. Secondly, the participants completed self-report measures. Subjective reporting may not accurately reflect the extent to which these participants experience the variables that were examined in the quantitative section of the study. Although the data collection strategy may have encouraged more survivors to participate in the study, the utilisation of anonymous online surveys prevented follow-up questions. Therefore, many participants gave short responses to the questions and

seeking elaboration for these answers was not possible. This limited the depth of the qualitative data significantly.

RECOMMENDATIONS

A study that investigates survivor experiences through in-depth interviews could offer a clearer understanding of survivor narratives related to the variables investigated in this study. Findings highlighted the importance of social media campaigns aimed at educating the public on sexual assault to diffuse the stigma associated with it. These campaigns may assist in alleviating self-blame as well as enabling more support for survivors in their communities. Findings also indicated the need for clinicians to offer psychoeducation to the members of survivors' informal support network on how they can best support survivors. Organisations must have appropriately trained professionals who maintain proper boundaries, are proficient in skills training and display accurate empathic understanding. Where possible, organisations and professionals working with this population should consider having a female MHP on staff for survivors. MHPs often challenge beliefs surrounding safety and distrust and encourage resilience-enabling activities amongst survivors. The findings of this study highlighted the importance of encouraging the development of post-trauma narratives - namely assisting the survivors to define themselves outside of the sexual assault and encouraging empowering thoughts and self-talk.

The findings presented in this manuscript highlighted the importance of including an assessment of barriers and facilitators to therapy, informal supporter psychoeducation, an outline of essential therapeutic characteristics and skills, an outline of skills that survivors need to be taught and cultivation of existing strengths and constructive post-trauma beliefs into the sexual assault treatment. It is crucial to include these components in strengths-based trauma-informed treatment guidelines.

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SECTION B - PHASE THREE

(Intervention guideline design)

The findings outlined in Manuscripts 1 and 2 will now be used to inform the trauma-informed strengths-based group intervention guideline. The design and outline of this guideline are described in Manuscript 4 below.

MANUSCRIPT 4: DESIGNING A TRAUMA-INFORMED STRENGTHS-BASED GROUP INTERVENTION GUIDELINE FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT.

PREFACE

The manuscript forms part of a larger study, which comprises three phases:

- Phase One – Rapid review (Manuscript 1);
- Phase Two – Convergent mixed-method study quantitative (Manuscript 2);
– Convergent mixed-method study qualitative (Manuscript 3); and
- Phase Three – Intervention guideline design (Manuscript 4).

The following manuscript reports on Research Objective 4: “To synthesise findings from the rapid review and convergent mixed-methods empirical study to inform the development of the trauma-informed strengths-based group intervention guideline for FSASA”. This manuscript outlines the intervention guideline informed by the rapid review (Phase One) and convergent mixed-method empirical study (Phase Two). The following secondary research question drove this part of the study: *What should be included in a trauma-informed strengths-based group intervention guideline for FSASA based on a rapid review and convergent mixed-methods empirical study? (Rapid review and empirical research).*

The guideline in this manuscript will undergo a Delphi evaluation on a postdoctoral level before it will be disseminated to local NGOs. Therefore, this manuscript is not currently meant for publication.

DESIGNING A TRAUMA-INFORMED STRENGTHS-BASED GROUP INTERVENTION GUIDELINE FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT

1 INTRODUCTION

Sexual assault against women is a global public health problem of epidemic proportions, requiring urgent action. Furthermore, South Africa's prevalence rates are high. As such, the South African context appears rife with trauma, and practitioners are in the precarious position of attempting to build and restore their clients' resilience. Current guidelines are focused on acute care (Dworkin & Schumacher, 2018; NACOSA, 2015); and most treatment modalities are predominantly driven by the deficit approach and do not focus on the inherent strengths of survivors. Trauma-informed strengths-based interventions prioritise empowerment and resilience in survivors that can assist in promoting recovery. By using these approaches, MHPs can challenge harmful societal messages and beliefs, promote social justice and equality, and empower survivors to become agents of change in their communities. In turn, longitudinally, this approach may decrease the burden of care on the professionals themselves. Strengths-based interventions encourage survivors to be engaged in counselling as they offer a balanced view wherein the survivors are not only seen as the victim but are and feel empowered as the agent of change in their recovery. Group therapy is advocated for in this guideline given its potential to reduce stigma, its cost-effectiveness in a low-resource context and its ability to act as a vehicle of healing (Callahan et al., 2004; Heard & Walsh, 2021; Lundqvist et al., 2004). In addition, Calhoun and Tedeschi (1999) cite that group settings provide a unique and helpful setting for the development of posttraumatic growth.

These guidelines were formulated to provide MHPs with an understanding of how strengths-based practice can be incorporated into current and trauma-informed interventions for South African FSASA. A strengths-based approach allows MHPs to work

with survivors to move beyond alleviating symptoms and enhancing well-being, including creating buffers against future adversity.

TIC and the strengths-based approach were used to understand how the findings of the studies informed this guideline. An awareness of how the trauma affected the survivors and the resources they used in their recovery was central to this research. Trauma-informed practice highlights how a clinician should approach a survivor to meet their needs for regaining safety and control after an assault. The strengths-based approach expands on how resources can be recognised to sustain change, and the Resilience Portfolio model identifies specific resource domains that should be targeted when building resilience. This resilience model integrates theory and research on resilience, positive psychology, PTG, and coping, providing a more comprehensive understanding of the health and thriving processes in individuals exposed to adversity (Grych et al., 2015). Within this model, several factors contribute to an individual's recovery from a traumatic event. These factors include i) the individual's exposure to violence; ii) the resources and assets available to the individual; iii) their appraisal and coping behaviours, and iv) their overall psychological health (Hamby et al., 2018). The model proposes that an individual's psychological health after exposure to violence is determined by the characteristics of the adversity, the assets, resources available to them, and their behavioural responses. This model enabled the researcher to identify factors that need attention when conducting an intervention aimed at increasing an individual's resilience.

2 IMPORTANT DEFINITIONS

This intervention guideline incorporates a combination of TIC and strengths-based principles. The components of these approaches are defined below.

2.1 Intervention Guideline

Clinical practice guidelines are concise practical documents that outline the most important clinical factors for therapists to consider when treating different psychological disorders or employing specific intervention techniques (Australian Psychological Society, 2013). Accordingly, these documents are formulated by experts in the field and act as a go-to document that outlines the best available research and clinical expertise and takes the client's characteristics, culture and preferences into account, while addressing their needs (APA, 2021).

2.2 Trauma-informed Care

The TIC approach consists of i) trauma awareness; ii) emphasis on safety; iii) opportunities to rebuild control, and iv) a strength-based approach (Guarino et al., 2009; Hopper et al., 2010; Yatchmenoff et al., 2017). There is a clear balance within the TIC between recognising trauma symptoms, keeping the difficulties inherent in the path to recovery in mind, and the strong inclination towards empowering survivors to actively participate in this process by emphasising their strengths.

2.3 The Strengths-based Approach

The strengths-based approach is defined as a wide range of practice principles, ideas, skills, and techniques to promote and draw out patients' resources, as well as environmental resources, to initiate, energise and sustain change (Cummins, Sevel & Pedrick 2012). Strengths-oriented practitioners aid in the process of uncovering their patients' suppressed areas of potential or resilience (Saleeby, 2013) by emphasising the autonomy, assets and goals of the individual client and increasing their overall PWB (Tse, Tsoi, Hamilton, O'Hagan, Shepherd, Slade, Petrakis, 2016). As noted above, this approach focuses on capitalising on the individual's strengths to enable recovery (Biswas-Diener et al., 2011; Clifton & Harter, 2003) by promoting resilience-driven coping

processes for PTG-enabling outcomes (Ai & Park, 2005; Prati & Pietrantonio, 2009). The group therapy context is particularly effective in helping survivors learn coping skills (Meaney-Tavares & Hasking, 2013); providing social support (Yalom & Leszcz, 2020) and challenging myths that perpetuate self-blame (Chivers-Wilson, 2006) that could build resilience and facilitate PTG. Along with these advantages, group therapy is both affordable and time-sensitive (Heard & Walsh, 2021), qualities that are particularly important in resource-constrained contexts such as NGOs.

2.4 Posttraumatic Stress Disorder

PTSD refers to characteristic symptoms following exposure to one or more traumatic events in line with the DSM-5 criteria (American Psychiatric Association, 2013a, 2013b). These can include fear-based re-experiencing and emotional and behavioural symptoms. These symptoms are characterised by intrusion, avoidance, negative alterations in cognition and mood, and marked alterations in arousal and reactivity.

2.5 Psychological Well-being

The culmination of emotional, mental, and social well-being. Also known as the state of flourishing or optimal functioning (Keyes, 2002).

2.6 Resilience

The psychosocial concept of resilience refers to an individual's adaptation and healthy development in the face of life stressors or strains. It encompasses the capacities needed to adapt successfully to significant adversity (Hetherington & Blechman, 2014; Kersting, 2003; Luthar et al., 2000; Masten, 2011).

2.7 Posttraumatic Growth

The experience of significant positive psychological change arising from the struggle with a major life crisis (Calhoun et al., 2000). People who have experienced PTG report

changes in five domains, namely appreciation of life; relating to others; personal strength; new possibilities; and spiritual, existential or philosophical change.

2.8 Group-based Intervention

Group interventions, which are used in healthcare for mental health recovery, behaviour modification, peer support, self-management, and health education, are therapies that are given to groups of people rather than to individuals (Biggs et al., 2020).

3 RATIONALE OF GUIDELINE

The rationale of the guideline is to inform MHPs about trauma-informed strengths-based principles to equip them with an evidence-informed guideline that may direct group interventions aimed at FSASA in South Africa. This guideline aims to provide survivors with an opportunity to learn how to incorporate the sexual assault experience into new self-schemas rather than merely treating the symptoms associated with the traumatic experience (Walker-Williams, 2012). This is accomplished by emphasising the survivor's strengths, which help them perceive themselves as competent and in control of the influence of the assault's repercussions.

4 GUIDELINE OBJECTIVES

The objectives for this guideline were developed in consultation with professionals within non-governmental institutions that offer counselling services to South African FSASA. These objectives include the following:

- Offer professionals guidance on intervention guidelines and outcomes that have appeared to work for FSASA;
- Equip MHPs with knowledge about the dynamics of resilience, PWB, and PTG in this population; and
- Empower MHPs to help survivors identify and harness their strengths and resources

to become more resilient when facing future challenges.

5 SCOPE OF GUIDELINE

This guideline has been written for MHPs for implementation with FSASA above 18 years in a group context. Although a summary is provided of immediate interventions that should be offered to survivors during acute care, this guideline focuses on survivors in a group context that present after the acute phase of the trauma (more than 24 hours after the assault). This intervention guideline highlights factors to assess survivors from a trauma-informed strengths-based perspective in a group context.

The guideline advocates for a group context where survivors are provided a safe space to share their experiences with other women with similar life journeys, develop interpersonal relationships that harness trust and the validation of trauma experiences while being in a context that reduces shame and stigma. According to Walker-Williams and Fouché (2017) the group context in sexual assault recovery serves as the vehicle for recovery as it provides an opportunity for witnessing other survivors' healing journeys which alleviates the stigma, betrayal and powerlessness usually experienced by survivors. Meekums (2000) refers to this "witnessing", as a sense of being benevolently seen, heard and understood in the presence of others.

6 Formulation of Guidelines

The guideline is informed by the stakeholder consultations in Phase One and the findings from the rapid review and empirical study of Phase Two of this study. It draws on the TIC and strengths-based intervention framework in a group context by employing the G4-F (Group 4-focus, formulate, facilitate, and follow-up) principle.

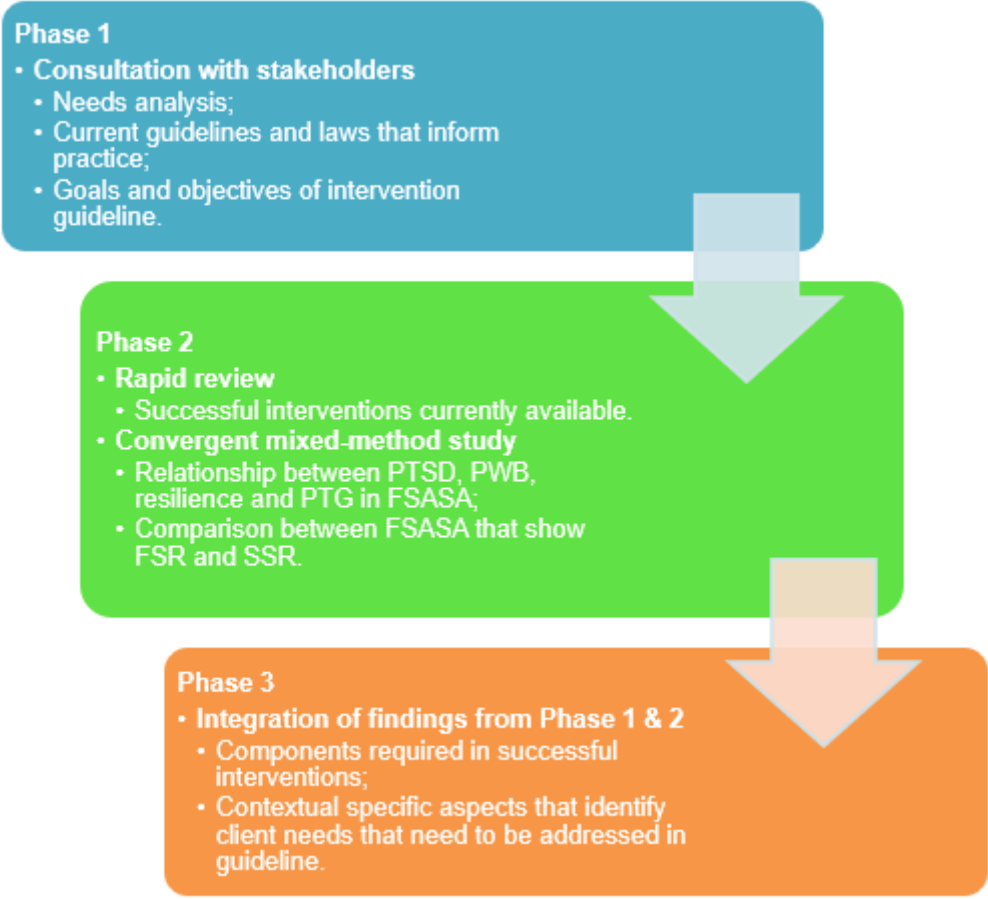
6.1 Process of Guideline Development

This guideline was built with five pillars in mind. These pillars are:

- Practice wisdom from experts in the field of sexual assault, including input from project managers and directors that work at NGOs which provide counselling services to sexual assault survivors;
- A rapid review synthesising the scientific literature that outlines evidence-based practice with survivors;
- An empirical study in the form of a convergent mixed-method study that investigated the experience of a sample of South African FSASA;
- Legislative and ethical considerations as outlined in existing guidelines used by local NGOs; and
- The trauma-informed strengths-based theoretical framework.

The first three phases of the D&D Model proposed for intervention design by Thomas and Rothman (1994) were used to guide the formulation of these guidelines. These phases include i) problem analysis and project planning; ii) information gathering and synthesis, and iii) design. These three phases are outlined in the figure below and are described thereafter.

Figure 7: Guideline development



6.1.1 Consultation with stakeholders

In the first phase, the researcher consulted with professionals that work within non-governmental institutions that provide counselling interventions for sexual assault survivors. During these consultations, the population's concerns were identified and analysed in order to set goals and objectives for the guideline. These consultations provided information on the professionals' context, barriers to service provision and the policies that currently inform their practice.

At the onset, stakeholders shared procedures that are followed when a survivor reports a sexual assault as outlined in standard policies and guidelines written by different departments of the South African Government. During these consultations, it became apparent that survivors that require intervention beyond acute care are referred for longer-

term counselling and support at non-governmental institutions. The organisations interviewed offer counselling services focusing on victim empowerment for individuals who have experienced GBV. However, there were main barriers to services which were highlighted during stakeholder consultations. Firstly, due to financial constraints, most of these organisations are often understaffed and do not have psychologists on staff in positions where they offer services directly to clients. Social workers, registered counsellors and auxiliary social workers offer to counsel survivors but are not always sufficiently trained to offer extensive psychosocial interventions and thus focus predominantly on psychological first aid. Secondly, many clients experience financial constraints that prevent them from attending follow-up sessions, and therefore disruptions of services are a frequent occurrence that impacts recovery rates. From these consultations, a strong need for building staff capacity, developing brief interventions and offering counselling to limit the need for follow-up sessions was identified.

The second phase in developing the guidelines consisted of information gathering and synthesis. This phase included a rapid review and convergent mixed-method study to develop this guideline. The objectives of this phase were to i) explore the current evidence-based interventions available to sexual assault survivors in South Africa and ii) gain a clearer understanding of how strengths-based variables present themselves within this population.

7 RAPID REVIEW OF EXISTING EVIDENCE-BASED INTERVENTIONS FOR FSASA

A comprehensive understanding of the components included in existing evidence-based interventions guided the components included in the intervention guideline. This understanding was informed by a rapid review that focused on English journal articles outlining evidence-based sexual assault interventions aimed at female adults that were published between 2012 and 2022. The rapid review informed the researchers about the

available interventions, the outcomes they measured, their limitations and the common aspects involved in successful interventions for this population.

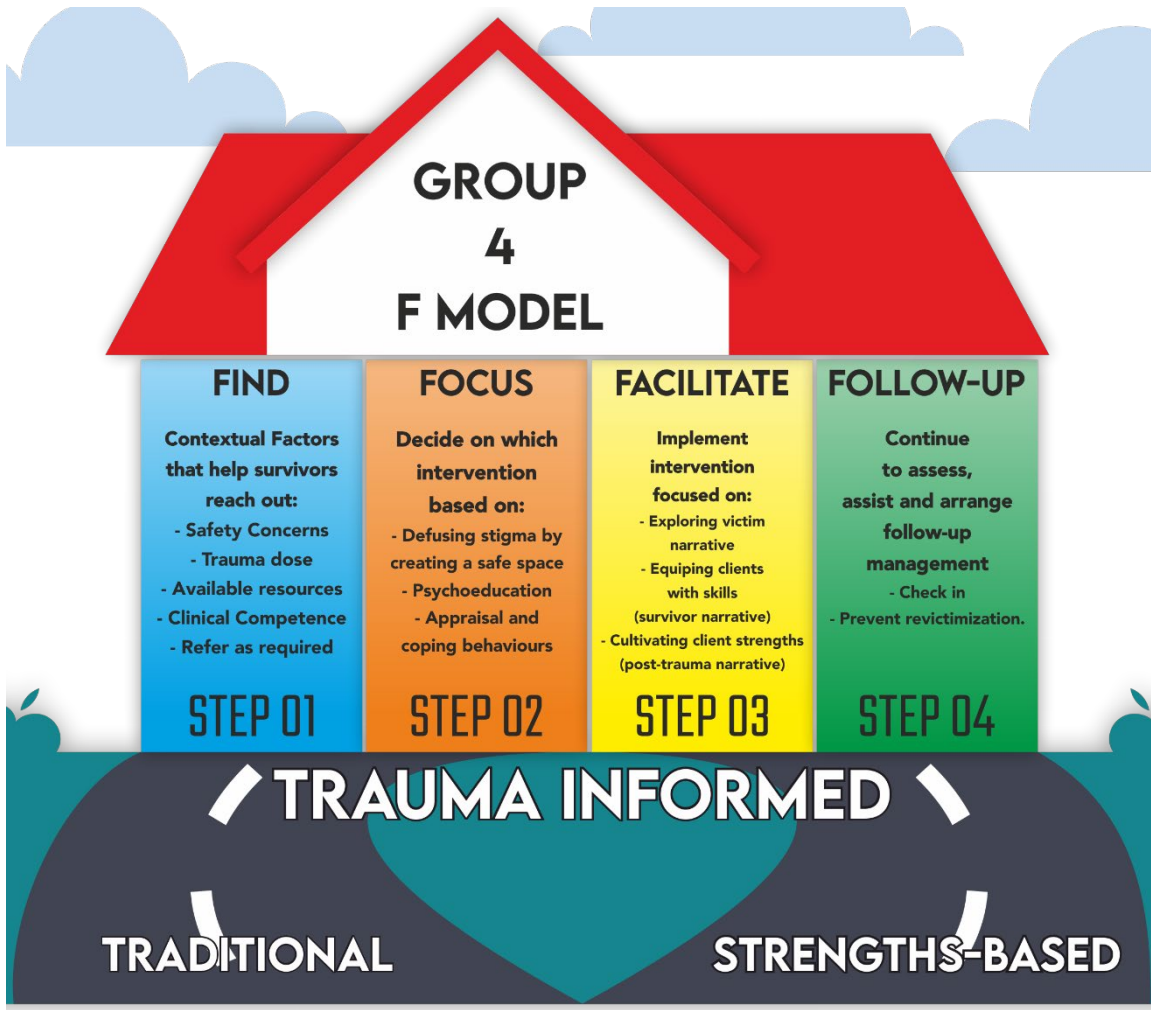
7.1 Convergent Mixed Method study

A convergent mixed-method study explored the psychological health of FSASA and the factors that affect their recovery. A sample of 50 South African FSASA from the Gauteng Province completed an online survey anonymously. Quantitative psychometric measures were used to evaluate the extent to which the sample experienced PTSD, resilience, PWB and PTG. Qualitative data consisted of responses to open-ended questions investigating barriers and facilitators to accessing mental health services, counselling experiences, PTSD symptomology, as well as aspects of resilience and PTG. Meta-inferences were made by comparing the qualitative data from the participants who scored the highest on the PCL-5 compared to the least symptomatic participants. The third phase in developing the guideline was design, which entailed identifying functional elements of successful models. For this phase, we integrated the findings from the previous two phases to develop the evidence-based guideline.

8 EVIDENCE-INFORMED GUIDELINE STATEMENTS

We deduced several areas of concern from the literature review, rapid review, and convergent mixed-method study findings. These helped inform evidence and practice-based guidelines for MHPs working with this population. The figure below outlines the summary of the guidelines; thereafter, each step of the model is described in detail. Findings from the rapid review have been integrated into the clinical competence aspects of the *focus* section and throughout the *facilitate* section of the G4-F intervention model. Findings from the convergent mixed-method study have also been integrated throughout the entire G4-F model.

Figure 8: Outline of the G4-F model



8.1 Find Appropriate Group Members

The first step in the guideline is to find appropriate participants for the group counselling cohort. The application of this step is outlined in the table below.

Table 15: Find appropriate participants

Trauma-sensitive G4-F guideline step 1: FIND appropriate participants		
GROUP CONTEXT: This section focuses on finding the appropriate group members for the group counselling cohort.		
FOCUS ON:	APPLICATION	IMPLEMENTATION
Safety concerns	Safety concerns to be addressed:	Participants need to be screened for suitability of inclusion. Screening is

	<ul style="list-style-type: none"> • Pre-existing relationship with the perpetrator; • Severity of symptomology (suicidality, dissociation, psychosis); • Avoidance behaviours such as substance use; • Screen survivor to determine whether individual or group counselling would be more suitable. 	<p>focused on the severity of symptoms and suitability for group therapy. Contextual risk factors for the individual are considered to assess whether additional referral for psychiatric or legal services to facilitate protection from the perpetrator, if required.</p>
Trauma dose	<p>A comprehensive assessment should be made of the client and their context:</p> <ul style="list-style-type: none"> • Assess predisposing, precipitating, perpetuating and protective factors (4Ps) which determine the trauma dose which needs to be unpacked in therapy/intervention. 	<p>This assessment can be facilitated through a clinical interview.</p>
Available resources	<p>The MHP should recognise and consider the survivors':</p> <ul style="list-style-type: none"> • Informal support network; • Possible barriers to treatment (financial constraints, difficulties accessing services). 	<p>Resources available in the participants' community are explored.</p>
Clinical competence	<p>Practitioners should consider the following:</p> <ul style="list-style-type: none"> • Appropriate training; • Adequate supervision should be provided where applicable; • Adequate self-care to prevent or address secondary traumatisation and compassion fatigue. 	<p>Adequate supervision should be available for staff alongside a referral list for appropriate services as required. NGOs should invest in continued professional development and professional self-care opportunities for staff to prevent compassion fatigue.</p>
Referral as required	<p>Practitioners should consider the following:</p> <ul style="list-style-type: none"> • Be aware of the services that may be available to survivors in the areas close to the community; 	<p>The survivor needs to be given autonomy and control; this can be done by offering the appropriate psychoeducation on the interventions available and informing them of the possible duration and risks of treatment. Survivors must be offered alternatives if they cannot attend</p>

	<ul style="list-style-type: none"> • Be aware of support services that can be accessed remotely, such as crisis lines. 	counselling physically, such as virtual services and call centre numbers.
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8.1.1 Safety concerns

The survivor's safety is of the utmost importance and should be the priority throughout treatment (Decker & Naugle, 2009). Most South African sexual assault survivors report that they know the perpetrator; as a result, the likelihood that the survivor will encounter the perpetrator again should be considered (Westefeld & Heckman-Stone, 2003). If the assault occurred within the context of a romantic relationship, special care should be taken to ensure the client's physical safety. A mitigation of risks must occur; this could include referral to organisations specialising in GBV with a protection element, such as women's shelters. Survivors are at high risk for suicide following the assault, and therefore the survivor's risk for self-harming behaviour should also be assessed and managed appropriately (Masho et al., 2005; Ullman & Brecklin, 2002a; Westefeld & Heckman-Stone, 2003). Management of suicidality could include hospitalisation and referral to a psychiatrist.

8.1.2 Trauma dose (individual's exposure to violence)

The 4Ps offer a helpful framework for categorising the factors that may lead to anticipatory distress (Sadock, 2015). However, each survivor is unique and should be conceptualised accordingly. The figure below provides some evidence-based factors that could be explored under each one of the 4Ps.

Figure 9: 4Ps of sexual assault impact

Predisposing factors: Attitudes affirming gender inequality, history of childhood sexual abuse, prior mental health issues;

Precipitating factors: High risk contexts, substance use, abusive relationship;

Perpetuating factors: Employment status, financial constraints, avoidance behaviours, substance use, survivor's appraisal of the circumstances of the violence, coping mechanisms, engagement in prosecution process; and

Protective factors: Personal strengths, informal support, good quality accessible mental health services.

During initial contact with the client, MHPs should make a clinical evaluation of the severity of the symptoms that survivors present with. Intermittent measurement of symptoms such as PTSD, depression and anxiety serves two main functions; i) for treatment planning, where the clinician can measure improvements and highlight further areas of intervention that are required, and ii) to show clients an outline of their improvement that can motivate engagement in treatment. After considering the resources at the client's disposal, the clinician should decide whether an intervention implemented in an individual format or a group format would be more applicable. This decision will predominantly be based on screening. Heard and Walsh (2021) highlight two primary functions of screening potential participants for interventions. Firstly, it facilitates the identification of behavioural problems and intense symptomology to offer crisis and psychiatric intervention required before participants can fully engage in an intervention. Secondly, it assesses potential participants' willingness, readiness, and commitment to participate in an intervention by preparing them for the content and structure of the intervention.

Additionally, in the context of an intervention administered in a group format, screening can also indicate how the individuals in the group might fit together. MHPs must screen

possible participants for severe psychopathology (psychosis, bipolar mood disorder, active suicidality, personality disorders and substance-related disorders) before inclusion in interventions. These indicators should be noted, and appropriate referrals need to be made if addressing these concerns are outside of the scope of the MHP. MHPs can make use of psychometric measures to establish their symptom profiles. Psychometric measures recommended for traumatic cognitions are the Trauma and Attachment Belief Scale (TABS) (Pearlman, 2003) or the Posttraumatic Cognitions Inventory (PTCI) (Foa et al., 1999). There are several indicators that the survivor may be at risk for developing chronic PTSD. These include persistent dissociation, rumination, disorganised memories of the trauma or inability to recollect some aspects of the trauma, maladaptive coping strategies, depression, and presence of physical reminders (for example scars), and overall severity of symptoms (Brewin et al., 2002; Dunmore et al., 2001; Ehlers & Clark, 2003; Halligan et al., 2003; McNally et al., 2003; Rachman, 2001).

The assessment tools used to measure the outcomes of the interventions are outlined in the table below. It is the responsibility of the practitioner to enquire about the ethical usage of these assessments, including required training for administration.

Table 16: Psychometric measures for treatment outcomes

Symptom	Measures
Trauma history	The Stressful Life Events Screening Questionnaire (SLESQ); Autobiographical Memory Questionnaire.
PTSD	Impact of event scale revised; Harvard Trauma Questionnaire, Clinician-Administered PTSD scale (CAPS); PTSD Checklist for diagnostic and statistical manual for mental disorders-fifth edition (PCL-5); Trauma Symptom Checklist (TSC).
Depression, Anxiety and Substance Use	Structured clinician-administered interview DSM-IV (SCID-V), MINI International Neuropsychiatric Interview. General Health Questionnaire 12 (GHQ-12); Hospital Anxiety and Depression Scale; Hopkins Symptom Checklist (HSCL-25), Beck Depression Inventory, Hamilton Depression Scale.
Depression	Patient Health Questionnaire (PHQ-9); Beck Depression Inventory (BDI). Suicidal Ideation Questionnaire (SIQ); The Beck Scale for Suicide Ideation (BSS); The Centre for Epidemiologic Studies Depression Scale; Ruminative Responses Scale (RRS); Best Scale; PFQ-2
Anxiety	Four-Dimensional Anxiety Scale (FDAS); Generalised Anxiety Disorder Scale (GAD-2) Structured Clinician Administered Interview; DSM-IV (SCID-V)

Personality Assessments	MMPI-II; MCMI
Sleeping disorders	Nightmare Distress Questionnaire (NDQ); Disruptive Nocturnal Behaviours associated with PTSD (PSQI).

8.1.3 Available resources

Whether a survivor will access mental health services is highly influenced by an interplay between overcoming personal apprehension and accessing necessary resources. Resource constraints reported by the participants indicate that mental health service delivery gaps are still prevalent in South Africa (Leibbrandt et al., 2010; Marais & Petersen, 2015; Petersen & Lund, 2011). Due to staff shortages and high demand, governmental and NGO services often use waitlists for mental health services. As female survivors have reported increased scepticism towards men following the assault, where possible, organisations and professionals working with this population should consider having a female MHP on staff for survivors. In some cases, the survivors may also be unable to access mental health services due to financial constraints that inhibit travel or work obligations.

It is pertinent that professionals screen clients for factors that could contribute to their apprehension to attend psychotherapeutic services. Risk factors include the circumstances in which the assault occurred, their perception of their role in the assault, their informal support network, financial resources at their disposal, history of previous assaults, their psychiatric history, and their experiences with previous service providers. The current study found that protective factors included the visibility of supportive services in their area, financial resources, and a supportive informal network.

8.1.4 Clinical competence

Legal frameworks and existing policies that MHPs working with this population should be aware of, as well as the recommended standards and guidelines, are shown in the

figure below. Since this intervention guideline is not intended for use in acute settings therefore these documents do not directly form part of the guideline. However, MHPs are encouraged to refer to these as necessary.

Figure 10: Laws, policies, standards and guidelines for sexual assault

LAWS AND POLICIES

- *The Criminal Law (Sexual offences and related matters) Amendment Act, 32 of 2007;*
- *The Children's Act, 38 of 2005 (as amended);*
- *Older Person's Act, 13 of 2006;*
- *National Instruction 3/2008: Sexual offences (issued by the South African Police Service);*
- *National Instruction 2/2012: Victim Empowerment (issued by the SAPS);*
- *The Victims' Charter;*
- *Domestic violence Act 14 of 2021.*

STANDARDS AND GUIDELINES

- *Guidelines and standards for the provision of support to rape survivors in the acute stage of trauma. (Developed by NACOSA);*
- *Protecting survivors of sexual offences: The legal obligations of the state about sexual offences in South Africa (Developed by women's legal centre and Rape Crisis Cape Town Trust (2013))*

Organisations must have appropriately trained professionals who maintain proper boundaries, are proficient in skills training and display accurate empathic understanding. All therapists must be able to build rapport with clients, accurately empathise with a client's experience and reflect on it and negotiate a contract for therapeutic practice (Edwards, 2009). Survivors are empowered when MHPs explain the services they provide and indicate the duration of treatment throughout. Furthermore, Van Rooyen (2018) found that the most helpful counselling aspects centred on the quality of the therapeutic relationship between the survivors and the MHP. Core therapeutic conditions that assist the client in recovery are therapist congruence, unconditional positive regard and accurate empathic understanding (Rogers, 1992). New therapists can consider using measures to evaluate the therapeutic alliance they have with clients, such as the Working Alliance Inventory Short-Form (WAI-S); or the Satisfaction with Therapy and Therapist Scale-Revised (STTS-R). Adequate supervision should be provided where applicable,

alongside adequate self-care to prevent or address secondary traumatisation and compassion fatigue.

In terms of therapeutic interventions, survivors benefit more from courageous therapists that could offer a safe space where clients could express their emotions fully and give them the skills they need to regulate them. Specific evidence-based interventions are outlined in the table in Addendum 7.

Implementing specific interventions for presenting problems requires specialised competencies (Lemma et al., 2008). These specialised competencies can be obtained through BPsych programs that focus on specific community concerns, as part of the Master's Degree in Psychology (Clinical or Counselling) programs or continuous professional development. Meta competencies, such as the ability to use clinical judgement during the implementation of treatment models to adapt interventions in response to client feedback, are a crucial element in effective counselling (Roth & Pilling, 2008). It is also an ethical obligation for MHPs to be sensitive to cultural differences, to choose interventions that are in line with the values of their clients (Corey, 2021).

8.1.5 Refer as required

Once MHPs have a clear understanding of the symptoms the survivor is experiencing, the 4Ps that may present challenges in therapy and their clinical competencies, they must select the appropriate intervention. Contextual factors such as financial constraints, work obligations and lack of informal support may inhibit survivors from attending therapy. If a clinician decides to implement a treatment that consists of several sessions, they need to make sure that the survivor would be able to access services regularly. Additional referrals (psychiatry, social work) should be offered where required. As noted above in Step 1, engaging informal support networks could aid recovery significantly. Tedeschi and Kilmer (2005) note that taking a client's ecological context into account can assist the

clinician in moving beyond how the client can change, by identifying factors and systems that can be incorporated into the intervention.

Support groups should be recommended if the survivor does not have anyone in their informal network that they trust enough to disclose to. If there are no support groups in their area that they can physically attend, social media platforms such as Facebook groups may offer some solace. However, given the often-unregulated nature of these groups, it is recommended that MHPs discuss the content posted with the survivor in sessions to clear up any misconceptions that may have been posted. Furthermore, bibliotherapy should also be considered; books that MHPs and survivors report to have been helpful include *The body keeps the Score: Brain, Mind and Body the Healing of Trauma* by Bessel van der Kolk and *Kwezi: The remarkable story of Fezekile Ntsukela Kuzwayo* by Redi Tlhabi.

The importance of accessing mental health services should be emphasised to these participants and alternatives to face-to-face counselling should be offered (for example telephonic counselling). Trauma call centres where clients can phone in, thus offering anonymity, may be a beneficial resource for clients who struggle with self-blame and can also assist in offering crisis counselling when required. Psychoeducation should be provided on the impact of sexual assault on survivors and the cycle of abuse so that their reactions can be normalised. Survivors should be given the option to return for services when they are ready, and professionals should follow up with them if they miss sessions.

8.2 Focus on Survivor Needs

Keeping the Resilience Portfolio model in mind, the clinician must formulate the appropriate intervention by gathering information about several aspects of the survivor. These include i) the individual's exposure to violence; ii) overall psychological health; iii) the resources and assets available to the individual, and iv) their appraisal and coping

behaviours (Hamby et al., 2018). The application areas for Step 2 of the model are outlined in the table below.

Table 17: Focus on the survivors' needs

Trauma-sensitive G4-R guideline step 2: FOCUS on the survivors' needs		
GROUP CONTEXT: Safety rules and commitments will be obtained in the group context these will take safety concerns, stigma, and supportive resources into account.		
FOCUS ON:	APPLICATION	IMPLEMENTATION
Defusing stigma by creating a safe space	Create a therapeutic space in which survivors feel comfortable disclosing and feel supported.	Use icebreakers to make group members comfortable. Establish appropriate group norms.
Psychoeducation	Explore the impact of sexual assault on their intrapersonal and interpersonal levels. Explain the dynamics of recovery (PTSD, resilience, PWB and PTG).	Psychoeducation on the different ways that sexual assault can impact their lives and ask about their own experiences. Psychoeducation on the dynamics of recovery and how this relates to their own experiences.
Getting to know the community context	Contextual risks that could lead to re-victimisation. Teach clients about resources in their area or online.	Allow survivors to talk about the risks they face and their sources of resilience (internally and externally).

8.2.1 Defusing stigma by creating a safe space

The survivor must be given autonomy and control; this can be done by offering the appropriate psychoeducation on the interventions available and informing them of the possible duration and risks of treatment. Survivors have the right to informed consent. By educating survivors about their rights and responsibilities, MHPs can build a trusting relationship while empowering survivors (Corey, 2021). The initial group sessions should focus on building a rapport between the MHP and the group members. Clarifying concerns and expectations for therapy with a survivor is also crucial; therefore, important boundaries, confidentiality limits, the non-judgemental nature of the group and other ethical concerns should be discussed with the group members (Walker-Williams, 2012).

This is crucial since apprehension, distrust, and self-blame were noted as barriers to seeking mental health services and garnering informal support (Sigurvinsdottir & Ullman, 2015).

Many sexual assault survivors struggle to overcome self-stigmatisation following an assault (Bhuptani & Messman-Moore, 2019). They also report experiences of not being believed when they disclosed, leading to distrust in the process of future disclosure which inhibits access to services, such as antiretroviral treatment. Furthermore, self-blame is one of the most prominent determinants of whether a survivor will seek professional mental health services. Self-blame and fear can significantly affect a survivor's openness to engaging in psychotherapeutic services and reporting perpetrators to the police. The amount of stigma a person experiences is also influenced by their informal support network to a large extent. Negative reactions from informal supporters were associated with increased self-blame and social withdrawal, whereas unsupportive acknowledgement led to maladaptive coping (Relyea & Ullman, 2015). Self-blame is often notable in a survivor's narrative about the assault. Given the high prevalence of self-blame and stigmatisation in this population, it is crucial to be patient with survivors as survivors may not be ready to accept what has happened to them and feel overwhelmed by the emotions they are experiencing. In domestic violence cases, survivors may also be fearful of the perpetrator or financially dependent on them.

Additionally, group therapy may be particularly relevant to breaking down stigma barriers. Beneficial outcomes of group therapy include group members developing interpersonal relationships, building confidence, and lowering shame and stigma through the sharing and validating of experiences (Schwartz et al., 2019; Yalom & Leszcz, 2020). To build survivors a sense of control, they should also be informed that they will not be forced to complete any activity in the group that they are not comfortable with (Elliott et

al., 2005). At the same time, group members should be encouraged to take an active role in the group to gain as much as possible from it (Walker-Williams, 2012).

8.2.2 Psychoeducation

Although psychoeducation is mentioned in this phase of the guideline, this element of the guideline will likely be implemented throughout any group intervention process. Throughout the counselling process, the content of psychoeducation may change but it should remain a core element to the intervention. The aim of psychoeducation for survivors is to create an understanding surrounding likely psychological responses, the dynamics of recovery and the rationale for treatment. Survivors should be made aware of factors that are relevant to their recovery. These include emotional and psychological turmoil they may experience, how the sexual assault may influence interpersonal relationships and the importance of counselling. When survivors are told by MHPs that their reactions to sexual assault fall within the expected spectrum of reactions to serious trauma, their degree of affect and the alternating cycles of flooding and numbness are less alarming (Roth et al., 1988). Group members should be encouraged but not required to share their own experiences of how sexual assault has impacted their lives (Driscoll, 2016). The behavioural and emotional responses to trauma are often ways to cope and adapt to one's environment; these responses can be framed as survival techniques that may offer relief but have negative consequences. This offers an opportunity to introduce the skills phase of intervention as an opportunity to learn new ways of responding that would still offer relief but with fewer negative consequences. After reflecting on how the sexual assault influenced their lives and normalising these reactions, MHPs can offer hope to survivors by providing psychoeducation on the dynamics of recovery.

The three stages that victims of all forms of sexual violence usually experience (Burgess & Holmstrom, 1974) should be highlighted to give survivors the perspective that

recovery will take time but that it is possible. The acute phase happens soon after the attack, when the victim is in distress and exhibits a variety of emotional responses that can be classified as expressive (such as shaking, crying, or yelling) or controlled (flattened affect, appearing outwardly calm and subdued). The second stage, known as outward adjustment, is frequently characterised by a strong denial component. During this time, survivors turn their attention from the attack to their regular daily activities. The final stage of recovery is long-term re-organisation, during which the victim reconciles their emotions toward the attacker and incorporates the assault into their conception of who they are. In terms of the dynamics of recovery, our study found that survivors that had high levels of PTSD reported lower resilience. This indicates that high levels of trauma may inhibit resilience initially. However, higher resilience was associated with higher PWB and PTG, indicating that interventions focused on building resilience may be of particular importance to building on a survivor's strengths.

As noted above, survivors should be informed about the rationale behind and processes involved in specific trauma modalities. Discussing different treatment options assists survivors in taking control and making informed decisions. For example, in CBT, clients are educated about how affect, behaviours and cognitions about the assault are interrelated (Belleville et al., 2018); thus, adaptive coping strategies are discussed. However, in exposure therapy, the role of avoidance in the maintenance of psychiatric symptoms is described (Karlsson et al., 2021). Psychoeducation related specifically to trauma-related nightmares is offered in IRT (Belleville et al., 2018), whilst in mindfulness-based interventions, the mind-body relationship is explored (Kelly & Garland, 2016). Importantly, rapport can be encouraged through mutual learning in the therapeutic relationship, therefore MHPs should be curious about how the survivors experience the community context that they live in.

8.2.3 Getting to know the community context

MHPs should allow survivors to talk about the risks they face and their sources of resilience in their community. In describing the socio-demographic and health characteristics of a rape cohort in South Africa, Abrahams et al. (2020) highlighted that survivors often have lower levels of education, live in areas with poor infrastructure and experience poverty. These findings show that survivors often battle other factors affecting their mental health in conjunction with trying to heal from the sexual assault that could inhibit their access to mental health resources. Therefore, it is not surprising that poor treatment follow-up and lack of psychological support have been reported in many studies (Linden et al., 2005). When survivors share common backgrounds (in addition to their trauma), group therapy can be particularly effective (Menon et al., 2020). By elaborating on community resources and risks, survivors can begin to build a group identity that can be fostered in between sessions. With a comprehensive understanding of the context of that survivor’s function, MHPs will be able to tailor their interventions to meet the survivor’s needs.

8.3 Facilitate the Client's Progress

Step 3 in the model focuses on the intervention itself. The application areas of this step are outlined in the table below.

Table 18: Facilitate the appropriate intervention

Trauma-sensitive G4-R guideline step 3: FACILITATE the appropriate intervention		
GROUP CONTEXT: Serves as a platform for survivors to support each other in embracing their transitioning narratives from victim to survivor to empowered post-trauma survivor.		
FOCUS ON:	APPLICATION	IMPLEMENTATION
Explore victim narrative	<ul style="list-style-type: none"> •Outline trauma narrative. •Explore and reframe the meaning assigned to the event. 	Journal writing or verbal processing (CPT).

	<ul style="list-style-type: none"> •Exploration and management of thoughts and feelings. •Address stuck points. <p>Explore and address concerns surrounding safety, trust, power/control, esteem, and intimacy through cognitive restructuring.</p>	Allow survivors to share their struggles and how they use their strengths identified in the FIND phase.
Equip clients with skills (survivor narrative)	Teach survivors skills to cope with overwhelming emotions and disengage from avoidance behaviours.	Provide psychoeducation about relaxation skills, grounding exercises and mindfulness. Give practical exercises on these.
Cultivate client strengths to create a post-trauma narrative	<p>Assist survivors in exploring how they can use their existing strengths to assist them in recovery.</p> <p>Emphasise empowering mindsets that could facilitate PTG.</p>	<p>Assess strengths that the client has through a narrative of instances in their past they have overcome or a psychometric assessment.</p> <p>Explore empowering mindsets that survivors have and can adapt.</p>

8.3.1 Explore the victim narrative

Survivors in our study indicated the importance of a safe space in which they could explore their experiences fully. For this element, survivors should be encouraged to share their current views of themselves and the assault alongside the coping behaviours that they employ. By sharing their account of the event, it can be assimilated and accommodated into existing cognitive frameworks, enabling survivors to reconcile themselves with what took place (Eagle, 2000). In our study, self-disgust, mistrust of others and scepticism of men were prevalent cognitive distortions following sexual assault. From the rapid review, it is evident that the interventions with an exposure component can be particularly helpful to survivors. Exploring the victim narrative includes eliciting a detailed description of the facts, feelings, cognitions, and sensations relevant to the story of the sexual assault (Walker-Williams & Fouche, 2017). Various techniques can be used for this exploration. For example in the WITS trauma model, these

techniques include starting the narration in detail before the event, using a metaphor of watching a movie in slow motion, encouraging sensory associations, and using the present tense narration (Eagle, 1998). In CPT, survivors are encouraged to write various drafts of their account of the trauma followed by Socratic questioning by the therapist (Resick & Schnicke, 1993, 1992). In exposure therapy, the survivor is asked to concentrate on and describe the assault repeatedly in a therapeutic space until their anxiety is reduced (Rothbaum & Schwartz, 2002). Protocol-based interventions such as EMDR, MLI focus on neurological integration of the memory while survivors visualise the assault (Marsay, 2020; Rajan et al., 2020; Stickgold, 2002). With these integration therapies, protocols are used where the client does not have to describe the distressing images related to the memories in full but monitor their change during the processing thereof (Kennedy, 2014). These interventions may be particularly relevant for survivors that struggle to verbalise their experiences. Furthermore, IRT entails a combination of pleasant imagery with nightmare rescripting (Belleville et al., 2018) whilst music therapy can be utilised to assist survivors in verbalising their experiences through songwriting (Cikuru et al., 2021). In group settings, participants share their memories one at a time (Karlsson et al., 2021) enabling them to experience less stigmatisation by letting them know that they are not alone. Lee and Cha (2021) made use of a virtual character that shared her process of recovery from sexual assault to help survivors feel understood. While clients share their stories, MHPs have to normalise their feelings and symptoms that are associated with the event (Eagle, 1998). If clients are sure that they have a variety of tools available to them in times of distress to help them refocus on the present, they may be less likely to try to avoid or control their unwanted internal experiences (Burrows, 2013).

In exposure therapy, breathing retraining and repeated exposure itself can assist in managing anxiety (Resick et al., 2002). It is important to note that some survivors may present with complex PTSD because of childhood sexual abuse. For these survivors, skills development for emotional regulation and interpersonal support may be beneficial before beginning exposure therapy (Kaminer & Eagle, 2017). Cognitive-based interventions such as CBT and CPT educate survivors about how to affect effects behaviours and schedule pleasant events to increase positive emotive experiences (Nixon, 2012; Nixon et al., 2016). Some survivors may believe that the immediate experience of the emotional impact of the trauma will never subside and lose motivation to rebuild their lives (Ehlers, Mayou, et al., 1998); for these survivors, it is important to address these dysfunctional beliefs.

Through exploration of the victim narrative, the clinician can find out more about the meaning that the client assigns to the event. Bryant et al. (2007) recommend that the initial focus is on the modification of catastrophic cognitive styles and avoidance tendencies since survivors that display these increase the likelihood that they might drop out of therapy due to PTSD. CPT is particularly useful in meeting this demand (Bass et al., 2013; Nixon, 2012; Nixon et al., 2016; Resick et al., 2002; Resick et al., 2012). Our study suggested that cognitions surrounding self-disgust, self-blame, mistrust of others and scepticism of men are particularly prominent within this population. Self-blame is often notable in a survivor's narrative about the assault. Behavioural and characterological self-blame predicts early symptoms of PTSD, and symptom severity predicts subsequent behavioural self-blame (Kline et al., 2021). These cognitive factors have been found to contribute to the onset and maintenance of PTSD by generating a sense of ongoing threat or motivating cognitive and behavioural strategies that prevent recovery (Dunmore et al., 1999; Ehlers & Clark, 2000). MHPs are encouraged to be

cognisant of these thoughts and to provide simple messages to tackle self-blame and guilt (Decker & Naugle, 2009). Addressing internalised and externalised stigma could significantly impact survivors' long-term mental health outcomes following sexual assault (Nöthling et al., 2022). Defusing self-blame and guilt goes beyond verbal messages of reassurance. Personality characteristics such as openness, patience, support, compassion, friendliness, professionalism, authenticity and non-judgemental are central to cultivating the therapeutic relationship (Van Rooyen, 2018).

CPT is seen as the gold standard to identify and address maladaptive beliefs (Resick et al., 2012). In this phase of treatment, unhelpful thinking patterns and assumptions related to self-blame and negative core beliefs related to safety, trust, power/control, esteem, and intimacy should be challenged. Scoring profiles in this study indicated that resilience and PTG can co-exist with PTSD and conducting a holistic assessment may lead to more impactful interventions. In addition to challenging unhelpful thinking patterns, MHPs should focus on constructing resilient beliefs and behaviours (Padesky & Mooney, 2012). Once the victim narrative has been processed, MHPs can start equipping survivors with skills to embrace the survivor narrative.

8.3.2 Equip clients with skills to embrace the survivor narrative

Survivors need to make a conscious choice to persevere in their journey of recovery; this choice takes significant courage as this journey may be long and painful (Walker-Williams, 2012). Metaphors of this journey could enable survivors to envisage recovery as a possibility (Williams & Poijula, 2002). Skills training for emotional regulation and cognitive distortions are of paramount importance in empowering survivors. Skills training should focus on anxiety management, assertiveness, self-care and self-protection (Edwards, 2009). Skills can be facilitated through psychoeducation, behavioural experiments, and cognitive restructuring. Active adaptive coping strategies such as

journaling should be encouraged amongst survivors to empower them on the road to recovery. In addition, MHPs can facilitate resilience by encouraging an internal locus of control, helping the client find a sense of purpose that is in line with their values and reframing experiences as offering the opportunity for growth (Orbke & Smith, 2013). Mindfulness-based interventions teach self-acceptance and self-compassion that can be particularly helpful in assisting sexual assault survivors with emotional regulation (Szoke & Hazlett-Stevens, 2019). Emotional dysregulation can impair not only daily functioning but may inhibit a survivor's ability to respond in a self-protecting manner in future potentially threatening situations (Villalta et al., 2020). Yoga, physical activity, and mindfulness meditation interventions can be particularly helpful for emotional regulation in sexual assault survivors (Jindani et al., 2015; Lee & Cha, 2021; Shors et al., 2018). According to Szoke and Hazlett-Stevens (2019), mindfulness may assist survivors in decreasing the avoidance, hyperarousal, and occurrence of negative thoughts associated with PTSD by increasing attitudes of acceptance of the present moment and self-compassion. Finally, art therapy offers survivors the opportunity to express emotions in a creative manner that may aid catharsis (Goodarzi et al., 2020).

Our study found that informal support was a core construct related to resilience. Many survivors may hesitate to disclose their assault to their informal support network, however, informal support is crucial to all survivors, irrelevant of whether they access mental health services. MHPs should discuss the risks and benefits associated with disclosure to informal supporters with survivors. Findings from our study indicated that survivors benefitted from informal supporters that offer both emotional reassurance and instrumental support. Nevertheless, active support that promotes access to mental health services and encourages survivors to actively participate in the emotional expression and

regulation inherent in the recovery process appears to have the greatest positive effect on survivor recovery.

Once cognitive distortions related to trust and safety have been addressed appropriately, survivors may be more open to building connections with others. Skills training focused on building positive relationships should be paramount in counselling. Brown (2017) highlights characteristics to look out for when choosing who to disclose to. Characteristics prevalent in trustworthy people include having been able to maintain appropriate boundaries, reliability, accountability, confidentiality, integrity, and being non-judgemental. It is important to note here that given the high sexual violence rates in South Africa, informal supporters themselves may have experienced similar traumatic incidences and may suffer from secondary traumatisation (Theunissen, 2017). Once the survivor has decided to disclose the assault, it is crucial to offer psychoeducation to family members and friends about; i) the impact of sexual assault; ii) possible reactions that the survivor may display; iii) the importance of psychotherapy, and iv) how they can cope with overwhelming emotions and assist the survivor in doing so as well. In discussions with members of their informal support network, MHPs are encouraged to find out more about the strengths that the survivors have. Assessing the strengths as well as the symptoms that the client is experiencing when communicating with individuals in the clients' informal support network can foster supportiveness and trust as well as facilitate positive supporter-client relationships that can help supporters focus on the client beyond their trauma and its consequences (Tedeschi & Kilmer, 2005).

8.3.3 Cultivate client strengths to create a post-trauma narrative

To develop a survivor narrative, survivors need to reframe their experience by resharing their stories from a new perspective focused on inner strength originating from struggle (Walker-Williams & Fouche, 2017). The final phase in the treatment process is

to enable survivors to create a post-trauma identity. Assessing strengths alongside risks can be affirming, empowering, and even motivating since it sends a message that the clinician recognises a client's identity and competencies beyond their presenting concern (Cowger, 1994; Saleebey, 1996; Tedeschi & Kilmer, 2005). Measuring strength-focused variables within survivors that present with symptoms indicative of high PTSD may enable MHPs to become aware of internal resources that they might miss when they do not take a strengths-based approach to client interventions. According to Harniss et al. (1999), understanding a client's strengths can help professionals shift their focus from fixing a problem to enhancing and building on a characteristic behaviour, thereby addressing concerns from a solution-focused perspective. Several measures have been developed to assess the symptoms that should be targeted during the intervention, as shown in the table below.

Table 19: Strengths measures

Client Strengths	VIA strengths questionnaire
PWB	MHC
Resilience	ARM-R, Connor Davidson scale
PTG	PTGI

Padesky and Mooney (2012) outline the process of assisting a client to construct a personal model of resilience. This process occurs by translating the identified strengths into strategies for maintaining resilience in areas of difficulty. Reflecting on how survivors have been able to remain resilient in the face of their daily stressors can assist MHPs in uncovering strengths that they can continue to employ when faced with future stressors. In addition to symptom relief, evaluating possible resilience-facilitating resources enhances assets and facilitates protective processes (Masten, 2014). Considering the broader context during this evaluation is essential since both internal and external factors play a role in resilience (Luthar & Cicchetti, 2000; Luthar et al., 2000). Tedeschi and Kilmer (2005), therefore, recommend that the aspects that should be evaluated are

associated with positive adjustment, competence in core domains and healthy outcomes under adversity. Although formalised resilience scales are available, MHPs can also use questions during their intake or evaluation focusing on potential protective factors such as self-efficacy, previous successes in coping or perceived social support (Tedeschi & Kilmer, 2005). Self-compassion is also a resilience factor that counteracts anxiety and depression in alcohol-involved sexual assault (Strickland et al., 2019).

Walker-Williams and Fouche (2017) facilitated personal growth in childhood sexual abuse survivors by asking them to reflect on how their ordeal elicited personal strengths and growth, thereby changing their narrative from victim to survivor-focused. Indicators of PTG in this sample were closely related to themes reported in other studies. The theme “the assault does not define you” is closely related to the *personal strength* domain in the PTGI that has been reported in other sexual assault survivor studies (Burt & Katz, 1987; Draucker et al., 2009; Frazier et al., 2004; Grubaugh & Resick, 2007; Guerette & Caron, 2007; Kleim & Ehlers, 2009). The “engaging in empowering self-talk” theme is closely related to the *appreciation of life domain* of the PTGI also reported in other studies with this population (Hou et al., 2013; Senter & Caldwell, 2002). Participants in this study that were part of the FSR group yet still showed high levels of PTG reported significant support in their informal networks. This finding is explained by other studies that found that sexual assault survivors experienced PTG as a result of deeper connections with their friends and family (Borja et al., 2006; Burt & Katz, 1987; Draucker et al., 2009; Frazier et al., 2001; Frazier et al., 2004; Frazier & Burnett, 1994; Guerette & Caron, 2007; Hou et al., 2013).

8.4 Follow-up with Additional Treatment as Needed

The last step in the model is focused on actions related to after-treatment care. The application of this step is outlined in the table below.

Table 20: Follow-Up during and after the intervention

Trauma-sensitive G4-F guideline step 4: FOLLOW-UP during and after intervention		
GROUP CONTEXT: A platform for survivors to engage in and encourage ongoing support and reflect on the positive experience of the group support context.		
FOCUS ON:	APPLICATION	IMPLEMENTATION
Ending off well	Safe termination of the group	Reflect on the therapeutic process, review the changes in outcomes and bring closure to the relationship.
Checking in	Follow-up	Check-in on survivors regularly and encourage engagement in support groups where possible.
Preventing re-victimisation	Teaching self-protective skills	Self-defence and protective measures.

MHPs need to be sensitive to and enquire about how survivors are experiencing group therapy (Knox et al., 2011). This sensitivity and open communication will aid MHPs to be aware of any issues that may arise during sessions or be cognisant of areas of exploration that may be needed for individuals in the group to address. It is essential to finish groups safely and provide continuous support after an intervention (Carey, 1999; Driscoll, 2016; Volker, 1997). MHPs are encouraged to discuss the positive feelings they have towards survivors, reflect on the changes that they have made, and assist the survivors in obtaining closure to the therapeutic relationship (Quintana & Holahan, 1992). During planning for the ending of therapy, MHPs should emphasise the skills learned in the group therapy process and the personal strengths that were uncovered that enabled everyone’s resilience. Areas of reflection could be how the group facilitated change, coping strengths and meaning-making, and post-trauma thriver (S2T) identity (Walker-Williams & Fouché, 2018). Strategies for following up should be discussed with the survivors. These include discussions on expectations related to follow-up and resources for additional services if they are required in the future.

In line with previous studies, our study found that survivors are often at risk for re-victimisation (Messman-Moore et al., 2013; Messman-Moore et al., 2005). Given the trauma-laden context of South Africa, it is important to teach survivors self-protective techniques. Self-defence classes may increase environmental mastery for survivors (Kelly & Sharp-Jeffs, 2016) and survivors who engage in anti-sexual assault activism have reported higher levels of coping self-efficacy, greater community connection and more meaning in life (Strauss Swanson & Szymanski, 2021). Intervention programs focused on prevention in communities are essential to creating safe spaces for survivors. Peer and community-level strategies for sexual assault prevention that are promising but underappreciated include social norms campaigns, bystander interventions, and men's anti-violence organisations (Casey & Lindhorst, 2009).

9 FUTURE RESEARCH NEEDS, IMPLEMENTATION, AND CLINICAL CONSIDERATIONS

This group intervention guideline will undergo a Delphi evaluation by professionals that work with sexual assault survivors before implementation. This evaluation will have three main functions. Firstly, it will act as a quality control measure to include components or aspects that have not been discussed fully or considered. Secondly, it will create awareness surrounding the guideline to garner sites of delivery for pilot testing. Finally, consultations with MHPs will inform the regulation of guideline usage.

10 LIMITATIONS

This intervention guideline outlines research-supported interventions for sexual assault survivors. Training in specific modalities listed herein should be acquired from the relevant training authorities in each. It is crucial to refer to the guideline as necessary, should symptom classification fall outside of the scope of the MHP offering counselling services to a specific survivor.

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SECTION C: CONCLUSIONS, LIMITATIONS, RECOMMENDATIONS AND CONTRIBUTIONS

1 INTRODUCTION

The main aim of this study was to design a trauma-informed strengths-based group intervention guideline. This aim was achieved by completing the first three phases of the D&D Model (Thomas & Rothman, 1994). These included i) problem analysis and project planning; ii) information gathering and synthesis, and iii) design.

In the first phase, the researcher contacted managers of NGOs in Gauteng to facilitate a needs analysis and complete the steps inherent in this phase. These steps included identifying clients, gaining entry and cooperation from settings, identifying concerns of the population, analysing concerns or problems identified and setting goals and objectives (Fouché et al., 2022). In this phase, clients were identified through a combination of findings from a literature review and the interest field of the researcher. Gaps in research with sexual assault survivors were identified in a literature review that investigated the current stance of research with sexual assault survivors. PTG is a long-term process that is not prevalent in acute care, therefore it was crucial to reach out to organisations that offered long-term follow-up services. To gain entry and cooperation from settings the researcher contacted numerous organisations, non-profits and NGOs (n=20) that work with FSASA but only four agreed to give input and provide access to their facilities for recruitment. Discussions with these managers outlined procedures that led survivors to their organisations and the services they offer. These managers also alerted the researcher to existing guidelines that the organisations need to follow and the laws that their staff need to be acquainted with.

In these discussions, two barriers to service delivery for FSASA were noted. The first one was the training needs of the staff. These organisations reported that they predominantly employ auxiliary social workers and registered counsellors to offer

counselling. Although these professionals can offer basic counselling assistance, the needs of clients with more complex cases like complex PTSD and other psychiatric disorders cannot be met. The counselling is focused on antiretroviral adherence and the number of sessions available to each client is limited due to funding constraints. Stakeholders also highlighted frequent disruptions in psychosocial services due to poor follow-up on the part of the clients. Managers indicated that the financial constraints the clients face are often so dire that they cannot afford to fund transport to attend sessions. From these discussions, it became evident that the guideline had to align with guidelines that already exist in these organisations. Furthermore, the staff would need to be trained in the implementation of the guideline. Clients would likely benefit more from group sessions than individual sessions because it could ease the arrangement of transport for women in the same area, this could assist in navigating the financial constraints keeping them from attending counselling. An additional strength of group therapy is that it can empower women to form a supportive ecosystem in their community. Lastly, alternatives should be included in the guideline that can be used by the survivors remotely if they cannot attend sessions. Upon completion of these consultations, three objectives for the guideline were outlined. Firstly, it aims to offer professionals guidance on intervention guidelines, and outcomes that have appeared to work for FSASA. Secondly, it will equip MHPs with knowledge about the dynamics of resilience, PWB, and PTG in this population. Thirdly, it will empower MHPs to assist survivors to identify and harness their strengths and resources to become more resilient when facing future challenges.

In Phase Two, the researchers completed studies aimed at information gathering and synthesis. Before the commencement of the studies in Phase Two, the research proposal was sent for review by readers within the Optentia Scientific Committee of the NWU and ethical approval was obtained from the NWU Health Research Ethics Committee (NWU-

00206-21-A1). This phase included using existing information sources, studying natural examples, and identifying functional elements of successful models. Existing information sources were investigated in the form of a rapid review aimed at identifying current interventions that are available to this population. In this rapid review, six databases were searched to include articles published between 2012 and 2023 that outlined interventions that were evaluated with adult sexual assault survivors. The reviewers (two) independently assessed the titles and abstracts of all the records and ineligible studies were excluded. The studies were quality appraised. Data were extracted by the researchers using a data extraction Excel table that outlined the methodologies employed, the participant profiles, the duration of the intervention, outcomes measured, scales used for measurement, key findings related to the review questions, components involved in the intervention and limitations of each intervention. Findings from the rapid review were outlined and discussed in Manuscript 1.

Natural examples were investigated in this study via a convergent mixed-methods study. In this study, the PWB of FSASA and the variables influencing their recovery were investigated. Participants were recruited via recruitment posters that were displayed at the NGOs that agreed to assist in recruitment. When that recruitment strategy did not yield enough participants, a targeted social media campaign was launched that yielded significantly more responses. Informed consent was facilitated online, and participants were sent an R30 data voucher upon completion of the survey and offered debriefing options that included a free session with an independent counselling psychologist or contact with their nearest NGO (telephonic or in-person). An online survey was completed anonymously by 70 FSASA from the Gauteng Province of South Africa. Unfortunately, some (n=20) participant responses had to be excluded due to ineligibility for the study based on their assaults occurring before the age of 18 years of age. The degree to which

the sample experienced PTSD, resilience, PWB, and PTG was assessed using quantitative psychometric measures (PCL-5, ARM-R, PTGI, MHC-SF). Quantitative data analyses included descriptive statistics (frequencies, means and standard deviation) that described the basic features of the sample. Cronbach's alphas were calculated where applicable to address reliability for the quantitative component of the study. The descriptive statistics, levels of skewness and kurtosis and reliability coefficients were computed in SPSS 27 (IBM Corporation, 2021). CFA could not be performed due to the small sample size, thus a decision was made to do an EFA in SPSS 27 (IBM Corporation, 2021) for the questionnaires to find any possible underlying factors or combinations of items not identified in previous samples. The practical and statistical significance of the correlations were reported in Manuscript 2 and will be discussed briefly in the section below. Responses to open-ended questions about counselling experiences, PTSD symptomology, features of resilience and PTG, and barriers and facilitators to using mental health services were included in the demographic questionnaire and made up the qualitative data. Meta-inferences were drawn by contrasting the qualitative data from the people who scored the highest on the PCL-5 with the ones who reported the fewest symptoms. The findings of this analysis were outlined in Manuscript 3 and will be discussed briefly in the section below.

In Phase Three, the trauma-informed strengths-based group intervention guideline was designed by integrating the findings from Phase One and Phase Two. The formulation process of the guideline was outlined, and the Group 4-F model was developed to guide MHPs through the intervention guideline.

2 THE RESEARCH AIMS AND RESEARCH QUESTIONS CONSIDERED

An outline of how the research and research questions were addressed is provided below. Thereafter, the research outcomes are addressed.

Table 21: Outline of research objectives and questions

	Manuscript 1: Phase Two: Information gathering using a rapid review	Manuscript 2: Phase Two: Information gathering employing a convergent mixed-methods study	Manuscript 3: Phase Three: Designing the trauma-informed strengths-based group intervention guideline
Secondary research questions	Research Question 1: What interventions reported in scientific literature promote recovery in FSASA?	Research Question 2: What is the relationship between demographic variables, PWB, resilience, and PTG of a group of FSASA residing in the Gauteng Province? Research Question 3: What can we learn from the upper (SSR) and lower (FSR) FSASA scorers regarding attributing factors to their PWB, resilience and PTG in Gauteng, South Africa?	Research Question 4: What should be included in a trauma-informed strengths-based group intervention guideline for FSASA based on a rapid review and convergent mixed-methods empirical study?
Design method	Rapid Review	Convergent mixed-method study	Integration of findings from informal consultations with managers at NGOs, the rapid review, and empirical convergent mixed-methods study.

Sampling, participants, and data collection method	Systematic review of 325 papers; 35 papers were quality-appraised; 18 studies were thematically analysed to extract content for a trauma-informed strengths-based group intervention guideline for FSASA	Purposive and snowball sampling; Online surveys that included psychometrically validated scales and open-ended questions.	N/A
Data analysis	Iterative data analysis; independent coding; consensus discussion.	Quantitative: EFA to outline the relationships between the variables identified. Descriptive statistics and mean comparisons to identify different groups of survivors. Qualitative: Constant comparative analysis for responses of different scoring groups; independent coding; consensus discussions.	Integrated findings from the rapid review and empirical convergent mixed-method study.
Outcome	First formulated the outline of group intervention guideline that highlights interventions currently	<u>Quantitative.</u> Survivors can experience PTSD and PWB, resilience and PTG at the same time. Highlighting	Integration of findings from Phases One and Two enabled the design of the trauma-informed strengths-based group intervention

	<p>available for FSASA. Components contributing to the guideline.</p> <ul style="list-style-type: none"> • Screening practices • Intervention types • Intervention components <p>DRAFT 1: TRAUMA-INFORMED STRENGTHS-BASED GROUP INTERVENTION GUIDELINE FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT</p>	<p>the importance of considering all aspects of holistic treatment.</p> <p>EFA highlighted the central role of resilience in recovery.</p> <p><u>Qualitative</u>;</p> <p>Distrust of others, self-blame and lack of resources can prevent survivors from seeking treatment. Informal support and resources can facilitate treatment access. Informal supporters require psychoeducation on survivor responses and how best to support them. MHPs need to be appropriately trained, receive supervision and maintain appropriate boundaries and self-care. MHPs need to provide a safe space for destigmatisation and teach skills for emotional regulation and challenging cognitive distortions. Distrust of others and self-blame need to be addressed in treatment. Resilience-enabling activities such as journaling, interpersonal support</p>	<p>guideline for FSASA to be evaluated at the post-doctoral level.</p> <p>DRAFT 3: TRAUMA-INFORMED STRENGTHS-BASED GROUP INTERVENTION GUIDELINE FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT</p>
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		<p>and engagement in therapy need to be encouraged. Survivors engaging in empowering self-talk can develop positive post-trauma identities.</p> <p>DRAFT 2: TRAUMA-INFORMED STRENGTHS-BASED GROUP INTERVENTION GUIDELINE FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT</p>	
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3 CONCLUSIONS

Findings from the rapid review indicated that there were several interventions available for sexual assault survivors. Whereas most of the interventions were developed from the deficit model, some interventions did incorporate strengths-focused components. PTSD was the primary outcome measured to evaluate the efficacy of interventions, followed by depression, anxiety, and other Axis I clinical disorders. Some variation between the measures used to measure these outcomes was evident across studies, preventing equivalent comparisons. A total of seven different intervention types were identified in the review, namely CBT, CPT, IRT, a brief exposure group intervention, neurological integration-based interventions, and mindfulness-based interventions. In addition, this review outlined common components across the interventions for sexual assault survivors. These components included psychoeducation and exposure and relaxation techniques.

Findings from the convergent mixed-method study indicated that even though the sample was highly symptomatic, some participants also reported high scores on variables indicative of PWB. The PTSD scores in this sample were similar to pre-treatment scores exhibited in international studies where survivors underwent psychotherapeutic interventions. This finding indicates that the participants in the study may benefit from psychotherapy to alleviate their PTSD symptoms; the negative cognitions subscale in the PCL-5 most of all. Participants' responses in the qualitative data showed distrust towards others, especially men, as well as negative changes in self-esteem following the assault. These findings indicate that participants could benefit from cognitive-based interventions. Qualitative findings that indicated themes of avoidance explained high scores in the avoidance subscale. Themes indicative of this were avoidant coping employed by the participants themselves (substance use and repression) and endorsed by informal

supporters in some cases (protecting them from people and places that could be triggering). Despite the high scores in PTSD, the sample reported high levels of PWB as evident in their scores on the MHC, ARM and PTGI.

Overall, the sample indicated average resilience scores. Participants scored higher on personal resilience than relational resilience, indicating a tendency to rely more on personal strengths than environmental resources. This explanation is also reflected in the resource deficiency, self-stigma, and lack of awareness of services available to them reported by many of the participants in the sample. Aspects of resilience that were evident in the qualitative data included engaging in activities that furthered emotional expression, seeking interpersonal support, and attending psychotherapy. High levels of PTG were reported with scores above average on all the PTGI subscales. Qualitative findings indicated that participants held several empowering mindsets. These included not letting the assault define them, embracing a survivor narrative instead of a victim identity, prizing self-forgiveness and taking their power back by defining the perpetrator as the weak one, and trusting God.

Although 36% of the participants reported that no one supported them, many participants reported that the members of their informal support network were supportive. When quantitative scores were considered, it is apparent that supporters that provided support that encouraged survivors to cope with the trauma in an active manner by advocating for psychotherapy were most helpful. More than half of the participants in the study attended psychotherapy; most utilised private psychologists or NGOs for this purpose. Barriers to therapy included apprehension and distrust of self and others as well as lack of resources (financial, transport, understaffing leading to waiting lists). The predominant amount of the participants who went to therapy spent longer than one month in therapy and the duration of therapy was positively correlated with scores on variables

indicating PWB. Participants reported both positive and negative experiences in therapy. Benefits of therapy included learning skills, having a safe space that was destigmatising, normalisation of their reactions and being able to reframe their experience. Unhelpful experiences included inaccurate empathy, insufficient containment, lack of skills training, and therapists with improper boundaries. These findings provide important implications for practice.

4 LIMITATIONS

Although this study has several limitations, it does identify a significant gap in the literature regarding therapies for sexual assault survivors. This review was restricted to peer-reviewed English articles that did not include anyone under the age of 18 years. Several interventions that were mentioned in past studies may not have been included due to the timeframe restrictions. To mitigate this limitation, the findings of this study were compared to previous reviews in the discussion section. The reference lists of the included articles and relevant systematic reviews were scanned for additional relevant articles for inclusion to compensate for any deficiency in the retrieval terms (Grayson & Gomersall, 2003; Papaioannou et al., 2010). This rapid review contained no meta-analyses that might have shown how the therapies compared in terms of efficacy. To maintain the focus on sexual assault interventions, this review omitted articles where the predominant number of participants in the sample presented with other traumas that did not include sexual assault. As a result, some interventions that may be effective with a wide variety of trauma types may have been excluded from the review. In addition, several interventions were found in the initial search of the databases but were excluded since they were not formally evaluated. Case studies were excluded from this review due to their poor evidence quality - this had the unintended effect that South African articles were excluded from the review.

Some limitations were also evident in the convergent mixed-method study. CFA was unsuccessful for the quantitative measures used in the study. The small sample size may have detracted from the generalisability of study findings, as well as constrained statistical power. A total of eight months of consistent efforts were employed to recruit participants for the study. Recruitment included posters at NGOs, snowball sampling and a targeted social media campaign. Recruitment posters were found to be ineffective in recruitment and yielded limited responses (n=3). The social media campaign was significantly more successful but also required significantly higher financial costs to maintain. Advertisements used for the social media campaign also had to be adjusted for specificity to exclude women who experienced sexual assault before the age of 18 years once it became clear that participants were not reading the inclusion criteria thoroughly. Although a real-time chat was available to survivors to ask any questions about the study before, during or after the study, this function was utilised infrequently (twice) throughout the data collection period. When utilised, participants asked about referral services more than the study itself. Upon reflection, the importance of a more interactive informed consent process was noted.

Secondly, data were collected via self-report questionnaires, which yielded subjective results. Using anonymous online surveys inhibited the researcher's ability to follow-up with participants for clarification and elaboration of answers. This impacted the trustworthiness of the findings since member-checking could not be performed. This strategy also impacted the depth of the qualitative responses since no probing could take place.

Due to the already complex nature of this study, the researcher and their supervisors decided to conduct a Delphi evaluation of the group intervention guideline during post-doctoral studies. Therefore, this guideline is limited in the sense that although initial

objectives were set in conjunction with MHPs, the guideline has not been evaluated by this population to date. Despite these limitations, the findings of the studies in this thesis have important implications for practice and future research.

5 CONTRIBUTIONS OF THE STUDY

This study makes contributions to knowledge and practice. First, the rapid review contributed to the global knowledge base by expanding on it. This offers an updated overview of the most recent interventions and incorporates strengths-based interventions that have historically been excluded in related reviews. In addition, this review outlined common components across the interventions for sexual assault survivors. These components included psychoeducation and exposure and relaxation techniques. Outlining these common components highlighted the components crucial to effective interventions for this population. This review equips practitioners with knowledge of which interventions are most appropriate for this population and informs them of the components required when developing a new intervention for this specific population.

Next, the quantitative part of the convergent mixed-method study contributed to the global literature on strengths-based variables prevalent in sexual assault survivors and opened this area of exploration in South African sexual assault survivors. In addition, a new, promising model of how PTSD, PWB, resilience and PTG are correlated was introduced. Accordingly, these findings indicate that interventions focused on increasing resilience amongst sexual assault survivors could assist them to benefit from lowered levels of distress, and increased PWB, and set them on the transitional trajectory towards PTG.

The qualitative part of the convergent mixed-method study highlighted barriers and facilitators of PWB amongst South African FSASA. This research compared the qualitative responses of participants that showed SSR by showing comparatively lower

scores on PTSD and higher on strengths-based measures to those who displayed the opposite profile (FSR). This comparison highlighted differences between the two groups in terms of interpersonal support, therapy attendance and coping strategies. Shame and self-blame were evident in both groups indicating the importance of addressing these symptoms in counselling. This study also outlined indicators of resilience that have historically not received significant attention. This is also the first study that highlighted PTG indicators for South African FASAs. Lastly, the guideline contributes to practice by offering MHPs working with sexual assault survivors guidance on aspects that need to be assessed, addressed and cultivated during treatment.

6 RECOMMENDATIONS FOR PRACTICE AND FUTURE RESEARCH

South African studies were absent from the studies evaluated in this review since there were no RCTs conducted in South Africa that evaluated interventions. As a result, these studies did not meet the inclusion criteria. Therefore, the need for RCTs within this context is clear. A systematic review can elaborate on the rapid review conducted in this study. A broader review such as this may include more interventions than the study identified. In such a review, studies that followed a case study design may also be included and evaluated. Such a synthesis will allow practitioners to assess survivors in a more comprehensive manner that includes a strengths-based focus.

This study introduced a new, promising model of how PTSD, PWB, resilience and PTG are correlated. Accordingly, these findings indicate that interventions focused on increasing resilience amongst sexual assault survivors could help them benefit from lowered levels of distress, increased PWB, and set them on the transitional trajectory towards PTG. A quantitative study investigating the prevalence of variables measured in the convergent mixed-method study can be replicated with a larger community sample. Replication of this study will enable researchers to investigate additional correlations

between the variables that may not have shown significance in this study due to the small sample. Furthermore, such a study could confirm the model of fit for the different measures in a bigger sample. Studies that investigate the personal resilience of survivors more thoroughly would give clinicians a better indication of the personal characteristics that could be reinforced in treatment towards enabling PTG enabling outcomes.

Before use, this group intervention guideline will go through a Delphi evaluation by experts who assist sexual assault victims. There will be three primary purposes for this evaluation. Firstly, including elements or facets that haven't been thoroughly discussed or considered will serve as a quality control measure. Secondly, it will raise knowledge of the directive to attract delivery sites for pilot testing. Thirdly, the regulation of guideline usage will be informed by MHP discussions.

7 PERSONAL REFLECTION

As a clinical psychologist in part-time private practice, I have been in awe of the strength and courage my clients show when facing their biggest fears and fighting their most ardent enemies - even if, at times, they are their own enemies. I have been blessed to be able to learn a tremendous amount about life, searching for answers and finding meaning in my clients by putting myself in their shoes and walking the road to recovery as their companion. Unfortunately, sexual violence is a traumatic experience that many of my clients carry with them. They courageously come to sessions to be heard so that they can let go of self-blame and redefine their narratives. This research was inspired by these therapeutic experiences of witnessing hope and tremendous inner strength in the face of destruction. Engaging in this research offered me the opportunity to offer a voice to the survivors that are on the journey of rebuilding their lives by informing client-centred practice.

I have always been inspired and energised by learning new things, so when I started my first steps on this research journey, I was excited for the growth ahead. Engaging in this research has been one of the most challenging endeavours I have ever undertaken. It has tested my perseverance and forced me to confront my fears and insecurities. This journey also enabled me to use many of my strengths and allowed me to cultivate new ones. I used humility and bravery when walking into new treatment environments to ask for assistance with recruitment. I had to employ creativity and engage in teamwork regarding problem-solving and recruitment material design. My sense of meaning, love of learning and gratitude for this opportunity enabled me to persevere through the times when I felt like I did not want to continue anymore. Along the way, I found two new strengths – seeing the humour in the journey and showing self-compassion when things did not go according to plan.

This research also made me question my purpose as an academic and clinician. As a young clinician, this study has reiterated the importance of the therapeutic relationship and exposed me to new interventions that I would like to learn about in the future. Despite the trials and tribulations of research, I have discovered that I enjoy the structured investigation that it entails. I have been exposed to experienced researchers in this journey and I have learned a tremendous amount from them. I know that there is still more to learn, and I hope that this is the start of a lifelong process of contributing to the field of intervention research and clinical practice.

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ADDENDUM 1: ETHICS APPROVAL LETTERS



Private Bag X1290, Potchefstroom
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Web: <http://www.nwu.ac.za/>

North-West University Health Research Ethics
Committee (NWU-HREC)

Tel: 018 299-1206
Email: Ethics-HRECAppl@nwu.ac.za (for human
studies)

30 January 2022

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North-West University Health Research Ethics Committee (NWU-HREC) on 30/01/2022, the NWU-HREC hereby approves your study as indicated below. This implies that the NWU-HREC grants its permission that, provided the general conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Trauma-informed strengths-based group intervention guideline for female survivors of adult sexual assault																															
Principal Investigator/Study Supervisor/Researcher: Prof HJ Walker-Williams																															
Student: S Theunissen - 22329390																															
Ethics number:	<table border="1"><tr><td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>2</td><td>0</td><td>6</td><td>-</td><td>2</td><td>1</td><td>-</td><td>A</td><td>1</td></tr><tr><td colspan="3">Institution</td><td colspan="5">Study Number</td><td colspan="2">Year</td><td colspan="5">Status</td></tr></table>	N	W	U	-	0	0	2	0	6	-	2	1	-	A	1	Institution			Study Number					Year		Status				
N	W	U	-	0	0	2	0	6	-	2	1	-	A	1																	
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Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation																															
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Commencement date: 30/01/2022																															
Expiry date: 28/02/2023																															
Approval of the study is provided for a year, after which continuation of the study is dependent on receipt and review of a six-monthly monitoring report and the concomitant issuing of a letter of continuation. Monitoring reports are due at the end of August and February annually until completion of the study.																															

General conditions:
<i>While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:</i>
<ul style="list-style-type: none">• The principal investigator/study supervisor/researcher must report in the prescribed format to the NWU-HREC:<ul style="list-style-type: none">- six-monthly on the monitoring of the study, whereby a letter of continuation will be provided annually, and upon completion of the study; and- without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.• The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the principal investigator/study supervisor/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.• Annually a number of studies may be randomly selected for active monitoring.• The date of approval indicates the first date that the study may be started.• In the interest of ethical responsibility, the NWU-HREC reserves the right to:<ul style="list-style-type: none">- request access to any information or data at any time during the course or after completion of the study;- to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;

- *withdraw or postpone approval if:*
 - *any unethical principles or practices of the study are revealed or suspected;*
 - *it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;*
 - *submission of the six-monthly monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and/or*
 - *new institutional rules, national legislation or international conventions deem it necessary.*
- *NWU-HREC can be contacted for further information via Ethics-HRECApply@nwu.ac.za or 018 299 1206*

Special conditions of the research approval due to the COVID-19 pandemic:

Please note: Due to the nature of the study i.e. (online and face-to-face collection of both quantitative and qualitative data from female survivors of sexual assault within specific non-governmental organisations), this study will be able to proceed during the current alert level, following receipt of the approval letter. No additional COVID-19 restrictions have been placed on the study, other than that indicated under the COVID-19 risk mitigation strategy in the application itself. The researcher must, however, ensure that before proceeding with the study that all research team members have reviewed the North-West University COVID-19 Occupational Health and Safety Standard Operating Procedure.

The NWU-HREC would like to remain at your service and wishes you well with your study. Please do not hesitate to contact the NWU-HREC for any further enquiries or requests for assistance.

Yours sincerely,



Digitally signed by
Prof Petra Bester
Date: 2022.01.31
14:15:12 +02'00'

Chairperson NWU-HREC

Current details: (23239522)G:\My Drive\9. Research and Postgraduate Education\9.1.5.4 Templates\9.1.5.4.2_NWU-HREC_EAL.docm
20 August 2019
File Reference: 9.1.5.4.2



Prof HJ Walker-Williams
Psychology
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Health Sciences Ethics Office for Research,
Training and Support

North-West University Health Research Ethics
Committee (NWU-HREC)

Tel: 018-299 2092
Email: Wayne.Towers@nwu.ac.za

13 April 2022

Dear Prof Walker-Williams

APPROVAL OF YOUR AMENDMENT REQUEST BY THE NORTH-WEST UNIVERSITY HEALTH RESEARCH ETHICS COMMITTEE (NWU-HREC) OF THE FACULTY OF HEALTH SCIENCES

Ethics number: NWU-00206-21-A1

Kindly use the ethics reference number provided above in all future correspondence or documents submitted to the administrative assistant of the North-West University Health Research Ethics Committee (NWU-HREC) secretariat.

Study title: Trauma-informed strengths-based group intervention guideline for female survivors of adult sexual assault

Study leader: Prof HJ Walker-Williams


Student: S Theunissen - 22329390

You are kindly informed that your amendment request (changes to demographic questionnaire and addition of a quantitative questionnaire) to the aforementioned project has been approved. Any future amendments to the proposal or other associated documentation must be submitted to the NWU-HREC, Faculty of Health Sciences, North-West University, prior to implementing these changes. These requests should be electronically submitted to Ethics-HRECApply@nwu.ac.za, for review BEFORE approval can be provided, with a cover letter with a specific subject title indicating, "Amendment request: NWU-XXXXX-XX-XX". The letter should include the title of the approved study, the names of the researchers involved, the nature of the amendment/s being made (indicating what changes have been made as well as where they have been made), which documents have been attached and any further explanation to clarify the amendment request being submitted. The amendments made should be indicated in **yellow highlight** in the amended documents. The *e-mail*, to which you attach the documents that you send, should have a *specific subject line* indicating that it is an amendment request e.g. "Amendment request: NWU-XXXXX-XX-XX". This e-mail should indicate the nature of the amendment. This submission will be handled via the expedited process.

Please note: Due to the nature of the study i.e. (online and face-to-face collection of both quantitative and qualitative data from female survivors of sexual assault within specific non-governmental organisations), this study will be able to proceed during the current alert level, following receipt of the approval letter. No additional COVID-19 restrictions have been placed on the study, other than that indicated under the COVID-19 risk mitigation strategy in the application itself. The researcher must, however, ensure that before proceeding with the study that all research team members have reviewed the North-West University COVID-19 Occupational Health and Safety Standard Operating Procedure.

We wish you the best as you conduct your research. If you have any questions or need further assistance, please contact the Faculty of Health Sciences Ethics Office for Research, Training and Support at Ethics-HRECApply@nwu.ac.za.

Yours sincerely

 Digitally signed by
Prof Petra Bester
Date: 2022.04.14
09:07:08 +02'00'

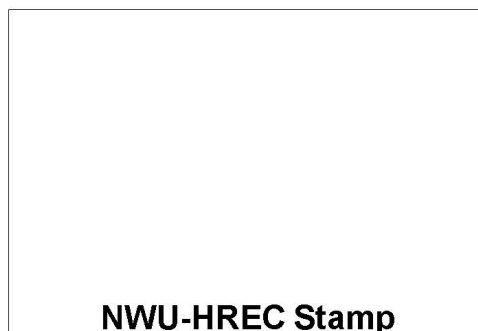
Chairperson: NWU-HREC

Current details: (23239522) G:\My Drive\9. Research and Postgraduate Education\9.1.5.3 Letters Templates\9.1.5.4.1_Approval_letter_Amend_Req_HREC.docm
30 April 2018
File reference: 9.1.5.4.1

ADDENDUM 2: CONSENT FORMS



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NWU-HREC Stamp

INFORMED CONSENT DOCUMENTATION FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT TO PARTICIPATE IN MIXED METHOD RESEARCH STUDY

TITLE OF THE RESEARCH STUDY: Trauma-informed strengths-based group intervention guideline for female survivors of adult sexual assault

ETHICS REFERENCE NUMBERS:

PRINCIPAL INVESTIGATORS: Prof HJ Walker-Williams and Prof A Fouché

PRIMARY INVESTIGATOR: Shanaé Theunissen

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1900

CONTACT NUMBER: 065 818 5895

You are being invited to take part in a **research study** that forms part of a Doctoral Dissertation. Please take some time to read the information, which will explain the details of this study and the process to follow. Should you have any questions or concerns please feel free to ask the person explaining this letter to you. It is very important that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** which means that you are free to say no to participating

in this study. If you say no, this will not affect you negatively in any way. You are also free to withdraw from this study at any time, even if you do agree to take part at the start.

This study has been approved by the **NWU-Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU**) and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- This study plans to develop a strength-based intervention for female survivors of adult sexual assault by investigating resilience, posttraumatic growth and psychological well-being of these female survivors. We want to find out more about what interventions benefit survivors in their recovery so that we can help other female survivors who have also experienced adult sexual assault.
- This study will be conducted in psychosocial support centres across the Gauteng Province. These centres include local non-governmental organisations like Lifeline and the Purple Foundation. The study will be done by experienced health researchers trained in administration and interpretation of quantitative and qualitative measures. A minimum of 107 participants will be included in this study.

Why have you been invited to participate?

- You have been invited to be part of this research because you are a female who is 18 years or older and has experienced sexual assault from the time of turning 18 years.
- You have access to internet or you are willing to complete the questionnaires face to face at a psychosocial support centre close to you.
- You are willing to sign a hardcopy of an informed consent form at the nearest psychosocial support centre OR give consent electronically via the link supplied to you.
- You have told someone about the assault and received some form of trauma counselling or debriefing and have worked through the acute or disclosure phase and feel that you can contribute to this study.
- You will unfortunately not be able to take part in this research if you are below the age of 18 years, male, have not attended any counselling for the assault or if you are currently involved in a court case pertaining to the assault.

What will be expected of you?

You will be expected to complete 4 short questionnaires. These include: (1) a demographic (personal information) questionnaire containing questions about your age, language and questions about your experiences in your recovery journey; (2) Resilience Research Centre Adult resilience measure which looks at which resources you have used to help you cope with the adult sexual assault; (3) Posttraumatic Growth Inventory that looks at the personal growth that you may

have experienced after the adult sexual assault; and (4) the Mental Health Continuum that assesses to what extent you are satisfied with your life at this current stage. These questionnaires will take approximately a minimum of 30 minutes to complete.

Will you gain anything from taking part in this research?

- You will be given or emailed resources that tell you more about resilience and posttraumatic growth skills which you can use in your recovery.

Are there risks involved in you taking part in this research and what will be done to prevent them?

- The risks to you in this study are that you may feel emotional after you have completed the questionnaires. This risk is limited by the fact that the questionnaires do not contain any questions about the event itself but is more focused on your experiences and how you are coping with and after the event. If you do however feel that the questionnaires were difficult for you to complete due to it reminding you of the adult sexual assault, you will be given a contact number of a professionally registered psychologist with many years of experience in working with female survivors of adult sexual assault, who you can contact for a free telephonic or online session, to assist you in working through these difficult emotions and with further coping skills.

How will we protect your confidentiality and who will see your findings?

- Your privacy will be respected by giving you an opportunity to complete the questionnaires in a quiet room with no distractions if you do this in person. If you do it online you can choose a safe space of your own. For this study we only need a name (does not have to be your real name, you can use a fake name) and cell phone number so that we can use to send you a data voucher once you have completed the questionnaires. We do not need any of your other details such as your address and in this way you can remain anonymous. Once we have sent you the data voucher your name and cell phone number will be erased so that your answers cannot be connected to you. The findings will be kept confidential and your identity protected by giving you a participant number on your questionnaires instead of adding your personal information. Your name and contact information will only be connected to your participant number and not your answers. Only the research team will be able to look at your findings. Findings will be kept safe by locking hard copies in locked cupboards in the supervisor's office and electronic data will be password protected. Data will be stored for 5 years on the North-West Universities Vanderbijlpark Campus.

What will happen with the findings?

- The findings of this study will be used to help the researcher develop an intervention for female survivors of adult sexual assault so as to assist survivors and organisations who provide services to women who have experienced sexual

assault in their recovery. This intervention will be focused on helping women identify their strengths and how they can use them on their journey of recovery.

How will you know about the results of this research?

- You will be sent resources like a pamphlet so that you can learn more about mental health, resilience and posttraumatic growth. This can guide you in your recovery. If you would like us to we can send you more information about the study by entering your email address on the informed consent form. If you do not have an email address you will be able to see the results at the psychosocial support centre where you are completing these questionnaires. These results will only show the overall findings of the research and no individual scores of the questionnaires or any personal details.

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

- This study is funded by the researcher. Travel expenses will be paid for those participants who have to travel to the psychosocial support centre to complete the questionnaires. You will also be given a face mask and hand sanitizer when you are completing the questionnaires in person that you can take home afterwards. For the participants that complete the questionnaire via the online link your data will be reimbursed to the extent of R30. PLEASE NOTE THAT YOU CAN ONLY COMPLETE THE QUESTIONNAIRES ONCE.
- Please note that there will be no costs involved for you, if you do take part in this study.

Is there anything else that you should know or do?

- You can contact the researcher Shanae Theunissen at 065 818 5895 if you have any further questions or have any problems.
- You can also contact the NWU-Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I agree to take part in the research study titled: Trauma-informed strengths-based group intervention guideline for female survivors of adult sexual assault.

I declare that:

- I have read this information or it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.

- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is voluntary and I have not been pressurized to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I choose to do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.
- I consent to providing my email address to receive follow-up information on this study.

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

Cellphone number.....

.....
Signature of participant

Name*:

Declaration by person obtaining consent

I (*name*) declare that:

- I clearly and in detail explained the information in this document to.....
- I did/did not use an interpreter.
- I encouraged her to ask questions and took adequate time to answer them.
- I am satisfied that she adequately understands all aspects of the research as discussed above
- I gave her time to discuss it with others if he/she wished to do so.

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

Cellphone number:

.....
Signature of person obtaining consent

Name*:.....

Declaration by researcher

I (*name*) declare that:

- I explained the information in this document to the participant.
- I did/did not use an interpreter
- I encouraged her to ask questions and took adequate time to answer them or I was available should she want to ask any further questions.
- The informed consent was obtained by an independent person.
- I am satisfied that she adequately understands all aspects of the research as described above.
- I am satisfied that she had time to discuss it with others if she wished to do so.

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

.....
Signature of researcher

ADDENDUM 3: INDEPENDENT PROFESSIONALS CONFIDENTIALITY

Ms Tebello Mabusela
COUNSELLING & INDUSTRIAL PSYCHOLOGIST

PS 0140 775, PR. No 091 3553

Masters: Counselling Psychology

64 Dr. James Moroka Street, 3 Octron Building, Potchefstroom, 2531

Email Address: Tebello. Mabusela@nwu.ac.za

018 294 4554

064 516 6489

Ms Shanae Theunissen 03 November 2020
School for Psychosocial Health
Vanderbijlpark Campus
North-West University

Dear Ms Theunissen,

STUDY: TRAUMA-INFORMED STRENGTHS-BASED GROUP INTERVENTION GUIDELINE FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT

I am willing to act as consulting counselling psychologist for the above-mentioned study. I agree to a first consultation of 30 to 45 minutes for those participants that have been identified to experience emotional, psychological, and sociological anxiety after completion of the questionnaires. The first consultation would be charged at R 100 per session after which my regular fees of R 750 would apply if follow-up session is required by the participant.

I would also like to stress that all consultations will be strictly confidential.

Please contact me if you have any further enquiries.

Kind regards,



Tebello Mabusela
PS 0140 775
PR.No. 091 3553
Counselling Psychologist in Private Practice

FORMS



03 November 2020

Ms Shanae Theunissen
School for Psychosocial Health
Vanderbijlpark Campus
North-West University

Dear Ms Theunissen,

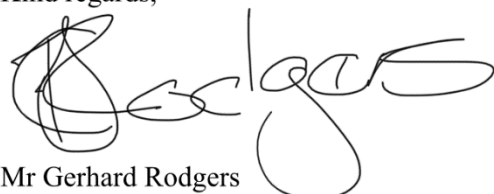
**STUDY: TRAUMA-INFORMED STRENGTHS-BASED GROUP INTERVENTION
GUIDELINE FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT**

I am willing to act as co-coder for the above-mentioned study. I agree to adhere to the ethical principles inherent in this process.

I would also like to stress that all consultations will be strictly confidential.

Please contact me if you have any further enquiries.

Kind regards,



Mr Gerhard Rodgers

ADDENDUM 4: QUESTIONNAIRE PACK

**Participants could select their preferred language to complete the informed consent and questionnaire in and were redirected accordingly.*

Research Study Questionnaire (English)

You are invited to take part in a research study about coping and rising above sexual trauma, as part of a Doctoral Dissertation. See <https://emthini.co.za> for more information.

The study aims to develop better strategies to help sexual assault survivors by learning from others what resources and coping strategies helped them. You can help other by sharing what has helped you, by answering five simple questionnaires about resilience and coping.

No sensitive information will be asked, and you will not be asked to relive or answer any questions about the event itself. We simply want to know what has helped you to deal with such traumas.

We will also send you a R30 data bundle to say thank you, and if you need someone to talk to you can contact us for a free counselling session.

If you are interested in participating, and meet the following criteria, please take some time to read the information below which will explain the study and the process to follow.

- Above 18 years of age
- Experienced a form of sexual assault more than 3 months ago
- Not currently in a legal battle pertaining to the event

This study has been approved by the NWU-Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00206-21-S1). Your participation is also entirely voluntary which means that you can quit at any time, and don't have to answer any questions you do not want to.

- You can contact the researcher Shanae Theunissen at 065 818 5895 or NWU-Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any further questions or have any problems.

What is this study about?

- This study plans to develop a strength-based intervention for female survivors of adult sexual assault by investigating resilience, posttraumatic growth and psychological well-being of these female survivors. We want to find out more about what interventions benefit survivors in their recovery so that we can help other female survivors who have also experienced adult sexual assault.

What will be expected of you?

You will be expected to complete 5 short questionnaires.

- (1) A demographic questionnaire containing questions about your age, language and experiences in your recovery journey;
- (2) Adult Resilience Measure which looks at which resources you have used to help you cope with the adult sexual assault;

- (3) Posttraumatic Growth Inventory that looks at the personal growth that you may have experienced after the adult sexual assault;
- (4) the Mental Health Continuum that assesses to what extent you are satisfied with your life at this current stage
- (5) the PCL-5 assesses the extent to which you are currently experiencing post-traumatic stress symptoms.

These questionnaires will take approximately a minimum of 30 minutes to complete.

Will you be paid to take part in this study and are there any costs for you

- This study is funded by the researcher.
- For the participants that complete the questionnaire via the online link your data will be reimbursed to the extent of R30.

PLEASE NOTE THAT YOU CAN ONLY COMPLETE THE QUESTIONNAIRES ONCE.

Will you gain anything from taking part in this research?

- You will be given resources that tell you more about resilience and posttraumatic growth skills which you can use in your recovery.

Are there risks involved in you taking part in this research?

- The only risks to you in this study are that you may feel emotional after you have completed the questionnaires. This risk is limited by the fact that the questionnaires do not contain any questions about the event itself but is more focused on your experiences and how you are coping with and after the event.

If you do however feel that the questionnaires were difficult for you to complete if it reminds you of the adult sexual assault, you will be given a contact number of a professionally registered psychologist with many years of experience in working with female survivors of adult sexual assault, who you can contact for a free telephonic or online session, to assist you in working through these difficult emotions and with further coping skills.

How will we protect your confidentiality?

- Your privacy will be respected at all time and all information will be anonymous
- You will be given the opportunity to complete the questionnaires in a quiet room with no distractions if you do this in person. If you do it online you can choose a safe space of your own.
- For this study we only need a name (please do not use your real name; you can use a fake name) and cell phone number so that we can use to send you a data voucher once you have completed the questionnaires.
- We do not need any of your other details such as your address and in this way you can remain anonymous.

Once we have sent you the data voucher your name and cell phone number will be erased so that your answers cannot be connected to you.

The findings will be kept confidential and your identity protected by giving you a participant number on your questionnaires instead of adding your personal information. Your name and contact information will only be connected to your participant number and not your answers. Only the research team will be able to look at your findings. Findings will be

kept safe by locking hard copies in locked cupboards in the supervisor's office and electronic data will be password protected. Data will be stored for 5 years on the North-West Universities Vanderbijlpark Campus.

What will happen with the findings?

- The findings will be used to help the researcher develop an intervention for female survivors of adult sexual assault so as to assist survivors and organisations who provide services to women who have experienced sexual assault in their recovery.
- This intervention will be focused on helping women identify their strengths and how they can use them on their journey of recovery.

How will you know about the results of this research?

- You will be sent resources like a pamphlet so that you can learn more about mental health, resilience and posttraumatic growth. This can guide you in your recovery. If you would like us to we can send you more information about the study by entering your email address on the informed consent form. If you do not have an email address you will be able to see the results at the psychosocial support centre where you are completing these questionnaires. These results will only show the overall findings of the research and no individual scores of the questionnaires or any personal details.

Contact Numbers

Prime Investigator
Ms Shanae Theunissen
065 818 5895

NWU-Health Research Ethics Committee
Mrs Carolien van Zyl
018 299 1206
carolien.vanzyl@nwu.ac.za

I hereby consent to participating in the study, knowing that my answers will be kept confidential and my identity will be remain anonymous.

Yes/No

Demographic Questionnaire (Questionnaire 1/5) (Open-ended questions)

- Cell phone number for data voucher
- Network for data voucher
- How old are you (years)?
- Ethnicity or Race
- Current relationship status
- Which suburb in Gauteng do you live in?
- Highest level of education completed
- Current occupation
- How long ago did the sexual assault happen?
- Did you experience a sexual assault more than once during adulthood? If yes how many times?
- Did you know the person who assaulted you?
- If yes to previous question, what was your relationship with the perpetrator?
- Who did you tell about your sexual assault?

- Did you report the assault to the police?
- Was the police helpful in assisting you to prosecute the perpetrator?
- How soon after the assault did you go for counselling/therapy?
- Which organisation did you go for counselling/therapy?
- How long were you in therapy after the sexual assault?
- Are there any things that made it hard for you to get access to counselling/therapy? If so, what?
- Did you find counselling/therapy helpful?
- Is there anything about the therapy/counselling that you found very helpful?
- Is there anything about the therapy/counselling that made you feel like it was a bad experience or unhelpful?
- What advice would you give counsellors working with sexual assault survivors?
- Who supported you after the assault?
- How did people support you after the assault?
- What did you do to help you cope with the sexual assault?
- Has the sexual assault changed the way you see yourself or others? If so how?
- What advice do you have for others who may have experienced a sexual assault to help them cope and work through it?
- Please share who referred you to the study or where you heard about it

Adult Resilience Measure (Questionnaire 2/5)

Indicate for each of the statements below the degree to which this change occurred in your life as a result of the crisis/disaster, using the following scale.

0 = I did not experience this change (as a result of my crisis)

1 = I experienced this change to a very small degree (as a result of my crisis)

2 = I experienced this change to a small degree (as a result of my crisis)

3 = I experienced this change to a moderate degree (as a result of my crisis)

4 = I experienced this change to a great degree (as a result of my crisis)

5 = I experienced this change to a very great degree (as a result of my crisis)

1. I get along with people around me
2. Getting and improving qualifications or skills is important to me
3. I know how to behave in different social situations (such as at work, home, or other public places)
4. My family is supportive towards me
5. My family knows a lot about me (for example, who my friends are, what I like to do)
6. If I am hungry, I can usually get enough food to eat
7. People like to spend time with me
8. I talk to my family/partner about how I feel (for example, when I am sad or concerned)
9. I feel supported by my friends
10. My family/partner stands by me when times are hard (for example, when I am ill or in trouble)
11. I feel that I belong in my community
12. My friends care about me when times are hard (for example, when I am ill or in trouble)
13. I am treated fairly in my community

14. I have opportunities to show others that I can act responsibly
15. I feel secure when I am with my family/partner
16. I have opportunities to apply my abilities in life (like using skills, working at a job, or caring for others)
17. I like my family's/partner's culture and the way my family celebrates things (like holidays or learning about my culture)

Posttraumatic Growth inventory (Questionnaire 3/5)

Indicate for each of the statements below the degree to which this change occurred in your life as a result of the crisis/disaster, using the following scale.

0 = I did not experience this change (as a result of my crisis)

1 = I experienced this change to a very small degree (as a result of my crisis)

2 = I experienced this change to a small degree (as a result of my crisis)

3 = I experienced this change to a moderate degree (as a result of my crisis)

4 = I experienced this change to a great degree (as a result of my crisis)

5 = I experienced this change to a very great degree (as a result of my crisis)

1. I changed my priorities about what is important in life.
2. I have a greater appreciation for the value of my own life.
3. I developed new interests.
4. I have a greater feeling of self-reliance.
5. I have a better understanding of spiritual matters.
6. I more clearly see that I can count on people in times of trouble.
7. I established a new path for my life.
8. I have a greater sense of closeness with others.
9. I am more willing to express my emotions.
10. I know better that I can handle difficulties.
11. I am able to do better things with my life.
12. I am better able to accept the way things work out.
13. I can better appreciate each day.
14. New opportunities are available which wouldn't have been otherwise.
15. I have more compassion for others.
16. I put more effort into my relationships.
17. I am more likely to try to change things which need changing.
18. I have a stronger religious faith.
19. I discovered that I'm stronger than I thought I was.
20. I learned a great deal about how wonderful people are.
21. I better accept needing others.

Mental Health Continuum - Short form (Questionnaire 4/5)

Please answer the following questions about how you have been feeling during the past month.

Place a check mark in the box that best represents how often you have experienced or felt the following:

During the past month, how often did you feel ...

(1) Never (2) Once or twice (3) About once a week (4) About 2 or three times a week (5) Almost every day (6) Every day

1. Happy
2. interested in life
3. satisfied with life
4. that you had something important to contribute to society
5. that you belonged to a community (like a social group, or your neighborhood)
6. that our society is a good place, or is becoming a better place, for all people
7. that people are basically good
8. that the way our society works makes sense to you
9. that you liked most parts of your personality
10. good at managing the responsibilities of your daily life
11. that you had warm and trusting relationships with others
12. that you had experiences that challenged you to grow and become a better person
13. confident to think or express your own ideas and opinions
14. that your life has a sense of direction or meaning to it

PCL-5 (Questionnaire 5/5)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

- 1 = Not at all
 2 = A little bit
 3 = Moderately
 4 = Quite a bit
 5 = Extremely

In the past month, how much were you bothered by:

1. Repeated, disturbing, and unwanted memories of the stressful experience?
2. Repeated, disturbing dreams of the stressful experience?
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?
4. Feeling very upset when something reminded you of the stressful experience?
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?
6. Avoiding memories, thoughts, or feelings related to the stressful experience?
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?
8. Trouble remembering important parts of the stressful experience?
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?
10. Blaming yourself or someone else for the stressful experience or what happened after it?
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?
12. Loss of interest in activities that you used to enjoy?
13. Feeling distant or cut off from other people?

14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?
15. Irritable behavior, angry outbursts, or acting aggressively?
16. Taking too many risks or doing things that could cause you harm?
17. Being “superalert” or watchful or on guard?
18. Feeling jumpy or easily startled?
19. Having difficulty concentrating?
20. Trouble falling or staying asleep?

Navorsings studie Vraelys

U word uitgenooi om deel te neem aan 'n navorsingstudie wat deel vorm van 'n Doktorale Verhandeling. Neem asseblief tyd om die inligting te lees wat die besonderhede van hierdie studie en die proses sal verduidelik om te volg. Indien u enige vrae of bekommernisse het, voel asseblief vry om die persoon te vra om hierdie brief aan u te verduidelik. Dit is baie belangrik dat u duidelik verstaan waaroor hierdie navorsing gaan en hoe u betrokke kan wees. Jou deelname is heeltemal vrywillig, wat beteken dat jy vry is om nee te sê vir deelname aan hierdie studie. As jy nee sê, sal dit jou op geen manier negatief beïnvloed nie. U is ook vry om te enige tyd van hierdie studie te onttrek, selfs al stem u in om aan die begin deel te neem.

Hierdie studie is deur die NWU-Gesondheidsnavorsingsetiekkomitee van die Fakulteit Gesondheidswetenskappe van die Noordwes-Universiteit (NWU-00206-21-S1) goedgekeur en sal uitgevoer word volgens die etiese riglyne en beginsels van Etiek in Gesondheidsnavorsing: Beginsels, Prosesse en Strukture (DoH, 2015) en ander internasionale etiese riglyne wat op hierdie studie van toepassing is. Dit kan nodig wees vir die navorsingsetiekkomitee lede of ander relevante mense om die navorsingsrekords te inspekteer.

Waaroor gaan hierdie navorsing?

- Hierdie studie beplan om 'n persoonlike sterktes gebaseerde intervensie vir vroulike oorlewendes van volwasse seksuele aanranding te ontwikkel deur die veerkragtigheid, posttraumatische groei en sielkundige welstand van hierdie vroulike oorlewendes te ondersoek. Ons wil meer uitvind oor watter intervensies oorlewendes bevoordeel in hul herstel sodat ons ander vroulike oorlewendes kan help wat ook volwasse seksuele aanranding ervaar het.
- Hierdie studie sal in psigo-sosiale ondersteuningsentrums regoor die Gauteng provinsie gedoen word. Hierdie sentrums sluit plaaslike nie-regeringsorganisasies soos Lifeline en die Purple Foundation in. Die studie sal gedoen word deur ervare gesondheidsnavorsers opgelei in administrasie en interpretasie van kwantitatiewe en kwalitatiewe matriëls. 'n Minimum van 107 deelnemers sal by hierdie studie ingesluit word.

Wat word van jou verwag?

- Daar word van u verwag om 4 kort vraelyste te voltooi. Dit sluit in: (1) 'n demografiese (persoonlike inligting) vraelys wat vrae bevat oor jou ouderdom, taal en vrae oor jou ervarings in jou herstelreis; (2) veerkragtigheidsnavorsingsentrum Volwasse veerkragtigheidsmaatreël wat kyk na watter hulpbronne jy gebruik het om jou te help om die volwasse seksuele aanranding te hanteer; (3) Posttraumatische groeivoorraad wat kyk na die persoonlike groei wat u na die seksuele aanranding van volwassenes ervaar het; en (4) die Mental Health Continuum wat bepaal in watter mate jy tevrede is met jou lewe

op hierdie huidige stadium en (5) PCL 5 wat kyk na die mate wat u tans PTSD simptome ervaar. Hierdie vraelyste sal ongeveer 'n minimum van 40 minute neem om te voltooi.

Sal jy enigiets kry om aan hierdie navorsing deel te neem?

- U sal toegang hê tot hulpbronne wat u meer vertel oor veerkragtigheid en Posttraumatische groeivaardighede wat jy in jou herstelproses kan gebruik.

Is daar risiko's verbonde aan jou deelname aan hierdie navorsing en wat sal gedoen word om dit te voorkom?

- Die risiko's vir jou in hierdie studie is dat jy emosioneel kan voel nadat jy die vraelyste voltooi het. Hierdie risiko word beperk deur die feit dat die vraelyste geen vrae oor die gebeurtenis self bevat nie, maar meer gefokus is op jou ervarings en hoe jy hanteer en na die gebeurtenis. As u egter voel dat die vraelyste vir u moeilik was om te voltooi as gevolg daarvan om u te herinner aan die volwasse seksuele aanranding, sal u 'n kontaknommer van 'n professioneel geregistreerde sielkundige kry met baie jare se ondervinding in die werk met vroulike oorlewendes van volwasse seksuele aanranding, wat u kan kontak vir 'n gratis telefoniese of aanlyn sessie, om jou te help om deur hierdie moeilike emosies en met verdere hanteringsvaardighede te werk.

Hoe sal ons jou vertroulikheid beskerm en wie sal jou bevindings sien?

- Jou privaatheid sal gerespekteer word deur jou die geleentheid te gee om die vraelyste in 'n stil kamer te voltooi met geen afleidings as jy dit persoonlik doen nie. As jy dit aanlyn doen, kan jy 'n veilige ruimte van jou eie kies. Vir hierdie studie het ons net 'n naam nodig (hoef nie jou regte naam te wees nie, jy kan 'n valse naam gebruik) en selfoonnommer sodat ons kan gebruik om vir jou 'n databewys te stuur sodra jy die vraelyste voltooi het. Ons het nie enige van jou ander besonderhede soos jou adres nodig nie en op hierdie manier kan jy anoniem bly. Sodra ons jou die databewys gestuur het, sal jou naam en selfoonnommer uitgewis word sodat jou antwoorde nie aan jou gekoppel kan word nie. Die bevindings sal vertroulik gehou word en jou identiteit beskerm word deur jou 'n deelnemernommer op jou vraelyste te gee in plaas daarvan om jou persoonlike inligting by te voeg. Jou naam en kontakinligting sal slegs aan jou deelnemernommer gekoppel word en nie jou antwoorde nie. Slegs die navorsingspan sal na jou bevindings kan kyk. Bevindinge sal veilig gehou word deur harde kopieë in geslote kaste in die toesighouer se kantoor te sluit en elektroniese data sal wagwoord beskerm word. Data sal vir 5 jaar op die Noordwes Universiteite Vanderbijlparkkampus gestoor word.

Wat sal met die bevindings gebeur?

- Die bevindings van hierdie studie sal gebruik word om die navorser te help om 'n ingryping vir vroulike oorlewendes van volwasse seksuele aanranding te ontwikkel om oorlewendes en organisasies te help wat dienste lewer aan vroue wat seksuele aanranding in hul herstel ervaar het. Hierdie ingryping sal daarop gefokus wees om vroue te help om hul sterk punte te identifiseer en hoe hulle dit op hul reis van herstel kan gebruik.

Hoe sal jy weet oor die resultate van hierdie navorsing?

- Jy sal hulpbronne soos 'n pamflet gestuur word sodat jy meer kan leer oor geestesgesondheid, veerkragtigheid en posttraumatische groei. Dit kan jou lei tot jou herstel. As u wil hê dat ons u meer inligting oor die studie kan stuur deur u e-posadres op die ingeligte toestemmingsvorm in te voer. As jy nie 'n e-posadres het nie, sal jy die resultate by die psigososiale ondersteuningsentrum kan sien waar jy hierdie vraelyste

voltooi. Hierdie resultate sal slegs die algehele bevindings van die navorsing en geen individuele tellings van die vraelyste of enige persoonlike besonderhede toon nie.

Sal jy betaal word om aan hierdie studie deel te neem en is daar enige koste vir jou?

- Hierdie studie word deur die navorser befonds. Reisuittgawes sal betaal word vir die deelnemers wat na die psigososiale ondersteuningsentrum moet reis om die vraelyste te voltooi. Jy sal ook 'n gesigmasker en handreiniger gegee word wanneer jy die vraelyste persoonlik voltooi wat jy daarna huis toe kan neem. Vir die deelnemers wat die vraelys via die aanlyn skakel voltooi, sal jou data in die mate van R30 vergoed word. LET ASSEBLIEF DAAROP DAT U SLEGS EEN KEER DIE VRAELYSTE KAN VOLTOOI.

- Let asseblief daarop dat daar geen koste vir u betrokke sal wees nie, as u aan hierdie studie deelneem.

Is daar iets anders wat jy moet weet of doen?

U kan die navorser Shanae Theunissen by 065 818 5895 kontak as u enige verdere vrae het of probleme het.

- U kan ook die NWU-Gesondheidsnavorsingsetiekkomitee kontak via mev Carolien van Zyl by 018 299 1206 of carolien.vanzyl@nwu.ac.za indien u enige bekommernisse het wat nie oor die navorsing beantwoord is nie of as u klagtes oor die navorsing het.
- U sal 'n afskrif van hierdie inligting en toestemmingsvorm vir u eie doeleindes ontvang.

Ek stem hiermee saam om die volgende vrae te antwoord met die wete dat my antwoorde konfidentieel sal bly en dat my identiteit anoniem sal wees.

Ja

Nee

Demografiese vraelys (Vul in vrae)

- Selfoon nommer vir data voucher na voltooiing van vorm
- Hoe oud is u?
- Wat is u ras?
- Huidige verhoudings status
- Watter dorp in Gauteng woon u?
- Hoogste vlak van geletterdheid wat u bereik het
- Wat is u huidige werksposisie?
- Hoe lang terug het die verkragting gebeur?
- Was u meer as een keer verkrag gedurende u volwasse jare? Indien wel, hoeveel keer?
- Het u die persoon wat u aangeval het geken?
- Indien u ja geantwoord het by die vorige vraag, watter tipe verhouding het u met die aanvaller gehad?
- Wie was die eerste persoon wat u van die aanval vertel het?
- Het u die aanval aan die polisie gerapporteer?
- Was die polisie bereid en hulpvaardig tot 'n mate waar die aanvaller aan gekla was?
- Watter tydperk het verstreek voordat u na berading/terapie gegaan het vir die aanval?
- Waar het u vir berading/terapie gegaan?

- Hoe lank en gereeld was u in berading/terapie na die verkragting?
- Is daar enige redes wat die moeilik vir u gemaak het om op 'n gereelde basis vir berading/terapie te gaan? Indien wel, watter?
- Het u berading/terapie hulvol gevind?
- Is daar enigeiets spesifiek van berading/terapie wat dit hulpvool gemaak het?
- Is daar enigeiets van berading/terapie wat dit 'n onaangename ervaring wat nie hulpvool was gemaak het?
- Watter advies sal u vir professionele mense gee wat met mense werk wat verkrag was?
- Wie het u ondersteun na die verkragting?
- Hoe het mense u ondersteun na die verkragting?
- Wat het u gedoen wat gehelp het om die verkragting te hanteer en te verwerk?
- Het die verkragting die manier wat u uself en ander sien verander, indien wel in watter manier?
- Watter advies het u vir ander mense wat 'n verkragting ervaar het wat hulle sal help om dit te verwerk?

Veerkragtigheidsvraelys (Adult Resilience Measure ARM)

Tot watter mate is die volgende stellings op jou van toepassing?

(1) Glad nie (2) Selde (3) Soms/Partykeer (4) Nogals baie (5) Baie van toepassing

Daar is geen regte of verkeerde antwoorde nie.

1. Ek kom oor die weg met mense rondom my.
2. Om kwalifikasies te win en my vaardighede te verbeter, is vir my belangrik
3. Ek weet hoe om in verskillende sosiale situasies op te tree (soos by die werk, huis of ander openbare plekke)
4. My familie ondersteun my
5. My familie weet baie van my (byvoorbeeld, wie my vriende is, wat ek graag wil doen)
6. As ek honger is, kan ek gewoonlik genoeg kos kry om te eet.
7. Mense hou daarvan om tyd saam met my deur te bring
8. Ek praat met my familie / lewensmaat oor hoe ek voel (byvoorbeeld wanneer ek hartseer of bekommerd is)
9. Ek voel my vriende ondersteun my.
10. Ek voel ek behoort in my gemeenskap.
11. My familie / lewensmaat staan by my wanneer tye moeilik is (byvoorbeeld wanneer ek siek of in die moeilikheid is)
12. My vriende gee om vir my wanneer tye moeilik is (byvoorbeeld wanneer ek siek of in die moeilikheid is)
13. Ek word regverdig behandel in my gemeenskap.
14. Ek het geleenthede om ander te wys dat ek verantwoordelik kan optree
15. Ek voel veilig wanneer ek saam met my familie / lewensmaat is

Post Traumatiese Groei Vraelys

Dui aan vir elk van die onderstaande stellings die mate waarin hierdie verandering in jou lewe plaasgevind het as gevolg van die krisis / ramp, met behulp van die volgende skaal.

0 = Ek het nie hierdie verandering ervaar as gevolg van my krisis nie.

1 = Ek het hierdie verandering in 'n baie klein mate ervaar as gevolg van my krisis.

2 = Ek het hierdie verandering in 'n klein mate ervaar as gevolg van my krisis.

- 3 = Ek het hierdie verandering tot 'n matige graad ervaar as gevolg van my krisis.
 4 = Ek het hierdie verandering tot 'n groot mate ervaar as gevolg van my krisis.
 5 = Ek het hierdie verandering in 'n baie groot mate ervaar as gevolg van my krisis.

1. Ek het my prioriteite verander oor wat belangrik is in die lewe.
2. Ek het 'n groter waardering vir die waarde van my lewe.
3. Ek het nuwe belangstellings ontwikkel.
4. Ek het 'n groter gevoel van selfstandigheid.
5. Ek het 'n beter begrip van geestelike dinge.
6. Ek sien duideliker dat ek op mense kan staat maak in tye van moeilikheid.
7. Ek het 'n nuwe pad vir my lewe gestap.
8. Ek het 'n groter gevoel van nabyheid met ander.
9. Ek is meer bereid om my emosies uit te druk.
10. Ek weet van beter dat ek probleme kan hanteer.
11. Ek kan beter dinge met my lewe doen.
12. Ek is beter in staat om die manier waarop dinge uitwerk, te aanvaar.
13. Ek kan elke dag meer waardeer.
14. Nuwe geleenthede is beskikbaar wat nie anders sou gewees het nie.
15. Ek het meer simpatie met ander.
16. Ek doen meer moeite in my verhouding.
17. Ek is meer geneig om dinge te verander wat moet verander.
18. Ek het 'n sterker geloof.
19. Ek het besef ek is sterker as wat ek gedink het ek is.
20. Ek het baie geleer oor hoe wonderlik mense is.
21. Ek het beter aanvaar dat ek ander nodig het.

Geestesgesondheids kontinuum (MHC-SF) (Keyes, 2006)

Antwoord asb die volgende vrae oor hoe jy die afgelope maand gevoel het. Kies die boks wat die mees toepaslik is om the wys hoe gereeld jy die volgende ervaar of gevoel het:

Gedurende die afgelope maand, how gereeld het jy gevoel/ervaar?

(1) Nooit (2) Een of twee keer (3) Omtrent een keer 'n week (4) Amper elke dag (5) Elke dag

1. Gelukkigheid
2. Geïntereesd in die lewe
3. Tevrede met die lewe
4. Dat jy iets belangriks het om aan die samelewing te bied
5. Dat jy aan 'n gemeenskap behoort (soos 'n sosiale groep of jou woonbuurt)
6. Dat die samelewing 'n goeie plek is, of better word vir alle mense
7. Dat mense in prinsiep goed is
8. die manier hie die samelewing werk vir jou in maak
9. dat jy van meeste van die gedeeltes van jou persoonlikheid hou
10. dat jy goed daarin is om die verantwoordelikhede in jou daaglikse lewe te bestuur
11. dat jy warm en betroubare verhoudings met ander het
12. dat jou lewenservarings jou uitgedaag het om te groei en 'n beter persoon te word
13. selfvertroue het om aan jou eie opinies en idees te dink en hulle te lig
14. dat jou lewe 'n mate van rigting en betekenis het

PCL - 5 Posttraumatiese stress simptome vraelys

Instruksies: Hieronder is 'n lys van probleme wat mense soms het in reaksie op 'n baie stresvolle ervaring. Lees asseblief elke simptome noukeurig deur en kies een van die nommers aan die regterkant om aan te dui hoeveel jy die afgelope maand deur daardie simptome gepla is.

- 1 = Glad nie
- 2 = 'n Bietjie
- 3 = Matig
- 4 = Redelik baie
- 5 = Uiters baie

In die laaste maand, hoeveel keer was jy gepla deur:

1. Herhaalde, ontstellende en ongewenste herinneringe van die stresvolle ervaring?
2. Herhaalde, ontstellende drome van die stresvolle ervaring?
3. Skielik gevoel of opgetree asof die stresvolle ervaring eintlik weer gebeur (asof jy eintlik terug daar was en dit herleef)?
4. Voel jy baie ontsteld wanneer iets jou aan die stresvolle ervaring herinner het?
5. Het jy sterk fisieke reaksies wanneer iets jou aan die stresvolle ervaring herinner het (byvoorbeeld hartklop, moeilike asemhaling, sweet)?
6. Vermy herinneringe, gedagtes of gevoelens wat verband hou met die stresvolle ervaring?
7. Vermy eksterne herinneringe aan die stresvolle ervaring (byvoorbeeld mense, plekke, gesprekke, aktiwiteite, voorwerpe of situasies)?
8. Sukkel jy om belangrike dele van die stresvolle ervaring te onthou?
9. Om sterk negatiewe oortuigings oor jouself, ander mense of die wêreld te hê (byvoorbeeld om gedagtes te hê soos: Ek is sleg, daar is iets ernstigs fout met my, niemand kan vertrou word nie, die wêreld is heeltemal gevaarlik)?
10. Om jouself of iemand anders te blameer vir die stresvolle ervaring of wat daarna gebeur het?
11. Het jy sterk negatiewe gevoelens soos vrees, afgryse, woede, skuldgevoelens of skaamte?
12. Verlies aan belangstelling in aktiwiteite wat jy vroeër geniet het?
13. Voel jy veraf of afgesny van ander mense?
14. Sukkel jy om positiewe gevoelens te ervaar (byvoorbeeld om nie geluk te voel of liefdevolle gevoelens vir mense na aan jou te hê)?
15. Prikkelbare gedrag, woede-uitbarstings, of aggressief optree?
16. Neem jy te veel risiko's of doen dinge wat jou skade kan berokken?
17. Om "superalert" of waaksaam of op hoede te wees?
18. Voel jy springerig of maklik geskrik?
19. Sukkel jy om te konsentreer?
20. Sukkel jy om te val of aan die slaap te bly?

Research Study questionnaire (Setswana)

O memelwa ho nka karolo phuputso ya patlisiso e etsang karolo ya Taba e Ngotsweng ya Lengolo la Bongaka. Ka kopo iphe nako ya ho bala tlhahisoleseding, e tla hlalosa dintlha tsa phuputso ena le mohato o tla latelwa. Haeba o ka ba le dipotso leha e le dife kapa dintho tseo o kgathatsehileng ka tsona, ka kopo ikutlwe o lokolohile ho botsa motho

ya o hlalose tsang lengolo lena. Ho bohlokwa haholo hore o utlwisise ka ho hlaka hore na phuputso ena e mabapi le eng le tsela eo o ka nngang wa kenella ka yona.

Hape, ho nka karolo ha hao ke boithaopo bo feletseng e leng se bolelang hore o lokolohile ho hana ho nka karolo Phuputsong ena. Haeba o hana, sena se ke ke sa o ama hampe ka tsela leha e le efe. Oboetse o lokolohile ho ikgula phuputsong ena ka nako leha e le efe, le haeba o dumetse honka karolo qalong.

Phuputso ena e dumeletswe ke Komiti ya Phuputso ya Melao ya Bophelo ya NWU ya Lefapha la Disaense Tsa Bophelo la Yunivesithi ya Leboa Bophirima (NWU-00206- 21-S1) mme e tla etswa ho latela melao ya tataiso le melaomotho ya Melao ya Phuputso ya Tsa Bophelo: Melaomotho, Mehato le Meralo (DoH, 2015) le tataiso e nngwe melao ya matjhaba e sebetsang phuputsong ena. Ho ka nna ha hloka hore ditho tsa komiti ya melao ya phuputso kapa batho ba bang ba tshwaneleheng ba hlahlobe direkoto tsa phuputso.

Phuputso ena ya patlisiso e mabapi le eng?

- Phuputso ena e reretswe ho ntshetsapele bokenadipakeng bo thehilweng matleng a batho bakeng sa mahlasipa a basadi a tlhekefetso ya thobalano ya batho ba baholo ka ho hlahloba matla a ho hlahlohelwa, kgolo ya ka mora tsietsi le bophelo bo botle ba kelello ba mahlasipa ana a basadi. Re batla ho tseba ka ho eketsehileng hore na ke bokenadipakeng ba mofuta ofe bo tswelang mahlasipa molemo ha a ntse a hlahlohelwa e le hore re ka thusa mahlasipa a mang a basadi ao le ona a ileng a tobana le tlhekefetso ya thobalano ya batho ba baholo.

- Phuputso ena e tla etsetswa ditsing tse tshehetsang batho maikutlong ho pholletsa le Porofensi ya Gauteng. Ditsi tsena di akarelletsa mekgatlo eo e seng ya mmuso e kang Lifelinele Purple Foundation. Phuputso ena e tla etswa ke bafuputsi ba tsa bophelo ba nang le boiphihlelo ba kwetliseditsweng botsamaisi le ho utlwisisa tekanyo ya bongata le kutlwisiso e tebileng ya taba. Bonyane bankakarolo ba 107 ba tla akarelletswa phuputsong ena.

Ke eng se tla lebellwa ho wena?

O tla lebellwa ho tlatsa dipampiripotso tse 4 tse kgutshwanyane. Tsona di akarelletsa: (1) pampiripotso ya setjhaba (tlhahisoleseding ya botho) e nang le dipotso tse mabapi le dilemo tsa hao, puo le dipotso mabapi le seo o fetileng ho sona leetong la hao la ho hlahlohelwa; (2) Setsi sa Phuputso ya Matla a ho Hlahlohelwa a Batho ba Baholo tekanyo ya matla a ho hlahlohelwa e hlahlobang mehlodi eo o ileng wa e sebedisa ho o thusa ho sebetsana ka katleho le tlhekefetso ya thobalano ya batho ba baholo; (3) Pokello ya Kgolo ka Mora Tsietsi e hlahlobang kgolo ya botho eo o bileng le yona ka mora ho tobana le tlhekefetso ya thobalano

ya batho ba baholo; le (4) Tshenyeho kapa Ntlafalo ya Bophelo ba Kelello e hlahlobang hore na ke ho isa boholog bofe o kgotsofetseng ka bophelo ba hao mothating wa ha jwale kanye ne-PCL-5 elinganisa izinga obhekene ngalo nezimpawu ze-PTSD njengamanje Dipampiripotso tsena di tla nka bonyane metsotso e ka bang 30 hore o di tlatse.

Na ho na le seo o tla se fumana ka ho nka karolo patlisisong ena?

O tla fuwa kapa o romellwe mehlodi ka email e o bolellang se eketsehileng ka matla a ho hlahlohelwa le boitsebelo ba kgolo ka mora tsietsi boo o ka bo sebedisang ha o ntse o hlahlohelwa.

Na ho na le mathata a ka bang teng ha o nka karolo patlisisong ena mme ke eng se tla etswa ho a thibela?

- Mathata ka a o hlahelang phuputso ena ke hore o ka nna wa utlwa bohloko ka mora hore o tlatse dipampiripotso. Bothata bona bo fokotswa ke hore dipampiripotso ha di na dipotso tse botsang ka ketsahahalo ka boyona empa di lebisitse tlhokomelo haholo tseleng eo o ikutlwang ka yona le hore na o sebetsana jwang le ketsahalo le ka mora yona. Haeba le ha hole jwalo o utlwa eka dipampiripotso di ne di o thatafalla ho di tlatse hobane di o hopotsa ka tlhekefetso ya thobalano ya batho ba baholo, o tla fuwa dinomoro tsa ho ikopanya tsa setsibi se ngodisitsweng sa tlhabollo ya kelello se nang le dilemo tse ngata tsa boitsebelo ba ho sebetsana le mahlasipa a basadi a tlhekefetso ya thobalano ya batho ba baholo, seo o ka buisanang mahala le sona ka founu kapa la buisana Inthaneteng ho o thusa hore o sebetsane le boikutlo bona bo boima le ka boitsebelo bo bong bo tla o thusa ho sebetsana le bona ho ya pele.

Re tla sireletsa lekunutu la hao jwang mme ke mang ya tla bona tlhahisoleseding eo o e ngotseng?

- Lekunutu la hao le tla hlomphele ka hore o fuwe monyetla wa ho tlatse dipampiripotso kamoreng e kgutsitseng e se nang ditshitiso haeba o etsa sena ka ho tla setsing. Haeba o tlatse ka Inthanete o ka ikgethela sebaka se bolokehileng. Bakeng sa phuputso ena re hloka feela lebitso (ha ho hloka hore e be lebitso la hao la nnete, o ka sebedisa lebitso leo o iqapelang lona) le nomoro ya hao ya selefounu e le hore re ka o romella voutjhara ya data hang ha o se o tlatsetse dipampiripotso. Ha re hloke dintlha tse ding tsa hao jwalo ka aterese ya hao mme ka tsela ena o ka dula o sa hlahelle hore o mang. Hang ha re qeta ho o romella voutjhara ya data lebitso la hao le nomoro di tla hlakolwa e le hore dikarabo tsa hao di se ke tsa amahanngwa le wena. Ditaba tse fumanweng di tla dula e le lekunutu mme o tla sireletswa hore o dule o sa tsejwe ka hore o fuwe nomoro ya monkarolo dipampiripotso tsa hao ho fapana le hore o kenye tlhahisoleseding ya hao. Lebitso la hao le tlhahisoleseding ya ho ikopanya le wena le tla matahangwa feela le nomoro ya hao ya monkarolo e seng le dikarabo tsa hao. Ke thimi ya phuputso feela e tla kgona ho bona dintho tseo o di ngotseng. Dintho tseo o di ngotseng di tla bolokwa di sireletsehile ka hore dintho tseo o ngotseng ho tsona di notlellwe ka khabotong e ofising ya mookamedi mme dikopi tsa elektroniki di tla di tla sireletswa ka password. Tlhahisoleseding e tla bolokwa ka dilemo tse 5 Yunivesithing ya Leboa Bophirima Khamphaseng ya Vanderbijlpark.

Ho tla etsahalang ka dintho tse fumanweng?

- Dintho tse fumanweng phuputso ena di tla sebedisetswa ho thusa mofuputsi ho ntshetsapele bokenadipakeng bakeng sa mahlasipa a basadi a tlhekefetso ya thobalano ya batho ba baholo molemong wa ho thusa mahlasipa le mekgatlo e fanang ka ditshebeletso ho basadi ba ileng ba tobana le tlhekefetso ya thobalano ha ba ntse ba hlahelwa. Bokenadipakeng bona bo tla lebisa tlhokomelo ho thuseng basadi hore ba lemohe matla a bona le hore na ba ka a sebedisa jwang leetong la bona la ho hlahelwa.

O tla tseba jwang ka sephetho sa patlisiso ena?

O tla romellwa mehlodi e kang diphamfolete e le hore o ka ithuta ka ho eketsehileng ka bophelo ba kelello, matla a ho hlahelwa le kgolo ya ka mora tsietsi. Sena se ka o tataisa ha o ntse o hlahelwa. Haeba o thabela seo, re ka o romella tlhahisoleseding e eketsehileng ka phuputso ka hore o ngole aterese ya hao ya email foromong ya tumello e etswang ka kutlwisiso. Haeba ha o na aterese ya email o tla kgona ho bona sephetho

setsing se tshehetsang batho maikutlong moo o tlatsetsang dipampiripotso tse na teng. Sepheho sena se tla bontsha feela kakaretso ya se fumanweng phuputso e seng sekoro sa motho ka mong sa dipampiripotso kapa dintlha leha e le dife tsa botho.

Na o tla patalwa ka ho nka karolo phuputso ena mme na ho na le ditjeho tseo o tla ba le tsona?

-Phuputso ena e tshehetswa ke mofuputsi ka ditjhelete. Ditjeho tsa leeto di tla lefuwa bankakarolo ba lokelang ho nka leeto ho ya setsing se tshehetsang batho maikutlong ho ya tlatsetsa dipampiripotso. O tla boela o fuwe semonkwana le sanithaeza ya matsoho tseo o ka tsamayang le tsona ha o qeta haeba o ikisitse ka ho toba ho ya tlatsetsa dipampiripotso. Ho bankakarolo ba tlatsetsang dipampiripotso ka linki ya Inthanete, le tla buseletswa tjhelete ya data ya lona ho isa ho R30. KA KOPO HLOKOMELANG HORE LE KA TLATSETSA DIPAMPIRIPOTSO KA LEKGETLO LE LE LENG FEELA.

- Ka kopo hlokomela hore ha ho ditjeho tseo o tla ba le tsona ha o nka karolo phuputso ena.

Na ho na le ntho e nngwe hape eo o lokelang ho e tseba kapa ho e etsa?

- O ka ikopanya le mofuputsi Shanae Theunissen ho 065 818 5895 haeba o na le dipotso tse ding tse eketsehileng kapa o na le mathata leha e le afe.

- O ka boela wa ikopanya le Komiti ya Phuputso ya Melao ya Bophelo ya NWU ka Mme Carolien van Zyl ho 018 299 1206 kapa carolien.vanzyl@nwu.ac.za haeba ho na le dintho leha e le dife tseo o tshwenyehileng ka tsona tse sa arajwang mabapi le phuputso kapa haeba o na le ditlaleho mabapi le phuputso.

- O tla fumana kopi ya tlhahiso eseding ena le foromo ya tumello bakeng sa ho sebediswa ke wena.

I hereby consent to answer the following questions, knowing that the answers will be kept confidential, and my identity will remain anonymous.

Yes/No

Demographic questionnaire (Open ended questions)

- Cell phone number for Data voucher upon completion of questionnaire
- O na le dingwaga tse kae?
- Lotso kgotsa bomorafe?
- Boemo jwa ga jaanong jwa nyalo?
- O nna kwa motse setoropong ofe mo Gauteng?
- Mophato wa thuto o o feletseng ka one?
- Ga jaanong jaana o dira tiro ya mofuta ofe?
- Go fetile lobaka lo lo kae fa e sa le o tlhaselwa ka thobalano?
- A go diregile gangwe fela mo nakong ya gago ya bogolo?
- A o ne o itse motho yo o neng a go tlhasela?
- Fa karabo, o ne o amana jang le motho yo o neng a go tlhasela?
- O ne wa bolelela jang ka tlhaselo e ya thobalano?
- A o ne wa bega tlhaselo e kwa mapodising?
- Fa karabo, A mopodisi a ne a thusa go dira gore mmeteledi wa gago a atlholwe?
- O ne wa ya go thobiwa maikutlo/go newa kgakololo marago ga lobaka lo lo kae?
- O ne wa ya kwa mokgathong ofe go ya go thobiwa maikutlo/newa kgakololo?
- O feditse lobaka lo lo kae o thobiwa maikutlo morago ga tlhaselo?

- A go na le dilo dipe tse di neng tsa go thatafaletsa go bona tšhono ya go thobiwa maikutlo/go newa kgakololo? Fa di le teng, ke eng?
- A o fitlhetse go newa kgakololo kgotsa go thobiwa maikutlo go thusa?
- A go na le sengwe se se kgethegileng se o neng wa se dira ka nako ya go newa kgakololo se o gopolang se ne se thusa thata?
- A go na le sengwe ka go thobiwa maikutlo/go newa kgakololo se se neng sa dira gore o ikutlwe gore e ne e le maitemogelo a a seng monate kgotsa a a sa thuseng?
- Badiri ba ba dirang ka batho ba ba kileng ba tlhaselwa ka thobalano, o ka ba naya kgakololo efe?
- O ne wa emiwa nokeng ke mang morago ga tlhaselo?
- Batho ba ne ba go ema nokeng jang morago ga tlhaselo?
- Ke eng se o neng wa se dira gore o kgonego itshokela ditlamorago tsa tlhaselo ya A tlhaselo ya thobalano e fetotse tsela e o itebang ka yone kgotsa ba bangwe ka yone? Fa e dirile jalo jang?
- O na le kgakololo efe e o ka e nayang ba bangwe ba ba kileng ba tlhaselwa ka thobalano go ba thusa go itshokela ditlamorago tsa teng le go berekana le tsone?

Baholo-E ntlafaditswe (Adult Resilience Measure-Revised (ARM-R))

Dipolelo tse latelang di sebetsa ho wena ho isa bohologeng bofe?

- (1) Ho hang
- (2) Hanyane
- (3) Ka tsela e itseng
- (4) Haholwanyane
- (5) Haholo

Ha ho na dikarabo tse nepahetseng kapa tse fosahetseng

1. Ke utlwana le batho ba mpotolohileng
2. Ho fumana le ho ntlafatsa mangolo a ka kapa bokgoni ho bohlokwa ho nna
3. Ke tseba ho itshwara maemong a fapaneng moo ke nang le batho (jwalo ka mosebetsing, lapeng, kapa dibakeng tse ding tsa setjhaba)
4. Ba lelapa leso ba a ntshehetsa
5. Ba lelapa leso ba tseba ho hongata ka nna (ka mohlala, hore na metswalle ya ka ke bomang, seo ke ratang ho se etsa)
6. Ha ke lapile, hangata ke fumana dijo tse lekaneng tseo nka di jang
7. Batho ba rata ho qeta nako ba na le nna
8. Ke bua le lelapa leso/molekane ka tsela eo ke ikutlwang ka yona (ka mohlala, ha ke kwatile kapa ke kgathatsehile)
9. Ke ikutlwa ke tshheditswe ke metswalle ya ka
10. Ke ikutlwa ke le setho sa baahi bao ke dulang le bona
11. Lelapa leso/molekane ba ema le nna dinakong tse thata (ka mohlala, ha ke kula kapa ke le mathateng)
12. Metswalle ya ka e ya ntsotella dinakong tse thata (ka mohlala, ha ke kula kapa ke le mathateng)
13. Baahi ba sebaka sa heso ba ntshwara ka toka
14. Ke na le menyetla ya ho bontsha ba bang hore nka etsa dintho ka tsela e nang le boikarabelo
15. Ke ikutlwa ke sireletsehile ha ka na le ba lelapa leso/molekane
16. Ke na le menyetla ya ho sebedisa bokgoni ba ka bophelong (jwalo ka ho sebedisa boitsebelo, ho sebetsa mosebetsing kapa ho hlokomela ba bang)

17. Ke rata setso sa lelapa leso/molekane le tsela eo lelapa leso le ketekang dintho kateng (jwalo ka matsatsi a phomolo kapa ho ithuta ka setso sa heso)

Lethathamo la Kgolo ka Mora ho Hlahelwa ke Tsietsi (PTGI)

Bontsha bakeng sa dipolelo ka ding tse ka tlaase sekgahla seo phetoho ena e etsahetseng ka sona bophelong ba hao ka lebaka la tsietsi/koduwa, o sebedisa sekala se latelang.

0 = Ha ke a ka ka ba le phetoho ena ka lebaka la tsietsi ya ka.

1 = Ke bile le phetoho ena ka tekanyo e nyenyane haholo ka lebaka la tsietsi ya ka

2 = Ke bile le phetoho ena ka tekanyo e nyenyane ka lebaka la tsietsi ya ka.

3 = Ke bile le phetoho ena ka tekanyo e bohareng ka lebaka la tsietsi ya ka.

4 = Ke bile le phetoho ena ka tekanyo e kgolo ka lebaka la tsietsi ya ka.

5 = Ke bile le phetoho ena ka tekanyo e kgolo haholo ka lebaka la tsietsi ya ka.

1. Ke fetotse dintho tse tlang pele mabapi le seo e leng sa bohlokwa bophelong.
2. Ke se ke ananela haholwanyane bohlokwa ba bophelo ba ka.
3. Ke se ke na le dintho tse ntjha tseo ke di thahasellang.
4. Ke na le boikutlo bo eketsehileng ba ho itshetleha ka nna.
5. Ke na le kutlwisiso e eketsehileng ya ditaba tsa semoya.
6. Ke bona ka ho hlaka haholwanyane hore nka tshepa batho dinakong tsa mathata.
7. Ke fumane tsela e ntjha ya bophelo ba ka.
8. Ke na le boikutlo bo eketsehileng ba ho atamelana le ba bang.
9. Ke ikemiseditse haholwanyane ho bontsha boikutlo ba ka.
10. Ke tseba ha molemo hore nka emela maemo a boima.
11. Ke kgona ho etsa dintho tse molemo ka bophelo ba ka.
12. Ke kgona ho amohela ha molemo tsela eo dintho di etsahalang ka yona.
13. Ke kgona ho ananela ha molemo letsatsi ka leng.
14. Ho na le menyetla e metjha e hlahileng eo mohlomong e ka beng e sa hlaha.
15. Ke na le kutlwelebohloko e eketsehileng ho ba bang.
16. Ke etsa boiteko bo eketsehileng dikamanong tsa ka le ba bang.
17. Ke ikemiseditse haholwanyane ho leka ho fetola dintho tse hlokang ho fetolwa.
18. Ke na le tumelo e matla haholwanyane ya bodumedi.
19. Ke hlokometse hore ke matla ho feta kamoo ke neng ke nahana kateng .
20. Ke ithutile haholo kamoo batho ba tsotelang kateng.
21. Ke amohela ha molemo hore ke hloka ba bang.

MENTAL HEALTH CONTINUUM (MHC-SF) (Keyes, 2006) (Setswana version)

Ka kopo, araba dipotso tse di latelang ka gore o ntse o ikutlwa jang fo kgweding e e fetileng. Ka boemo ba maikutlo a gago, o kare: SEPE, GANNGWE KGOTSA GABEDI KA GANNGWE MO BEKENG, GA 2 KGOTSA GA 3 KA BEKE, GANTSI KA METLHA, KAMETLHA

Mo kgweding e e fetileng, ke ga kae o ntse o ikutlwa jaana ...

1. Itumela
2. Go itumelela botshelo
3. Kgotsofetse
4. Gore o ne o na le sengwe se se botlhokwa go se abela morafe
5. Gore o karolo ya morafe (jaaka setlhopha sa boago, boagalano ba gago, teropo ya gago)

6. Gore morafe wa rona o ntse o nna bonno bo botoka ka batho
7. Gore batho ba siame mo motheong
8. Gore tsela e morafe wa rona o dirang, go dira tlhaloganyo go wena
9. Gore o rata dikarolo tse dintsi tsa seriti sa gago
10. O siame mo go tsamaiseng maikarabelo a botshelo ba letsatsi le lengwe le lengwe la botshelo jwa gago
11. Gore o ne o na le botsalano bo bo thuthafetseng ebile bo ikanyega ka ba bangwe
12. Gore o na le maitemogelo a a kgwetlhang go gola le go nna motho yo o siameng
13. Boitshepo ba go akanya kgotsa go ntsha dintlha le dikakanyo tsa gago
14. Gore botshelo jwa gago bo na le tsela kgotsa bokao go bona

PCL-5 (Setswana)

Ditaelo: Fa tlase fano, ke lenaane la mathata ao batho ka dinako tse dingwe ba nnang le one fa ba tsibogela maitemogelo a bone a go tshwenyega thata mo tlhaloganyong. Tsweetswee buisa bothata bongwe le bongwe ka kelotlhoko o bo o sekeletsa nngwe ya dinomore ka fa mojeng go bontsha gore o tshwentswe go le go kana kang ke bothata joo mo kgwedding e e fetileng

- 1 = Le e seng
- 2 = Go le gonnye
- 3 = Ka selekanyo se se mo magareng
- 4 = Thatanyana
- 5 = Go feta selekanyo

Mo kgwedding e e fetileng, o ne wa tshwennngwa go le go kana kang ke:'

1. Go gopola maitemogelo a a sa batlegeng a a go tshwenyang thata mo tlhaloganyong, a a ipoeletsang le a a go itayang tsebe?
2. Ditoro tse di ipoeletsang, tse di go itayang tsebe tsa maitemogelo a a go tshwenyang thata mo tlhaloganyong?
3. Gore go ise go ye kae o bo o ikutlwa kgotsa o itshwara jaaka e kete maitemogelo a a go tshwenyang thata mo tlhaloganyong a a direga gape (jaaka e kete o boetse morago kwa go one a a direga gape)?
4. Go sa itumele gotlhelele fa sengwe se go gopotsa maitemogelo a a go tshwenyang thata mo tlhaloganyong?
5. Go nna le ditsibogo tse di bogale mo mmeleng fa sengwe se go gopotsa maitemogelo a a go tshwenyang thata mo tlhaloganyong (ka sekai, go uba ga pelo, bothata jwa go hema, go fufulelwa)
6. Go tila go gopola dilo, dikakanyo, kgotsa maikutlo a a amanang le maitemogelo a a go tshwenyang thata mo tlhaloganyong?
7. Go tila dilo tse o di bonang di direga tse di go gopotsang maitemogelo a a go tshwenyang thata mo tlhaloganyong (ka sekai, batho, mafelo, metlotlo, ditiro, dilo, kgotsa maemo a a rileng)?
8. Bothata jwa go gopola dikarolo tse di botlhokwa tsa maitemogelo a a go tshwenyang thata mo tlhaloganyong
9. Go sa ithate gotlhelele, go sa rate batho ba bangwe, kgotsa lefatshe (ka sekai, go nna le dikakanyo tse di jaaka: Nna ke motho yo o bosula, go na le sengwe se se masisi se se sa siamang ka nna, Ga ke ikanye ope, lefatshe le kotsi fela thata)?

10. Go ipona molato kgotsa go o pega mongwe ka ntlha ya maitemogelo a a go tshwenyang thata mo tlhaloganyong kgotsa ka ntlha ya se se diregileng morago ga one?
11. Go nna le maikutlo a a nonofileng a a sa siamang jaaka poifo, letshogo, kgalefo, go ikutlwa o le molato, kgotsa go nna ditlhong?
12. Go felelwa ke kgatlhego ya go dira ditiro tse o neng o tle o ipelele go di dira?
13. Go ikutlwa o le kgakala le batho kgotsa o lomologane le bone?
14. Bothata jwa go sa kgone go nna le maikutlo a a siameng (ka sekai, go sa kgone go ikutlwa o itumetse kgotsa go nna le maikutlo a lerato mo bathong ba o amanang thata le bone)?
15. Go serega, go phatloga ka bogale, kgotsa go nna le tshekamelo ya go lwa le ba bangwe?
16. Go ipaya gantsi mo maemong a a kotsi kgotsa go dira dilo tse di ka go gobatsang?
17. Go nna o "ntshitse matlho dinameng ka metlha" kgotsa o itisitse?
18. Go ikutlwa o tlhobaela kgotsa go garoga pelo go sekae?
19. Bothata jwa go sa kgone go tlhoma mogopolo?
20. Bothata jwa go thulamela kgotsa go tlhora boroko?

ADDENDUM 5: RECRUITMENT POSTERS

EMPHATICALLY VICTORIOUS ALL ECHOES

YOUR VOICE MATTERS

ARE YOU A SEXUAL ASSAULT SURVIVOR?

WHO CAN PARTICIPATE?

Are you female above the age of 18 who has experienced a sexual assault?

Do you have access to internet or you are willing to complete the questionnaires face to face at a psychosocial support centre?

You can not participate in this study if you are currently involved in a legal matter pertaining to the assault.

You have told someone about the assault and received some form of trauma counselling or debriefing and have worked through the acute phase and feel that they can contribute to the study?

WHAT WILL BE EXPECTED OF YOU?

You will be expected to complete 4 short questionnaires. These include:

- 1 a Demographic questionnaire containing questions about your age, language and other characteristics. And also your journey of recovery.
- 2 Resilience Research Centre Adult resilience measure which looks at which resources you have used to help you cope with the assault.
- 3 Posttraumatic Growth Inventory that looks at the personal growth that you have experienced after the assault.
- 4 The Mental Health Continuum will assess your current emotional well-being.

These questionnaires will take approximately 30min in total to complete.

WHAT IS THE STUDY ABOUT?

We plan to develop a strength-based intervention for adult survivors of sexual assault by investigating **resilience, posttraumatic growth and psychological well-being** of sexual assault survivors. We want to find out more about what works on the journey to recovery for survivors so that we can help others who have also experienced a similar traumatic event.

Contact Shanae Theunissen at 065 818 5895 OR Carla Pretorius at 079 885 6945 if you have any further questions and would like to volunteer to take part in this research study.

This study has been approved by the NWU-Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University.
Title of the research study: Trauma-Informed Strengths-based group intervention guideline for female survivors of adult sexual assault.
NWU-Health Research Ethics Committee: Mrs. Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za



YOUR VOICE MATTERS

ARE YOU A
SEXUAL ASSAULT
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ADDENDUM 6: SOCIAL MEDIA CAMPAIGN DOCUMENTS

Social Media Campaign Advertisement wording

Are you a female sexual assault survivor above 18 in Gauteng?

Do you feel like others can learn from your journey of recovery?

Make your voice heard!

We are developing an intervention guideline for professionals working with sexual assault survivors. This guideline will focus on female empowerment and seeks to address the needs of survivors. We need your help to understand more about the strengths and resources you used that helped you cope with what happened to you. You can offer advice to professionals on how to provide the best care and share things that helped you recover so we can share them with other survivors. **Your voice matters in helping us serve survivors better.**

To protect you, the questionnaires can be filled out anonymously. These online questionnaires do not ask questions about the event itself. The focus is on its impact on your life and what helped you cope. You can complete it from the comfort of your home, and it will take about 40min in total.

We are looking for women

- above the age of 18
- living in Gauteng
- experienced a sexual assault more than three months ago,
- told someone about the assault (friend, family or therapist)
- is not currently in a legal dispute about the assault

To access the questionnaires and for further information, please go to this link: www.emthini.co.za

For any additional questions about the study, please contact Shanae Theunissen at 065 818 5895 or theunissenshanae@gmail.com

This study has been approved by the NWU-Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University. It is entitled Trauma-informed Strengths-based group intervention guideline for female survivors of adult sexual assault.



YOUR VOICE MATTERS - THE MEDIA PLAN

TRAUMA-INFORMED STRENGTH-BASED GROUP INTERVENTION GUIDELINE
FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT

Presented to:
Shanae Theunissen

Date of
03 JUNE 2022



Media Plan Outline

PART 1	Introduction
PART 2	Campaign Flow - Channels
PART 3	Campaign Flow - The Booking
PART 4	Campaign Placement Mock-Up
PART 5	Conclusion



Shanae Theunissen

TRAUMA-INFORMED STRENGTH-BASED GROUP INTERVENTION GUIDELINE FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT

02



Introduction

The purpose of this media plan is to highlight elements of the #yourvoicematters digital media campaign, showcasing content focus as well as media placement elements.

The campaign will include: Social Media, Google, Vodacom Display, as well as Vodacom Mobile SMS.



Shanae Theunissen

TRAUMA-INFORMED STRENGTH-BASED GROUP INTERVENTION GUIDELINE FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT

03



Campaign Flow - The Booking

1 SOCIAL MEDIA

Facebook and Instagram display adverts will run for a month, with guaranteed clicks up to 120, and estimated clicks of up to 300.

2 WEBSITE

A website has been created for the academic project brand: www.emthini.co.za

4 GOOGLE

All advert clicks will link to the website, where the link to the survey is hosted, and redirected to Google for the survey.

3 MOBILE SMS

Through the Vodacom database, 1100 sms's will be sent with a URL link to the website.

5000 Page Impressions of a display advert will also be placed on the various Vodacom channels, to Run Off Site (ROS), meaning that the advert will not be limited to a particular channel.

Multi-Channel communication in order to reach diverse groups for the research.

Shanae Theunissen

TRAUMA-INFORMED STRENGTH-BASED GROUP INTERVENTION GUIDELINE FOR FEMALE SURVIVORS OF ADULT SEXUAL ASSAULT

06



Campaign Flow - The Channels

- 1 SOCIAL MEDIA**
Two social media accounts have been created for the Emthini Over-Comers project, namely Facebook and Instagram. The brand is registered as a Non-Profit Organization, for the purpose of this academic research project.
- 2 WEBSITE**
A website has been created for the academic project brand: www.emthini.co.za
- 3 MOBILE SMS**
Through a partnership with Vodacom SA, and to facilitate a compliant campaign in accordance with the POPI ACT and all advertising regulators, Emthini will run a SMS and display campaign with URL links to the website, to protect the identities of all entries.
- 4 GOOGLE**
Google documents will be used to host the contact form for the questionnaire. This will ensure that the audience information is protected and redirected from social media.

Multi-Channel communication in order to reach diverse groups for the research.



Campaign Placement Mock-Up

Headline advert that leads to the main advert, as part of the targeted content .

300 X 250 size advert with multiple slides to include important content from the advert copy sent on the Word Document. Also example of Facebook/Instagram advert copy.

Full display advert on mobile phone

TARGETED AUDIENCE:
WOMEN, 18 - 66 YRS,
HEALTH CLINICS
CONTENT, SEXUAL
HEALTH CHANNELS.

Conclusion

The Emthini Over-Comers campaign will run over a period of a month, reaching a South African audience of women aged 18+ who have experienced sexual assault/abuse, from various cultural groups and backgrounds.

- HIGHLIGHT 1**
Social Media is Powerful for Mass Reach
 - Multi-cultural audiences
 - The campaign will get guaranteed 120 clicks
 - Comments set with pre-approval to ensure 0% inappropriate content and for the protection of the commenters' identity.
- HIGHLIGHT 2**
The Website
 - Private and confidential consumption of content, as well as direct contact with researcher.
 - Links to survey and T's & C's hosted on website
- HIGHLIGHT 3**
SMS & Display
 - 5000 Page Impressions for display adverts
 - Display adverts spread to Facebook and Instagram with link to the website.

ADDENDUM 7: RAPID REVIEW TABLE

Authors, year of publication	Interventions compared	Study design	Sample	Setting	Outcomes and assessment instruments
Allon (2015)	Individual EMDR, Integrative Group treatment Protocol EMDR (EMDR-IGTP)	Quasi-experimental	Females (n=37) Mean age: 37 females selected by the local Malteser trained coordinators for the assistance program. No formal inclusion or exclusion criteria but all were sexually assaulted	Kakwende and Kasika in the Eastern Congo	Severity of trauma-related symptomology: <i>Impact events scale (IES)</i> Subjective units of distress: <i>SUD</i>
Au et al., 2017	Compassion-based therapy and control group	RCT	Female (n=10) Median age: 20 Age range 18-32 Inclusion criteria:) a least 18 years of age; (b) exposure to a traumatic event, as defined by DSM-5 PTSD Criterion A, at least 1 month prior to the screening; (c) elevated PTSD symptoms (PTSD Checklist [PCL-5] score \geq 27, (d) elevated shame related to the traumatic event and/or its sequelae (Internalized Shame Scale [ISS] pastmonth score \geq 40, per Cook [2001]; estimated ISS score before the trauma \leq 40 and at least 10 points lower than past-month ISS); and (e) if taking psychotropic medications, stabilized dose for at least 8 weeks. Exclusion criteria were: (a) elevated current risk requiring a higher level of care, including current suicidal ideation and intent, psychosis, bipolar disorder, or current or recent (within 3 months) history of substance use disorder (not including caffeine, nicotine, or cannabis use disorder); or (b) concurrent psychotherapy for trauma-related problems.	USA, University	PTSD PCL-5 Shame Internalized shame scale Self-compassion Self-compassion scale Self-blame Posttraumatic Cognitions Inventory

Authors, year of publication	Interventions compared	Study design	Sample	Setting	Outcomes and assessment instruments
Bass et al. (2014)	Cognitive Processing therapy Individual support	RCT	Females (n = 405) Mean age; therapy group (36.9) Individual support group (33.8) <u>Inclusion criteria:</u> Women who had experienced or witnessed sexual violence (translated as “rape” locally) were eligible for the study if they had a total symptom score of at least 55 (i.e., an average score of 1 for each of 55 symptoms, comprising the HSCL-25 items, the HTQ items, and additional locally relevant symptoms) and a functional-impairment score of at least 10 (i.e., dysfunction on at least half the activities). <u>Exclusion criteria:</u> Suicidality that was judged by clinical staff to require immediate treatment was a criterion for exclusion.	Organisation providing psychosocial support to adult female survivors of sexual assault in North and South Kivu in the Democratic Republic of the Congo	Depression and Anxiety HSCL-25 - Hopkins symptom checklist PTSD HTQ
Beleville, Dube-Frenette & Rousseau (2018)	Imagery Rehearsal Therapy Cognitive Behavioural Therapy	RCT	Total (n=42) Female (n = 37) Male (n = 5) Mean age: Female: 29.45 Male; 31.45. <u>Inclusion criteria:</u> (a) over 18 years of age; (b) able to understand and speak French; (c) history of unwanted sexual experience; (d) PTSD diagnosis according to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000); (e) sleep complaints, as established by a Pittsburgh Sleep Quality Index (PSQI; Buysse, Reynolds, Monk, Berman, & Kupfer, 1989) score of 5 or more and a mean of one or more nightmares per week for at least 1 month; (f) psychotropic medication dosage that had been unchanged for the past 3 months (if the participant reported using a psychotropic medication); and (g) available for in-person assessments and therapy sessions. distress, poor sleep quality, and disruptive nocturnal behaviours. <u>Exclusion criteria</u> included (a) past or present psychotic episode, bipolar disorder, or organic mental disorder (e.g., dementia); (b) current substance use disorder; (c) sleep apnoea diagnosis; (d) use of prazosin to treat nightmares; (e) currently in treatment for psychological difficulties; and (f) suicidal thoughts requiring immediate intervention. In addition, at the time of recruitment and for the duration of the study, participants were required to agree to (a) not make changes to dose or type of prescribed psychotropic medication, (b) not initiate a new psychotropic medication, and (c) not receive any other psychotherapy or supportive intervention.	University students and referrals from rape crisis centres and mental health organizations in Canada	Posttraumatic stress disorder CAPS (PTSD), PSIQ-A, MPSS-SR Axis 1 d/o SCID-IV Nightmares Sleep quality NDQ: Nightmare Distress Questionnaire Sleep Quality (PSQI) Disruptive nocturnal behaviours associated with , PTSD symptoms Functional impairment WHODAS Quality of life SF-36

Authors, year of publication	Interventions compared	Study design	Sample	Setting	Outcomes and assessment instruments
Cikuru et al. (2020)	Healing in Harmony program on three different village groups; No control group	Step wedge designed study	Females (n =167) Mean age: 37; Range 15 -69 years Two-thirds were of reproductive age (15–44 years) and one-third were 45 years and older. three-quarters of the women reported having ever experienced a traumatic event, 41.3% reported being the survivor of sexual violence, and one-third reported being a refugee, displaced, or having had to abandon their home. The proportion who reported a trauma within the past 3 months at the pre-test, post-test, and 3-month follow-up interview was 9.7% (n = 16), 14.6% (n = 23), and 25.2% (n = 28), respectively.	Rural hospital affiliated with a group of villages situated in South Kivu province of the Democratic Republic of the Congo. (Ongoing conflict setting)	Anxiety and Depression: Hopkins Symptoms Checklist, posttraumatic stress disorder: Harvard Trauma Questionnaire
Goodarzi, Sadeghi & Foroughi (2020)	Mindfulness and art making intervention Control group	RCT	Females (n = 16) Mean age: Experimental group (32.6) Control group (29.1) Age Range: 20-49 Inclusion criteria: The population of the study consisted of sexually assaulted females who had sought professional help in psychotherapy clinics of Hamedan and were informed of this program by clinicians. Exclusion criteria: Diagnostic criteria of full-blown PTSD, schizophrenia, or delusional disorders, bipolar type I, substance abuse, suicidal ideation or personality disorders (examined by SCID-I and SCID-II), and the patients' unwillingness to continue participation.	Psychotherapy clinics in Hamedan, Iran	Severity of trauma-related symptomology: Impact events scale (IES) Axis I disorders Structured clinician administered interview DSM-IV Depression Beck Depression Inventory-2, Anxiety Becks Anxiety Inventory Shame and Guilt PFQ-2

Authors, year of publication	Interventions compared	Study design	Sample	Setting	Outcomes and assessment instruments
Galovski et al. (2012)	Modified Cognitive Processing Therapy (MCPT) Symptom-monitoring Delayed Treatment (SMDT)	RCT	<p>Female (n = 69) Male (n = 31) Mean age: 39.80, Range: 19-68 Race: Black (51%) White (42%) Hispanic (7%) <u>Inclusion criteria:</u> Participants had to be at least 18 years of age and meet full criteria for PTSD secondary to a sexual or physical assault in childhood or adulthood as assessed by the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990). At least 3 months needed to have transpired between the trauma and the initial assessment and individuals could not currently be in an abusive relationship or currently be the target of stalking. Participants could endorse lifetime drug and/or alcohol dependence but needed to be in remission for at least 6 months. People meeting criteria for alcohol and drug abuse were not excluded from the study. Participants needed to be stable on psychiatric medications for 1-month prior to the initial assessment and needed to hold medication usage constant during treatment. <u>Exclusion criteria</u> included current mania, psychosis, or suicidal intent.</p>	Self-referred from the greater St. Louis area in the United States of America	<p>Posttraumatic stress disorder symptoms <i>Clinician Administered Posttraumatic stress scale</i> <i>Posttraumatic stress diagnostic scale</i> Depression <i>Beck Depression Inventory-II</i> Trauma related guilt <i>Trauma Related Guilt Inventory (TRGI),</i> Quality of life <i>Quality of life Inventory</i> Physical Health <i>36-item Short-form health survey</i></p>
Karlsson et al. (2014)	Brief exposure-based group treatment intervention No control group	Quasi-experimental Pilot study	<p>Females (n=14) Mean age; Range: 14 women who committed nonviolent felonies (10-15 months). 13 caucasian, one latina and black. 13 have children 11 were previous in therapy. including eligibility criteria (being a victim of sexual violence, defined as having experienced unwanted sexual contact, threats if the person did not agree to sexual contact, or rape, and currently struggling with trust, anger, or sadness as a result of the sexual violence), The analyses below focus on the 14 women who provided pre- and posttreatment data. All were incarcerated for committing nonviolent felonies (mainly drug-related and money fraud). Typical length of stay was 10–15 months, with a maximum stay of 2 years. Thirteen women (92.9%) reported having at least one child. Eleven women (78.6%) reported previous therapy experiences (10 individual therapy only; 1 both individual and group therapy).</p>	Women incarcerated in a minimum-security prison in the USA	<p>Posttraumatic stress disorder <i>PCL-5; PTSD Checklist for diagnostic and statistical manual for mental disorders-fifth edition</i> Depression <i>PHQ-9 - Patient Health Questionnaire</i> Generalized Anxiety Disorder <i>GAD-2 - Generalized anxiety disorder scale</i></p>

Authors, year of publication	Interventions compared	Study design	Sample	Setting	Outcomes and assessment instruments
Karlsson, Zielinski, & Bridges (2020)	Brief exposure-based group treatment intervention No control group	Quasi-experimental	<p>Females (n = 32) Mean age; Range 18- <u>Inclusion criteria:</u> (a) being a woman incarcerated at the facility (age 18 or older) during the study enrollment period; (b) endorsing lifetime experience of at least one instance of sexual violence (examples provided during recruitment included being touched when you did not want, being threatened if you did not have sex, and being gang raped); (c) self-endorsing having at least one difficulty potentially related to the trauma (examples provided during recruitment included sadness, anxiety, anger, or trust issues); and (d) expressing interest in this study. <u>Exclusion criteria:</u> (a) current participation in the substance abuse program at the facility; and (b) having a parole date that would preclude participation in the 8-week treatment protocol.</p>	Women incarcerated in a minimum-security prison in the USA	<p>Posttraumatic stress disorder <i>PCL-5; PTSD Checklist for diagnostic and statistical manual for mental disorders-fifth edition</i> Depression <i>PHQ-9 - Patient Health Questionnaire</i> Generalized Anxiety Disorder <i>GAD-2 - Generalized anxiety disorder scale</i></p>
Lee & Cha (2021)	Reflective writing and meditation intervention Control group (audio-guided meditation)	Mixed method study with a nonequivalent control group pretest-posttest design for pilot study	<p>Females (n = 34) Age Range: 18-24 Inclusion criteria: Female survivors of sexual violence (rape, sexual abuse, or sexual harassment) who had experienced sexual violence within 6 months from the time of data collection because the focus was on healing from the long-term impacts of sexual violence (Kwon & Jang, 2003). Exclusion criteria: Women receiving formal therapy were excluded to solely evaluate the intervention effects of this study.</p>	Online intervention for women in South Korea	<p>Perceived support Korean version Multidimensional Scale of Perceived Social Support scale. The negative impacts of sexual violence on the survivors Long-Term Negative Impact of Sexual Violence to Adolescents Suicidal ideation Suicidal Ideation Questionnaire</p>

Authors, year of publication	Interventions compared	Study design	Sample	Setting	Outcomes and assessment instruments
Littleton et al. (2016)	Online therapist facilitated CBT-based interactive program Self-help psychoeducational website	RCT	Females (n = 87) Mean age: 22 <u>Inclusion:</u> Diagnosis of rape-related PTSD currently enrolled as a student at one of four universities/community colleges. <u>Exclusion</u> currently receiving psychotherapy, lack of stability on psychotropic medication, active suicidality (Scale for Suicidal Ideation), substance use disorder (SCID-IV)	Online intervention for students at one of four universities in USA	PTSD symptoms: PTSD Symptom Scale-Interview (PSSI) Depressive symptoms: Centre for Epidemiological Studies Depression Scale Anxiety symptoms: Four Dimensional Anxiety Scale Stressful life events: Stressful Life Events Screening Questionnaire Therapeutic alliance: Working Alliance Inventory Short-Form (WAI-S) Satisfaction with Therapy and Therapist: Satisfaction with Therapy and Therapist Scale-Revised (STTS-R)
Nixon (2012)	Cognitive Processing therapy Supportive counselling	RCT	Female (n = 16) Male (n= 14) Mean age CPT (40.59) SC (40.69) Inclusion criteria: diagnosis of ASD and ability to attend weekly therapy sessions. Exclusion criteria: included the trauma not occurring in the previous 4 weeks, non-assault-related trauma, significant current suicidal ideation, client still in a traumatic situation, already receiving treatment for the trauma, change of anxiolytic or antidepressant medication/ dosage since the trauma, substance dependence, or current PTSD to a prior trauma	Self-referred to Posttraumatic Stress Research unit in Australian University	Acute stress disorder Acute stress disorder scale Posttraumatic stress disorder Posttraumatic diagnostic scale Posttraumatic cognitions Posttraumatic Cognitions Inventory Depression Beck Depression Inventory II

Authors, year of publication	Interventions compared	Study design	Sample	Setting	Outcomes and assessment instruments
Nixon et al. (2017)	Cognitive Processing therapy and Treatment as usual group	RCT	<p>Females (n=24) Males (n=1). Mean age: CPT (32.46) TAU (29.95) Ethnicity: CPT (83% caucasian) TAU (91% caucasian) <u>Inclusion criteria:</u> 18 years or older who had experienced rape or sexual assault in the past month and were able to attend face-to-face counselling. Clients had to meet criteria for ASD, and for those taking psychotropic medication this had to be stable for the 4-week period prior to beginning therapy. <u>Exclusion criteria:</u> Uncontrolled psychosis, current substance dependence requiring immediate attention, insufficient English, significant cognitive impairment or disability, significant suicide risk, or ongoing traumatisation (e.g., being stalked) were excluded.</p>	Community centre in Australia	<p>Acute Stress Disorder and PTSD diagnosis and symptom severity Clinician-Administered PTSD scale (CAPS) Current comorbid mood, other anxiety and substance use disorders <i>MINI International Neuropsychiatric Interview.</i> <i>The Beck Depression Inventory.</i> Expectations regarding treatment success. Credibility and Expectancy Questionnaire Therapeutic relationship Working Alliance Inventory short form</p>
Rajan et al. (2020)	Modified lifespan integration intervention (episodic memory integration) Treatment as usual group	RCT	<p>Females (n=38) Mean age 24; Range 15-65 100% caucasian. Inclusion criteria: PTSD symptoms after one sexual assault during the past 5 years. Exclusion criteria: Poor understanding of Swedish, multiple traumas, active substance abuse, active psychosis, ADHD, or autism spectrum disorder.</p>	Specialized clinic for sexually traumatized patients in Stockholm, Sweden	<p>PTSD IES-R (Impact of event scale revised) PTSD (PCI-5) National Stressful Events Survey PTSD short scale Nonspecific Psychological Distress GHQ12</p>

Authors, year of publication	Interventions compared	Study design	Sample	Setting	Outcomes and assessment instruments
Resick et al. (2021)	Cognitive Processing Therapy Prolonged Exposure Waiting condition	Follow up on RCT	Females (n = 121) Mean age: 32 Inclusion: experienced at least one rape a minimum of 3 months prior to seeking treatment (no upper limit). Most participants (86%) had experienced other traumatic victimizations in addition to the index rape. Forty-one percent of the sample had been sexually abused (genital contact) as children. The participants reported an average of 6.4 adult crime incidents (SD = 4.9) in addition to the index rape. Participants on medications were stabilized per psychiatric consult based on type of medication. Participants had to agree to refrain from other trauma-focused psychotherapy but were permitted to continue with stabilized medications or ongoing supportive therapy.	Follow up on previous RCT study	PTSD Symptom Scale (PSS) Beck Depression inventory (BDI) and Clinician administered PTSD scale (CAPS) Structured Clinical Interview (SCID)
Shors Tracey et al. (2018)	Mental and Physical Training, Mental Training Alone, Physical Training Alone, Control group	Pilot study	Females (n=105) Mean: 20y. Range 18-32 years Inclusion criteria: Women aged 18–40 years; not engaged in a regular exercise program (<3 days/wk for 20-min or less per session over the past month); not engaged in any formal meditation practice (not meditating more than 30-min total per week and less than 200-h in lifetime); free from physical limitations or contraindications to exercise; and able and willing to provide informed consent. Exclusion criteria: severe psychopathology, including bipolar spectrum disorders, schizophrenia spectrum disorders, and substance use disorders and those at high risk for suicide.	Student body in a Northeastern University in the United States of America	PTSD cognitions: Post-traumatic Cognitions Inventory Rumination related to depression: Ruminative Responses Scale Self-worth: Best scale Strength of stressful life memory: Autobiographical Memory Questionnaire
Tarquinio et al. (2012)	Integration of Emergency EMDR protocols (Recent Traumatic Episode Protocol, Modified abridged EMDR Protocol) and Psychological debriefing; No control group	Quasi-experimental	Females (n=17) Mean age: 32.2; Range 18-60 years First time rape consultation taking place between 24-72 hours before. Filed a complaint with the police, reside in France and fluent in French, no psychiatric diagnoses, abstains from substances, no contraindications for EMDR.	Research centre in France, referred by psychologists, family doctors or regional associations offering aid to victims	Severity of trauma-related symptomology: Impact events scale (IES) Subjective units of distress: SUD Two questions related to sexuality; desire and excitement

Authors, year of publication	Interventions compared	Study design	Sample	Setting	Outcomes and assessment instruments
Vang, et al. (2020)	Cognitive behavioural group based intervention No control group	Quasi-experimental	<p>Females (n = 96) Mean age: 21.2 years. Age 36 adolescents (13-18) 60 adults (19-37)</p> <p>The mean time since the assault was 46.2 months, but a standard deviation of 67.7 months suggested that there was a considerable variability in time since the assault (range = 1–479, median = 16, mode = 3 months).</p> <p>Inclusion criteria: Survivors of sexual assault referred to CRV for mental health problems associated with a sexual assault that took place at least a month before referral.</p> <p>Exclusion criteria: psychosis, incest, not reporting PTSD symptoms, having an active substance abuse, cognitive impairment or inability to schedule an appointment, male, missing data, due to multiple sexual assaults.</p>	Danish centre for rape victims	PTSD Harvard Trauma Questionnaire (HTQ) Other types of trauma symptomatology Trauma Symptom Checklist (TSC)

SECTION 2 OF RAPID REVIEW TABLES

Authors, year of publication	Number and length of sessions	Style of delivery	Facets of intervention	Treatment outcomes	Frequency	Topic/Themes
Allon (2015)	2 sessions for both individual and group administration	Group Individual	Standardised EMDR protocol	Intrusive and avoidance symptoms	2 sessions for both individual and group administration	Standardised EMDR protocol
Au et al., 2017	6 weekly 60-90 minute sessions	Individual	Psychoeducation Meditation	Decreases in PTSD, self-blame and shame. Increases in self-compassion	6 weekly sessions	<p>Session 1: Main goals: General PTSD psychoeducation and mindfulness instruction. Key exercises: PTSD psychoeducation, mindful breathing, grounding</p> <p>Session 2: Main goals: Define self-compassion, build motivation to increase self-compassion, and practice self-compassion for everyday difficulties. Key exercises: Coach A vs Coach B, Self-Compassion Break, self-compassion letter</p> <p>Session 3: Main goal: Practice self-compassion for everyday, non-trauma-related difficulties. Key exercises: compassionate scent, Sending Compassion, Perfect Nurturer</p> <p>Session 4: Main goal: Apply self-compassion practices from Sessions 2 and 3 to the index trauma. Key exercise: Perfect Nurturer</p> <p>Session 5: Main goal: Continue practicing self-compassion in response to the trauma. Key exercise: Compassion Antidote</p> <p>Session 6: Main goal: Review and wrap-up. Key exercise: mindfulness/self-compassion exercise of participant's choosing</p>

Authors, year of publication	Number and length of sessions	Style of delivery	Facets of intervention	Treatment outcomes	Frequency	Topic/Themes
Bass et al. (2014)	1 individual and 11 group sessions	Both	Session 1: Introduction to therapy (individual) Session 2: Introduction to Cognitive Processing Therapy Session 3: Meaning of the Event Session 4: Identification of Thoughts and Feelings Session 5: Identification of Stuck Points (maladaptive beliefs) Session 6: Challenging Questions Session 7: Challenging Beliefs Session 8-12: Cognitive Modules: Safety, Trust, Power/Control, Esteem, Intimacy	PTSD and Functionality	12 sessions of 2 hours	Cognitive processing therapy cognitive-only model
Beleville, Dube-Frenette & Rousseau (2018)	5 sessions IRT and 15 sessions CBT OR 15 sessions CBT	Individual	1. Psychoeducation (sleep, nightmares and IRT rationale) 2. Pleasant imagery 3. Nightmare rescripting 1. Psychoeducation (PTSD symptoms and diaphragmatic breathing) 2. Exposure to traumatic memories via imagery 3. in vivo exposure to feared objects, activities and situations 4. Relapse prevention	Posttraumatic stress disorder Axis 1 d/o Nightmares Sleep quality Sleep Quality Functional impairment Quality of life	5 weekly sessions for 60min	1. Psychoeducation (sleep, nightmares and IRT rationale) 2. Pleasant imagery 3. Nightmare rescripting 1. Psychoeducation (PTSD symptoms and diaphragmatic breathing) 2. Exposure to traumatic memories via imagery 3. in vivo exposure to feared objects, activities and situations 4. Relapse prevention

Authors, year of publication	Number and length of sessions	Style of delivery	Facets of intervention	Treatment outcomes	Frequency	Topic/Themes
Cikuru et al. (2020)	12 week program sessions held twice per week.	Group	Music therapy (songwriting;) Verbalisation	PTSD Depression Anxiety	12 week program sessions held twice per week.	Healing in Harmony Music program six stages: 1) Introduction 2) Relaxation, 3) Verbalization, 4) Songwriting, 5) Rehearsing/Recording 6) Dissemination
Galovski et al. (2012)	Varying based on participant requirements (4-8 sessions)	Individual	12 session CPT protocol	PTSD, DSM-IV Axis I d/o, Depression Trauma related guilt inventory, quality of life, health	12 session CPT protocol	Cognitive processing therapy psychoeducation and then uses Socratic dialogue to assist the survivor in resolving inaccurate thoughts or interpretations (i.e., stuck points) resulting from the trauma.
Goodarzi, Sadeghi & Foroughi (2020)	Session 8 2 hours per session	Mixture of individual and group sessions	Mindfulness and Art activities	Depression; Anxiety, PTSD	Session 8 2 hours per session	Mindfulness and Art activities Mindfulness content (1) present moment awareness, relaxation, diaphragmatic breathing, body scan meditation (2) foundations of mindfulness, anchoring attention in breath, (3) Exploring the mind-body relationship, gentle stretching, pre-assessment and post assessment of mind/body relationship (3) exploring mind-body relationships, stretching (4) Creative problem solving, acceptance and cultivating receptive attention, self-care imaging (5) Expanding awareness and sitting with thoughts and feelings (6) Physiology of stress and stressful communication (7) loving-kindness meditation (8) loving kindness meditation, speaking about the therapy program, guided imagery. Art activity (1) make collage of whole body experience during body scan practice, draw picture of your safe place (2) mindful exploration of art materials draw 5 pictures about different stimuli (3) figure with clay doing stretching (4) draw emotions associated with pain re to traumatic experience (5) cardboard hat with thoughts and feelings at the time of the trauma (6) draw pleasant event and reflect on how it makes you feel (7) mask of the trauma and write down a conversation between the two you's (8) collage of the loss that you have experienced and its meaning for you. Against sexual assault motto.

Authors, year of publication	Number and length of sessions	Style of delivery	Facets of intervention	Treatment outcomes	Frequency	Topic/Themes
Karlsson et al. (2014)	Eight 1.5 hour sessions	Group	<ol style="list-style-type: none"> 1. Psychoeducation (sexual violence and sequelae, role of avoidance in maintenance of psychiatric symptoms and the rationale of exposure therapy) 2. Sharing sexual abuse memories for 2 sessions and then 3 sessions of discussion McCann, Sakheim and Abrahams themes (safety, trust, power/control, esteem and intimacy CBT) 3. Increasing coping strategies (Self-care, defining health sexual relationships) 4. Reflections on what has been learned (continuing areas of development and additional resources) 	PTSD , Depression and Anxiety	8 sessions of 1.5 hours each	<p>Psychoeducation (sexual violence and sequelae, role of avoidance in maintenance of psychiatric symptoms and the rationale of exposure therapy)</p> <ol style="list-style-type: none"> 2. Sharing sexual abuse memories for 2 sessions and then 3 sessions of discussion McCann, Sakheim and Abrahams themes (safety, trust, power/control, esteem and intimacy CBT) 3. Increasing coping strategies (Self-care, defining health sexual relationships) 4. Reflections on what has been learned (continuing areas of development and additional resources)
Karlsson, Zielinski, & Bridges (2020)	Eight 1.5 hour sessions	Group	<ol style="list-style-type: none"> 1. Psychoeducation (impact of trauma on safety, trust, power/control, esteem and intimacy) 2. Imaginal exposure to memories 3. Verbalisation / Sharing their stories 4. Relapse prevention and continuing recovery 	PTSD and GAD	7 sessions of 1.5 hours each	<ol style="list-style-type: none"> 1. Psychoeducation (impact of trauma on safety, trust, power/control, esteem and intimacy) 2. Imaginal exposure to memories 3. Verbalisation / Sharing their stories 4. Relapse prevention and continuing recovery

Authors, year of publication	Number and length of sessions	Style of delivery	Facets of intervention	Treatment outcomes	Frequency	Topic/Themes
Lee & Cha (2021)	Bi-weekly for 4 weeks	Individual	Perceived support, negative impact of sexual violence and suicidal ideation - Mindfulness meditation	Perceived support, negative impact of sexual violence and suicidal ideation	Bi-weekly for 4 weeks	reflective writing and mindfulness meditation, 1 #1 Confusion Emotional turmoil after sexual violence Standing meditation #2 Aftermath: Family and friends Difficulties of being treated as an outcast from school and family who wanted to conceal the event or blame her Chopping wood meditation 2 #3 Aftermath: Society Process of suing and trial and how people viewed her Chopping wood meditation #4 Feminism and social support Enlightened by feminism and getting support from sexual violence relief centre Walking meditation 3 #5 Sharing feelings and empathizing Vicarious learning about other sexual violence victims' experience and the importance of having trusted someone/pet Sitting meditation #6 Getting professional help Getting help expressing and controlling feelings through professional consultation and medication Sitting meditation 4 #7 Expressing my feelings Letting out of my feelings through art activities and getting out from negative thoughts from outdoor activities Relaxation meditation #8 Looking ahead to the future Viewing myself from sexual violence victim to survivor and serving other sexual violence victims Self-compassion meditation

Authors, year of publication	Number and length of sessions	Style of delivery	Facets of intervention	Treatment outcomes	Frequency	Topic/Themes
Littleton et al. (2016)	14 sessions of online content	Individual	1, Psychoeducation (coping stigma ; 2, Relaxation exercises & Grounding exercises 3, Adaptive coping strategies 4, challenging maladaptive thoughts	PTSD Depression Anxiety	14 sessions of online content	(1) Welcome to the program: psychoeducation about frequent issues encountered following unwanted sex, think of ways it has affected them and ID strengths. (2) Relaxation and grounding: emotional and physiological responses to stress, introduce relaxation and grounding exercises. (3) adaptive and maladaptive coping: evaluate coping approaches and select adaptive coping strategies. (4) Automatic thoughts: introducing cognitive model and ID maladaptive thoughts (5) Challenging questions: useful tool to challenge maladaptive thoughts and modify patterns (6) Coping with stigma, thoughts of low self-worth and shame: psychoeducation ID role of cognitions and emotions may be playing in their lives challenging questions and pros and cons techniques to evaluate concerns (7) Trust and intimacy concerns: difficulties with trusting others and physical intimacy, challenging questions and behavioural experiments (8) Self-blame: ID ways they are blaming themselves and reattribution technique employed (9) Safety concerns: Avoiding dangerous situations or ID cues that makes a situation dangerous, evaluate safety.
Nixon (2012)	7 sessions 90min weekly	Individual	CBT; identifying faulty thinking, stopping avoidance, trauma themes adressed	Acute stress disorder, PTSD, depression and Posttraumatic cognitions	7 sessions 90min weekly	CBT; psychoeducation identifying faulty thinking, stopping avoidance, trauma themes adressed

Authors, year of publication	Number and length of sessions	Style of delivery	Facets of intervention	Treatment outcomes	Frequency	Topic/Themes
Nixon et al. (2017)	5-6 sessions weekly for 90min each	Group	<ol style="list-style-type: none"> 1. Psychoeducation re trauma symptoms, presentation and rationale for treatment, ABC model 2. Challenging unhelpful thinking patterns related to self-blame and potential of negative core beliefs (safety, trust) 3. Discussing beliefs and introducing theme of power/control and esteem 4. Challenge unhelpful assumptions 5. Pleasant events scheduled 6. Theme of intimacy and relationships 7. Rewriting impact stagement, evaluating change and composing future goals. 	PTSD and Anxiety	5-6 sessions weekly for 90min each	<ol style="list-style-type: none"> 1. Psychoeducation re trauma symptoms, presentation and rationale for treatment, ABC model 2. Challenging unhelpful thinking patterns related to self-blame and potential of negative core beliefs (safety, trust) 3. Discussing beliefs and introducing theme of power/control and esteem 4. Challenge unhelpful assumptions 5. Pleasant events scheduled 6. Theme of intimacy and relationships 7. Rewriting impact stagement, evaluating change and composing future goals.
Rajan et al. (2020)	One session	Individual	Requires accreditation for using protocol	PTSD and GHQ	One session	Requires accreditation* Phase one: Rapid exposure Phase 2 Cue Jumping and Timeline repetition Phase 3: Rescript and Timeline repetition

Authors, year of publication	Number and length of sessions	Style of delivery	Facets of intervention	Treatment outcomes	Frequency	Topic/Themes
Resick et al. (2021)	CPT 12 sessions 90 minutes PE 9 sessions 90 minutes	Individual	Cognitive processing therapy Prolonged exposure therapy	PTSD Depression Axis I disorders	CPT 12 sessions 90 minutes PE 9 sessions 90 minutes	<p>CPT: 1. Psychoeducation about PTSD, an overview of treatment, and an assignment to write an impact statement about the personal meaning of the event.</p> <p>2. ABC model introduced based on session 1 homework</p> <p>3. An account of the trauma including emotions thoughts and sensory details, encouraged to experience these</p> <p>4. Account is read to therapist and Socratic questioning employed re self-blame and other distortions re the event.</p> <p>5. Account written a second time.</p> <p>6. Teaching the client to challenge and change beliefs about the meaning of the event and the implication of trauma in thier lives.</p> <p>7. Identify problematic patterns of cognitions and ways to develop and practice more balanced self-statements</p> <p>8. Different themes each week (safety, trust, power-control, esteem or intimacy) and correct overgeneralized beliefs.</p> <p>9. rewrite impact statements to reflect current beliefs including revised statements.</p> <p>10. Evaluate gains and areas that still need to be worked on.</p> <p>PE:1. Education-rationale - symptoms of PTSD and rationale for treatment in the context of avoidance reduction and habituation of conditioned negative emotional responses</p> <p>2. breathing retraining - psychoeducation re breathing retraining, subjective units of distress ratings and in vivo exposure hierarchy</p> <p>3. Behavioural exposures - 45-60 min exposure session and processing the exposure with nondirective statements (education about reactions, paraphrasing, reiterating the treatment rationale and normalizing reactions</p> <p>4. Imaginal exposures - listen to tape of imaginal expose sessions each day and engage in behavioural exposures with increasing difficulty for at least 45min per day.</p>

Authors, year of publication	Number and length of sessions	Style of delivery	Facets of intervention	Treatment outcomes	Frequency	Topic/Themes
Shors Tracey et al. (2018)	2 sessions a week for at least 6 weeks Mental training alone: 30 min Physical Training: 30 min Both: 60min	Group	Mindfulness (meditation; slow walking) Exercise (aerobic)	PTSD Depression	2 sessions a week for at least 6 weeks Mental training alone: 30 min Physical Training: 30 min Both: 60min	Mental training and Physical training. Each session of Mental and Physical (MAP) Training consists of 20-min of sitting meditation, followed by 10-min of very slow walking meditation, ending with 30-min of aerobic exercise with heart rate maintained at 60–80% of the participant’s maximum.
Tarquinio et al. (2012)	Single session	Individual	Standardised EMDR protocol	Intrusive and avoidance symptoms	Single session	URGent EMDR treatment protocol
Vang, et al. (2020)	8 sessions	Group	Exposure therapy	PTSD	8 sessions	1 Exposure in sensu by trauma narrative, psychoeducation about trauma reactions 2 Exposure in sensu by trauma narrative, psychoeducation about trauma reactions 3 Exposure in sensu by trauma narrative, psychoeducation about the relationship between thoughts, feelings and behavior, exposure in vivo 4 Psychoeducation about sexual problems and physical reactions, exposure in vivo 5 Visit by a sexologist counselor, exposure in vivo 6 Avoidance and risk behavior, exposure in vivo 7 Visit by police, exposure in vivo 8 Relapse prevention, end of therapy

ADDENDUM 8: CHARACTERISTICS OF PARTICIPANTS IN CONVERGENT MIXED METHOD STUDY

Characteristics of the participants (n=50)

Item	Category	Frequency	Percentage
Ethnicity	White	13	26.0
	Black	34	68.0
	Mixed-Race	3	6.0
Age group	18-20 years	10	20.0
	21-30 years	20	40.0
	31-40 years	12	24.0
	41-50 years	6	12.0
	51-60 years	2	4.0
Relationship status	Single	20	40.0
	In relationship ^a	21	42.0
	Married	5	10.0
	Separated	2	4.0
	Divorced	2	4.0
Level of education	Grade 9	1	2.0
	Grade 10	0	0.0
	Grade 11	1	2.0
	Grade 12 / Matric	27	54.0
	Diploma / Certificate	2	4.0
	Undergraduate degree	13	26.0
	Post-graduate degree	6	12.0
Did you experience more than one assault?	No	18	36.0
	Yes	32	64.0
How many times were you assaulted?	More than once / Unsure how many times	6	12.0
	Once	18	36.0
	Twice	9	18.0
	Three times	9	18.0
	Four times	3	6.0

	More than four times	5	10.0	
Time since (last) assault	3-6 months	12	25.0	
	7-12 months	6	12.5	
	13-18 months	3	6.3	
	19-24 months	4	8.3	
	3-5 years	9	18.8	
	6-10 years	10	20.8	
	11-15 years	1	2.1	
	16-20 years	1	2.1	
	More than 20 years	2	4.2	
Was the perpetrator known to you?	No	14	28.0	
	Yes	36	72.0	
Relationship to perpetrator	Husband / Partner	6	12.8	
	Boyfriend			
	Child(ren)'s father / Ex-boyfriend	3	6.4	
	Friend / Best friend / Online friend	8	17.0	
	Male family member	2	4.3	
	Stepfather	1	2.1	
	Colleague(s) / Manager	3	6.4	
	Date	1	2.1	
	Acquaintance	6	12.8	
	Stranger	14	29.8	
	Multiple perpetrators, multiple incidents	3	6.4	
	Who in your informal support network did you tell?	No-one	13	26.0
		Parent / Caregiver	7	14.0
Family member		7	14.0	
Friend		9	18.0	
Partner		4	8.0	
MHP / Professional person only		6	12.0	

	Numerous organisations	4	8.0
Did you file a police report?	No	30	60.0
	Yes	20	40.0
Was the police helpful in prosecuting the perpetrator(s)?	No report filed	29	59.2
	No, they were not	13	26.5
	They were somewhat helpful	2	4.0
	Yes, they were	6	12.2
How soon did you go for therapy?	Never	22	47.8
	Immediately – 1 month after	7	15.2
	2-6 months after	3	6.5
	7-12 months after	5	10.9
	13-24 months later		
	3-5 years	2	4.3
	After more than 5 years	4	8.7
	Multiple times, multiple incidents	1	2.2
Where did you go for therapy?	An NGO	6	13.6
	A private psychologist / therapist	9	20.5
	A mental health care centre / Government organisation	3	6.8
	Numerous providers	4	2.3
	Church	4	9.1
	Gay and lesbian network	3	6.8
How much time did you spend in therapy?	I went once	5	10.0
	One month	6	12.0
	Two months	2	4.0
	A few months	6	12.0
	A few years	5	10.0

	Still / currently in therapy	3	6.0
Did you find therapy helpful?	Not at all	4	8.0
	Somewhat	8	16
	Yes, very helpful	16	32.0
Who supported you after the assault?	No-one	18	36.0
	Family	9	18.0
	Friend(s)	8	16.0
	Partner	5	10.0
	Professional HCP	2	4.0
	God	1	2.0
	Support group	1	2.0
	Numerous sources	6	12.0

ADDENDUM 9 TOP AND BOTTOM 20 PARTICIPANTS

PIC	ARM_TOT	PTGI_TOT	MHC_SF	PCL5_TOT
P33	48,00	81,00	68,00	29,00
P8	80,00	100,00	81,00	31,00
P49	81,00	105,00	82,00	33,00
P19	64,00	84,00	65,00	35,00
P21	77,00	91,00	67,00	36,00
P34	72,00	89,00	70,00	39,00
P48	62,00	97,00	80,00	46,00
P24	66,00	69,00	37,00	49,00
P17	37,00	66,00	55,00	50,00
P4	17,00	79,00	67,00	51,00
P7	58,00	93,00	52,00	52,00
P12	55,00	63,00	23,00	53,00
P35	34,00	51,00	38,00	57,00
P15	75,00	99,00	71,00	58,00
P13	45,00	35,00	33,00	59,00
P29	65,00	88,00	72,00	59,00
P22	54,00	97,00	69,00	60,00
P30	83,00	99,00	74,00	60,00
P28	59,00	71,00	43,00	63,00
P31	57,00	53,00	39,00	64,00
P20	56,00	85,00	63,00	77,00
P25	50,00	92,00	38,00	77,00
P6	24,00	16,00	36,00	78,00
P1	42,00	72,00	52,00	80,00
P44	60,00	89,00	43,00	81,00
P45	60,00	89,00	43,00	81,00
P9	71,00		46,00	83,00
P36	56,00	78,00	34,00	84,00
P26	45,00	28,00	28,00	85,00
P38	39,00	78,00	31,00	86,00
P50	76,00	94,00	68,00	86,00
P18	58,00	84,00	40,00	87,00
P27	57,00	63,00	43,00	87,00
P11	46,00		32,00	93,00
P14	49,00	100,00	50,00	96,00
P2	67,00	87,00	48,00	97,00
P10	25,00	27,00	23,00	97,00
P42	39,00	88,00	51,00	98,00
P43	48,00	51,00	24,00	98,00
P47	47,00	85,00	51,00	98,00
P32	61,00	101,00	59,00	100,00

*red indicates a score above the sample mean and green indicates a score below the sample mean

ADDENDUM: CONSTANT COMPARATIVE METHOD FINDINGS

Category	Codes	Examples [Recovered] Significant signs of recovery	Examples [Not Recovered] Few to no signs of recovery
Access	Apprehension	Always finding male psychologist in the public hospitals made it difficult for me to open up about the assault [P7] Was afraid [P29] Shame [P33] I stayed quiet for many years because people saw me as a liar. I accepted help very recently from people I trust. [P48]	I was not ready to face what had happened [P2] The therapist was next door to the perpetrators house [P9] No it was not hard but I think am ok [P50] No female therapist available [P14] I was angry at myself for getting myself in that position [P26] Not for me personally but I understand the need for victims that are dependent on the public health sector for assistance [P32] I feared talking about it after the negative response from those I have already told. [P38] Yes I wanted to go but the first person I told, made me feel like it was my fault [P45]
	Lack of Resources	Finances, transport [P13] Finances [P17] Lack of information on therapist available around my area [P15]	Money and time [P11] Money [P43] Work [P14] I don't have money to pay for therapy [P18] No . I was ready but I'm still on a waiting list. [P36] Counsellor that I was comfortable with was 70km away from me. [P47]
	No access difficulties	I'm blessed to be able to say no [P4] No [P8,P12,P19,P21,P34, P49]	No P10 P27 P32 P42 No it was not hard but I think am ok [P50]

Category	Codes	Examples [Recovered] Significant signs of recovery	Examples [Not Recovered] Few to no signs of recovery
Therapy helpful	Skills	I was held accountable for not allowing my feelings to consume me [P4] getting advice on how to deal with my emotions after the assaults [P7] DBT was one of the most valuable skills for me since it helped me recognise my emotions and manage them in a healthier manner. EMDR helped a lot with the flashbacks. Helped me feel less isolated [P13] The psychologist handled it in such a way that she could help me, but also taught me to cope with anything that came my way. [P48]	x
	Therapist Characteristics	My psychiatrist and my counsellor both have gone through similar experiences, their empathy is what keeps me going, the fact that I can zoom call them or Facebook call or even WhatsApp them also helps heaps [P22]	
	Destigmatising (safe space)	The space to be able to be as upset as I wanted [P4] Being able to talk to someone about what I've been through [P7] Safe space, without judgement or pity [P17] Talking helped a lot [P21] Being affirmed in that you did nothing to bring the assault upon yourself [P12]	X
	Reframing	Acceptance that it was not my fault [P19] Yes though I won't forget but I have managed to love myself more and not to blame myself [P49]	Yes clarity because I blamed no body but me [P14] That I did things to please people and now I should be looking out for me [P26] No [P2, 10,18, 27,42, 50]
	Not helpful		I felt like I didn't open up too much to the therapist I keep some of the things [P42] Eish it is but because am angry for me and God no [P50]* only went once.

Category	Codes	Examples [Recovered] Significant signs of recovery	Examples [Not Recovered] Few to no signs of recovery
Therapy unhelpful	Ineffective	Some issues were made about the assault which I didn't feel was accurate [P17]	I cannot remember much about it [P9] Just wasn't worth it [P10] They kept mentioning I should move on but I always asked how [P26]
	Harmful	Yes, the therapist became the client and I the therapist [P33] My first therapist tried to work through the traumatic events via talk therapy which resulted in a massive breakdown involving weeks of isolation and self-harm with no support structure in place. I saw a couple's therapist with a partner for help since I was having panic attacks during intimacy - his solution was that I should just let my partner "fuck me with the lights off". That was incredibly invalidating and the guilt I felt around the panic attacks worsened and I spiralled [P13]	Nothing at all apart from the looks of pity from support staff at the offices there. I guess they knew why the clients that came there are for what type of abuse [P32] She made me feel like it was my fault [P45]
	Therapist Characteristics	The hospital not having female psychologist for rape victims. Always finding male psychologist in the public hospitals made it difficult for me to open up about the assault [P7]	Talking to a male counsellor made me feel unhelpful. [P14]
	Difficulties opening up	No unhelpful	I felt like I didn't open up too much to the therapist I keep some of the things [P42] 5 participants nothing unhelpful

Category	Codes	Examples [Recovered] Significant signs of recovery	Examples [Not Recovered] Few to no signs of recovery
Therapist characteristics	Empathic	Listen empathetically and with no judgement. Don't blame and shame. [P4] Patience, understanding of guilt feelings even if irrational [P17] Never say "I know how you feel" or "I can imagine how you feel" [P21] Do not be patronising or say it will get easier [P33] Try to coach them to let go of any and all shame because none of it is inherently theirs to hold onto. [P4]	stop victimising, makes me feel worthless [P10] To be very gentle when dealing with victims [P38] Be gentle – For me as a person this is something serious that has impacted my life physically and emotionally up until today. Sometimes unknowingly words hurt more than it makes us better.[P45] Have the emotional intelligence to not bring your issues to your cases. You're dealing with people not numbers. What turns victims off from counselling is the fact that it's just quota for you and not really about the healing of the victim [P32]
	Patience	Most importantly patience every survivor is different. [P4] Be gentle. And please don't give up on victims if they don't open up or not want to talk during the first session. It's difficult to know whom to trust or not and at times we need to be comfortable with your presence to be able to trust and talk to you. [P7] To always be patient and try to understand the sexual assault survivors because it is not easy for them to tell their story. [P8]	Have patience [P9] Just be patient with us. It is already very hard trying to talk about it [P11] That they should be patient with us and again let them not try to force us to talk when we not ready [P42] They should understand that opening up is not easy [P2] Also, please exercise patience to your victims. Especially for those who are denying what has happened to them [P32]
	Trustworthy	Information must be kept confidential. [P19]	To please always check up on them and guide them . Also create employment for them. [P36]Your safety has been stolen from you and the only way that you will recover from the fight and flight response is to return back to feeling safe within yourself. The only way this happened is if the person that is sitting opposite you and to with who you share is safe. It is more than trust; you know deep inside that you are safe [P47].
	Let them express their emotions	They must let you cry to keep out the anger [P34] Not to speak over survivors - allow them to fully express all negative emotions before exploring the rationality of those emotions [P12]	Dive deeper into the survivors emotions they're struggling to control that, emotions are overwhelming [P26] they must gave us time to cry [P50]

Category	Codes	Examples [Recovered] Significant signs of recovery	Examples [Not Recovered] Few to no signs of recovery
Therapist skills	Don't give up	And please don't give up on victims if they don't open up or not want to talk during the first session. It's difficult to know whom to trust or not and at times we need to be comfortable with your presence to be able to trust and talk to you. [P7]	They must not gave up if they see someone is not coming to the session they must remind the person [P50]
	Help them let go of shame	Validating the experience is the most helpful thing and helps so much with the self-doubt and guilt and self-blame. It's hard enough loosing trust in other people, never mind completely losing trust in myself so reinforcing any trust I have in myself helps ground me. Having a professional tell me it wasn't my fault especially despite the number of occurrences was my lifeline [P13] Try to coach them to let go of any and all shame because none of it is inherently theirs to hold onto. Don't allow them to let their trauma become them it will only hurt them in the long run. [P4] Tell the victim its not their fault [P35]	x
	Help them make sense of it	Not all of us know what's going on in our brains after experiencing so much trauma. [P7]	x
	Equip victims	Give out tips about self-care [P15] I just want to say that professionals should treat victims as people, be calm and remind the women that they are special and that they should use the rape to make themselves stronger [P48]	Maybe to offer tools to help recognise behaviour that stems from the abuse and also to help build up self-worth that is damaged after that. [P43]
	Help them build an identity outside SA	Try to coach them to let go of any and all shame because none of it is inherently theirs to hold onto. Don't allow them to let their trauma become them it will only hurt them in the long run. [P4]	x

Category	Codes	Examples [Recovered] Significant signs of recovery	Examples [Not Recovered] Few to no signs of recovery
Informal Support	Emotional	Always giving me the space to be upset and talk, they are remarkably patient with me and so loving I truly am so blessed ♥ [P4] Helping me deal with my emotions when I'm not in therapy. [P7] She made sure i stay calm and try to seek counselling [P8] Very understanding about my emotions [P21] They keep telling me to love myself [P49] Talked to me [P12]	They let me know that whatever I decide they'll support me [P9] They were constantly by my side and dealt with every trauma I had [P38] They called and checked up on me [P2] He listens and is there, he does not reject me because of it [P45] Everyday they call and come to my place and my kids they are supportive even if this is hard for them [P50]
	Instrumental	Going to therapy with me. Knowing and limiting inviting me to places that trigger me. [P4] Prayed with me. [P19] My adoptive parents were always there and made sure that I am safe. My friend that passed away in May last year saved my life. I wanted to hang myself, I wanted to phone a female friend but phoned him by accident. His parents stepped in after his death, they are like parents to me and take care of me. [P48] They offered to take me to therapy [P12] They were good psychologists and psychiatrists [P13]	Checking with police if the case has gone through and sitting down and reassuring me [P11] talking [P10] By sharing my story [P14] He attended every court case with me until judgement and sentencing. My friends helped me by taking my mind off the rape, going to fun places and church [P32]
	No support		I didn't tell people close to me [P42] No one supported me [P27] No one supported me [P18]
	Activities	Journaling [P4] Trying different hobbies until I found the one that helped me keep calm [P7] Reading books [P15] I was active in sports [P34] Wrote out my emotions [P12]	Drawing and writing poetry. [P44]

Category	Codes	Examples [Recovered] Significant signs of recovery	Examples [Not Recovered] Few to no signs of recovery
Constructive coping	Reaching out to others	Helping others [P4] Talked about the rape to my family [P19] Being around people that cared and loved me [P21]	My kids help me to cope everyday they always show me how important I am to them and never gave up [P50]
	Mindset	Did my best to live my life as I always have, I did not shackle myself out of fear. [P4]	X
	Religious	I confided in God [P8] Pray [P33] I prayed to God to help me heal [P49]	I prayed [P18] I became strong and prayed. [P36]
	Professional services	Therapy [P4] Went for my sessions with my social worker. [P8] Only months later I was able to confront what had happened, with a psychologist, but sadly could only go a month due to finances. [P17] Went for therapy [P46]	X
	Self destruction	At first very toxic ways, I drank heavily and used marijuana and the occasional stronger drug. [P17] I drank alcohol. [P24] Then I started going out was for drinking [P29] self-mutilated [P33] Self-harm, binge eat/purge, drinking. DBT emotional regulation techniques (freezing cold showers help the most). Took unpaid leave from work. Hospitalization [P13] drinking alcohol [P35]	Drugs and Alcohol [P10] Drank and smoked weed [P26] Smoking cigarettes [P42]
	Avoidance	X	Took my mind off it until I was ready to deal with it [P9] I went out with friends to try distract myself with the thoughts [P11] Isolation [P14] Nothing. I moved on with my life [P38]

Category	Codes	Examples [Recovered] Significant signs of recovery	Examples [Not Recovered] Few to no signs of recovery
Destructive coping	Did not cope	X	I am still looking for help because I realise now that it has affected me in more ways than one [P43]Nothing [P27]Nothing [P2]I don't think I ever came to terms with it [P45]
	Emotional expression without action	X	I let the emotions be. I cried. I screamed. Till this day I sleep with the lights on because of the nature of my case. But I learnt to be patient with myself and let the healing process happen when it wants to. [P32]
	Self-confidence affected	It helped me regain my self-confidence and [P8]	Yes. I am insecure. I look for the love I was robbed of from people who actually don't care about me. [P43] Am now having low self-esteem [P42] My selfself-esteem is down am always angry at my self and my son [P2] It did to a certain extent because now I'm very guarded. I'm currently working on being the happy for lucky inquisitive girl I used to be before the two SA incidences. That in itself is hard [P32]
	No one can get me down	Yes, I know I'm a strong woman and that nobody can get me down [P21]	Nothing. I moved on with my life [P42]
Positive view changes	Help others	always try to help others who have been through the worst. [P8]	X
	Changes in view of men	I'm extremely pessimistic when it comes to men [P4]Trust in men will never be the same. I get a weird feeling about some men- may be wrong but the feeling hasn't been wrong in keeping me safe. A sixth sense if you will, I know in a way if someone is capable of abuse, silly as it may seem. [P17]Saw all men to be bad. [P19]I have developed a negative view of men. There is only a handful that I can trust. [P48]Definitely! My husband still can't cuddle me at night, I still don't allow people to touch me, I still get shivers down my spine when I see a man I don't know walk in my direction. [P22]	Yes, I am not very uneasy about older men within the family and more so strangers [P9]I despise men [P26]I find myself behaving differently around males and I feel as if all I am good for is sex rather than looking at the awesome person I used to be and still can be [P43]It made me a bitter ugly person especially towards men [P45]I've developed an intense hatred for men [P44]
	Unspecified good	No [P29, P34]	No [P27]

Category	Codes	Examples [Recovered] Significant signs of recovery	Examples [Not Recovered] Few to no signs of recovery
Negative view changes	Don't trust others	I tend to conduct my life as if everybody is a bad person until proven otherwise when even though I know and understand it's the other way around. [P4] I hardly trust strangers/new people in my life [P7] Yes because I feel like everyone is capable of assaulting someone and I have fear that history might repeat itself [P15] Yes. I am a great social worker but I am always cautious and alert. I'm not comfortable in situations where I lack control [P33] Others: untrustworthy, [P13] Yes, I feel like a target [P35]	Yes I struggle to trust others [P45] Yes it has made me trust less [P44]
	Insecurities about self	For a very long time I've been insecure about my body. [P7]	yes, I hate myself [P10] Yes, I no longer feel like a woman [P26]
	Suicidal		Yes. I seen understand that life is a choice, everyday is decision [P14]
	Mental health difficulties	Yes. I've stopped physically fighting because I am tired now and no matter what I do during the assault, it doesn't change that my body will become a crime scene that day [P12] Yes. Damaged, weak driven by disgusting desires, manipulative. [P13]	Yes when I see the scar in my leg .he was putting cigarettes in my leg so everyday when I bath when I see those things I cry and the smell of the man is still there to me [P50]
	Unspecified bad	Yes [P24]	Yes[P18]

Category	Codes	Examples [Recovered] Significant signs of recovery	Examples [Not Recovered] Few to no signs of recovery
Recovery strategies Mindset (PTG)	The assault does not define you	You are not your assault it was an awful thing that happened to but it does not have to become you [P4] you need therapy to get the trauma out of your body before the trauma becomes your new norm [P7]	X
	Empowering thoughts	Lastly through it all just remember you between the two of you your perpetrator is the weak one not you don't allow yourself to be broken by somebody so weak. [P4] They took absolutely nothing from you, they didn't take your soul, they didn't take your body, they took nothing and you still have everything. You are either a victim or a survivor and you can choose which one you want to be. [P22]	Be you no matter how hard it is to be you, take accountability and find resolutions for those in the future. [P14]
	Don't blame yourself	Don't turn towards substances to try and torture yourself. You did not deserve this nor bring it on yourself. [P17] don't forget to believe that it really was not your fault [P33] Love yourself more anything that happen to you is not your fault. Keep your head high [P49] Forgive yourself [P35]	Don't blame yourself. Forgive yourself. Understand that you are not responsible for their actions and love yourself enough not to let people hurt you like that again [P43] Above all know it's not your fault, you didn't deserve it, you worthy. [P44]
	Move forward with courage	most importantly as tough as it as soon as you are ready don't shackle yourself you cant and don't have to live your life tip toeing around something as fragile as a penis. [P4]	be easy on yourself and give your mind some time. [P11] Acknowledge it and make peace with it so you can move on. [P32]

Category	Codes	Examples [Recovered] Significant signs of recovery	Examples [Not Recovered] Few to no signs of recovery
Recovery strategies Action (Resilience)	Get therapy	You need therapy, whether you think your sexual assault is not that bad or you don't want to deal with it because of other things in your life [P7]They must seek counselling and make sure they talk about it with the people they trust. [P8]Get help as soon as possible [P15]Accepting, and know that you are not alone, there is help for healing. [P19]Make sure you go for counselling and if you can't talk about it write in your diary so that social worker can read and understand your pain. [P49]But if it was a random stranger asking me then I'd tell them to see a psychologist THAT SPECIALISES IN SEXUAL ASSAULT so they're at least somewhat understanding [P13]	Talk about it, talking helps [P11]Talk about it. Get counselling [P43]That they must get help [P18] Seek counselling as soon as possible [P44] The advice I can give is to go to counselling and have someone to talk to don't hide this to yourself and have safe space where u talk [P50]
	Express yourself	Healing start with letting out all your anger and pain. [P8] Talk about it even if it's extremely hard and never feel ashamed [P21] Go to the hospital. Keep talking until someone believes you and [P33]	Don't hide when you are in pain [P38]
	Perpetrator comments	and report the perpetrator [P15]	if you can forgive him [P43] report it [P44]
	Find support in your informal network	At least have someone to talk to [P29]Find at least one person who can support you, understand your triggers and uphold you during difficult days [P12]	Don't be afraid to share your story, you might find someone who can relate [P9]TELL SOMEONE YOU KNOW WILL LISTEN AND HELP YOU, JUST TALK [P26]Speak out [P27]To speak to someone and to be strong and fight by your side .[P36]Get support from someone you trust [P44] all the people who are assaulted they talk the experience that they went it help a lot because u see u are not alone and to accept and always talk about it if u need to cry pls cry and advice young people to talk because this end up making you have bad mental health [P50]