



Reports of traumatic sexualisation in a group of female survivors of childhood sexual abuse

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DECLARATION

I declare that the study 'Reports of traumatic sexualisation in a group of female survivors of childhood sexual abuse' is my own work, guided by the supervisors, and that I followed the referencing and editorial style as prescribed by the Publication Manual (6th edition) of the American Psychological Association (APA) to indicate and acknowledge all sources used in this dissertation.

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PREFACE

The reader should take cognisance of the fact that the article format was chosen for writing this dissertation. The researcher, Mrs Ina Theunissen conducted the research and wrote the manuscripts within this dissertation under the guidance of Prof Ansie Fouché (supervisor) and Dr Hayley Walker-Williams (co-supervisor).

THIS DISSERTATION COMPRISES THREE SECTIONS:

SECTION A: Overview of the study

SECTION B: Manuscript 1: Traumatic sexualisation in survivors of childhood sexual abuse: A scoping literature review.

Manuscript 2: Childhood sexual abuse: Reports of traumatic sexualisation in women survivors.

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

Section A provides an overview of this study. Section B consists of two manuscripts. Manuscript one describes phase one of the study, which consists of the findings of a scoping literature review and qualitative interviews. Manuscript two delineates phase II of the study, which consists of qualitative secondary analysis conducted on two data sets of the Survivor to Thrive (S2T) collaborative strengths-based group-intervention programme. Each manuscript contains its own research objectives and related

methodology used to answer specific research questions. The manuscripts are written in the article format according to North-West University's policy related to this method of presentation. The different manuscripts are also prepared for specific journals of which the author guidelines are provided at the beginning of each manuscript. However, the technical style of these manuscripts and dissertation overall were kept consistent. Section C provides the conclusions drawn from the study, and summarises the contributions and limitations of the study, as well as the recommendations for future research. Considering the article method followed in this dissertation, it should be noted that some duplication of content across the three sections can be expected. None of the two manuscripts have been submitted for publication. Feedback from the examiners will be incorporated and submissions of the articles will only take place after finalisation of the examination process.

EDITOR DECLARATION



26 April 2018

I, **Ms Cecilia van der Walt**, hereby declare that I took care of the **editing** of the **dissertation** of **Ms CJ Theunissen** titled *Reports of traumatic sexualisation in a group of female survivors of childhood sexual abuse*.

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Abstract

The main aim of this study was to explore what is known from literature and practice about traumatic sexualisation in a group of South African women, who had experienced childhood sexual abuse (CSA), and who participated in the Survivor to Thriver (S2T) collaborative strengths-based group-intervention programme for women survivors of CSA. The current study was conducted in two phases using exploratory qualitative research with Finkelhor and Browne's traumagenic dynamics as a conceptual framework. During phase I, a scoping literature review of sixty-six studies was conducted. Thematic analysis of the studies identified in the scoping literature review revealed three main themes describing how traumatic sexualisation presented in women survivors of CSA, namely *negative sexual association*, *negative body image* and *distorted sexual development*. These three themes support the findings of Finkelhor and Browne's framework in their categorisation of traumatic sexualisation. However, two additional sub-themes were identified in the literature on women survivors of CSA, namely *hiding the feminine self / body harm* (categorised under *negative body image*) and *self-capacity disturbances* (categorised under *distorted sexual development*). Hereafter qualitative interviews comprising of a focus-group discussion and two semi-structured interviews were conducted with six helping professionals working within the scope of CSA with female survivors in order to obtain input and/or identify any additional emerging themes of traumatic sexualisation. During these qualitative interviews the above findings were confirmed with no additional themes being reported. In phase II, qualitative secondary analysis (QSA) was conducted using two sets of data collected during treatment sessions (N=16) of the S2T collaborative strengths-based group-intervention programme. All the traumatic sexualisation themes that were identified during the scoping literature review were found within the datasets.

However, one additional sub-theme, namely *distorted view of males*, was found and could be categorised under the main theme of *distorted sexual development*. Future research is recommended to verify and expand the findings of this study, so as to inform treatment interventions for CSA survivors - especially within the South African context.

Keywords: *childhood sexual abuse, female, survivors, traumatic sexualisation, women*

Opsomming

Die hoof doel van die studie was om verslae van traumatiese seksualisering te vind in literatuur sowel as in die praktyk, soos gerapporteer deur 'n groep Suid-Afrikaanse vroue wat as kinders seksueel misbruik is en deelgeneem het aan die Survivor to Thriver (S2T) samewerkende sterkpunt-gebaseerde groepsintervensieprogram. Hierdie verkennende kwalitatiewe studie is in twee fases uitgevoer. Tydens die eerste fase is 'n literatuur-bestekopname van ses-en-sestig empiriese studies uitgevoer, gevolg deur 'n fokusgroep-bespreking / individuele onderhoude met ses deskundiges wat as maatskaplike werkers / sielkundiges werk met vroue wat as kinders seksueel misbruik is. Tydens die tematiese analise van die data is drie hoof temas van traumatiese seksualisering geïdentifiseer, naamlik *negatiewe seksuele assosiasie*, *negatiewe liggaamsbeeld* en *verwonge seksuele ontwikkeling*. Hierdie drie temas ondersteun die bevindinge van Finkelhor en Browne in hul kategorisering van traumatiese seksualisering. Twee bykomstige sub-temas is egter geïdentifiseer, naamlik *die verbergings van die vroulike self / liggaamskade* (gekategoriseer onder *negatiewe liggaamsbeeld*) en *selfkapasiteitsversteurings* (gekategoriseer onder *verwonge seksuele ontwikkeling*). Tydens die tweede fase is 'n kwalitatiewe sekondêre analiese (KSA) uitgevoer deur gebruik te maak van twee stelle data wat ingesamel is tydens groepsbesprekings (N=16) van die S2T samewerkende sterkpunt gebaseerde groepsintervensieprogram. Al die temas wat tydens die literatuurstudie geïdentifiseer is, is ook deur die groep vroue wat by die groepintervensieprogram betrek is, gerapporteer. Daar is egter een bykomstige sub-tema deur die vroue gerapporteer wat nie so duidelik in die literatuur na vore gekom het nie, naamlik *verwarring rakende opvattinge oor manlike figure*. Die bevindinge van die studie kan ter ontwikkeling van intervensieprogramme geïmplementeer word. Verdere navorsing rakende traumatiese

seksualisering word aanbeveel om die bevindinge van hierdie studie te bevestig en uit te brei - veral in die Suid-Afrikaanse konteks.

Sleutelwoorde: *seksuele mishandeling van kinders, vroue, oorlewendes, traumatiese seksualisering*

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SECTION A

OVERVIEW OF THE STUDY

The following overview will provide the background and rationale for this study. A literature overview, conceptual framework, research questions and objectives; research methodology and a design map that depicts this research process will be included. Hereafter, the ethical considerations that were not highlighted during the discussion in the methodology will be explained. The summary of this study's findings, limitations and contributions will then be elucidated followed by the layout of the study and the reference list.

1.1 Background and Rationale of the Study

Childhood sexual abuse (CSA) is a universal epidemic with far reaching long-term effects for those who experienced it. A body of research found a high prevalence of mental health disorders (e.g. vulnerability to depression, anxiety and post-traumatic stress disorder), sexual difficulties (e.g. promiscuity and sexual aversion) and intra- and interpersonal problems (e.g. self-esteem and trust issues as well as unstable relationships) (Maniglio, 2013; Mathews, Loots, Sikweyiya, & Jewkes, 2012; Priebe, Kleindienst, Zimmer, Koudela, & Ebner-Priemer, 2013; Walker-Williams & Fouché, 2017). CSA is seen as a multifaceted trauma and consequently researchers have attempted to explain the associated trauma causing factors of this phenomenon (Allnock & Hynes, 2012).

Earlier researchers, Finkelhor and Browne (1985) proposed a framework that explains the experience of sexual abuse in terms of four trauma-causing factors, or what they

term traumagenic dynamics, namely: (i) betrayal (due to the misuse of the trust relationship between the child and the perpetrator); (ii) powerlessness (the child feels unable to prevent or stop the abuse due to the disposition in authority); (iii) stigmatisation (due to the guilt and shame as well as the self-blame and secrecy surrounding the abuse) and lastly (iv) traumatic sexualisation (as a result of the sexual dysfunctional feelings and attitudes that the child develops in order to cope with the trauma). The combination of these dynamics makes the trauma of sexual abuse unique and different from other childhood traumas. As such, these dynamics alter the child's cognitive and emotional orientation to the world and cause trauma by distorting their self-concept, world view and affective capacities (Allnock & Hynes, 2012; Van der Merwe, 2009). Of the four traumagenic dynamics, traumatic sexualisation appears to be one of the main developmental areas affected by CSA (Finkelhor & Browne, 1985; Easton, Coohy, O'leary, Zhang, & Hua, 2011). Therefore, when facing recovery, these survivors often have to redevelop their perceptions regarding sexuality.

Traumatic sexualisation affects the CSA survivor's social functioning on two levels, namely on an emotional level (e.g. avoidance or fear of sexual intimacy and / or feelings of guilt during sex) and on a behavioural level (e.g. problems experienced with touch and sexual arousal) (Easton et al., 2011; Matorin & Lynn, 1998; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005). Furthermore, the development of sexually aversive feelings and attitudes can often effect the survivor's psychosexual development and functioning for example, identity confusion, sexually dysfunctional behaviour and interpersonal relationship problems (Lamoureux, Palmieri, Jackson, & Hobfoll, 2012; Najman et al., 2005; Waseem, 2016). Consequently, this may result in compulsive and addictive behaviours in order to suppress the memories of fear and anxiety surrounding the CSA (Timms & Connors, 2008). In this regard, Timms and Connors (2008)

indicated that such compulsive and addictive behaviours may reflect an attempt to gain mastery over the original abuse and perpetrator. This in itself would have a profound effect on the CSA survivor's functioning into adulthood.

A body of research points to differences with regards to the impact of CSA into adulthood between males and females. Women tend to internalise their experience (with e.g. mood disorders) and men tend to externalise (with e.g. physical aggression or violence) their CSA trauma (Artz et al., 2016; Beitchman et al., 1992; Gill & Tutty, 1999; Sigurdardottir, Halldorsdottir, & Bender, 2014). As such, distinguishing between trauma causing factors and how it presents in women and men is imperative in order to enhance understanding and inform treatment practices in this regard. Recently, Henning, Walker-Williams, and Fouché (2018) conducted a scoping literature review in order to summarise what had been written in literature about the various trauma causing factors including traumatic sexualisation in CSA women. This study found no empirical studies done within South Africa on traumatic sexualisation in women survivors of CSA.

The exploration of traumatic sexualisation in survivors of CSA is challenging due to the known secrecy surrounding this phenomenon, as well as the personal and sensitive nature of exploring sexuality difficulties from CSA survivors. It thus, raises several ethical dilemmas if a research study aims to solely explore the CSA survivor's traumatic sexualisation experiences. Nevertheless, this should not stop researchers from exploring this sensitive phenomenon, as such, alternative research methods were considered in this regard. One such method was qualitative secondary data analysis (QSA), whereby existing data was used to provide valuable information on the CSA

survivor's experiences and could thus ultimately inform prevention and treatment programmes.

An existing therapeutic programme in South Africa, which renders an opportunity to obtain available data on how traumatic sexualisation presents in women, is the Survivor to Thrive (S2T) collaborative strengths-based group-intervention programme for women survivors of CSA (Walker-Williams & Fouché, 2017). This collaborative strengths-based group-intervention programme focused on: South African-based empirical research exploring the coping behaviours, posttraumatic growth, and psychological well-being of a sample of women who had experienced CSA (Walker-Williams, 2012); an eclectic mix of therapeutic theories (e.g. psychodynamic, cognitive-behavioural and psycho-education) (Callahan, Price, & Hilsenroth, 2004; Ullman, 2014); a South African trauma treatment model (the Wits trauma model) (Eagle, 2000) and a strengths-based model (e.g. posttraumatic growth model) (Tedeschi & Calhoun, 1996). The S2T collaborative strengths-based group-intervention programme is an evidence-informed promising practice and aims to enable posttraumatic growth by not only transitioning women from victim to survivor but also to a thriver identity (Walker-Williams & Fouché, 2017). The S2T collaborative strengths-based group-intervention programme has been implemented to date with two groups of women survivors of CSA and is part of a longitudinal research project. Therefore interviews were audio-taped and transcribed, ethical consent was obtained for the use and re-use of the data for research processes. The principal researchers and facilitators of the S2T collaborative strengths-based group-intervention programme are the two study leaders of this study. Due to the dataset available, the focus of this study was on women survivors of CSA. However, the devastating impact on male survivors, is not discounted and should receive urgent attention in future research studies.

In summary the main aim of this study was twofold: firstly, to explore what is reported in literature about women survivors of CSA's experiences of traumatic sexualisation by conducting a scoping literature review and then qualitative interviews with helping professionals working in practice with CSA women survivors. Secondly, to employ QSA of existing datasets collected during two S2T collaborative strengths-based group-intervention groups with women survivors of CSA. After the scoping literature review, the findings from both the scoping literature review and QSA were integrated with a proposed conceptual framework in order to contribute to the global knowledge base and potentially inform treatment practices for the treatment of women survivors of CSA.

Next a literature overview will be provided, which will include the definitions of the study's core concepts.

1.2 Literature Overview

1.2.1 Child sexual abuse (CSA) defined.

No universal definition exists for CSA. The Children's Act 38 of 2005 (RSA) defines sexual abuse in relation to a child as follows;

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

(p. 16)

In South Africa a person can not be criminally charged with ‘CSA’. However, the Criminal Law provides the different themes of sexual offences. These themes provide a framework to guide prosecution. For one to understand traumatic sexualisation, it is imperative to explore the different types of sexual activities to which children could be exposed and which might subsequently lead to traumatic sexualisation. The Criminal law (Sexual offences and related matters) amendment Act 32 of 2007 (RSA, 2007) provides definitions highlighting specific sexual acts that could be performed against children under the age of eighteen years (see Table 1).

Table 1

Sexual Offences Against Children

Sexual offences	Criminal Law (Sexual Offences and Related Matters) Amendment Act 32, 2007
Contact crime Rape	<ul style="list-style-type: none"> • Engaging in an act that constitutes a sexual offence • Engaging in an act of sexual violation • Engaging in an act of self-masturbation • Engaged in sexually suggestive acts • Engaged in any conduct or activity characteristically associated with sexual intercourse • Engaging in an act of sexual penetration
Non-contact crimes	<ul style="list-style-type: none"> • Displaying the genital organs of such person in a state of arousal or stimulation • Unduly displaying the genital organs or anus of such person • Displaying any form of stimulation of a sexual nature of such person's breasts
Sexual exploitation	<ul style="list-style-type: none"> • Showing or describing the body, or parts of the body, of such person in a manner or in circumstances which, within the context, violate or offend the sexual integrity or dignity of that person • Showing or describing such person (i) participating in, or assisting or facilitating another person to participate (ii) being in the presence of another person who commits or in any other manner being involved in

Adapted from the Criminal Law (Sexual offences and related matters) amendment Act 32 of 2007 (RSA, 2007)

The sexual acts against children indicated above have a detrimental effect on the child's sexual development. In this regard, Finkelhor and Browne (1985, p. 2) argued that sexual abuse is: 'a process in which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional way as a result of the childhood sexual abuse.'

1.2.2 Prevalence of CSA.

To date, several meta-analyses were conducted to determine the worldwide prevalence of CSA. The findings of these studies are illustrated below in Table 2 and a brief discussion of these meta-analyses and other studies then follows.

Table 2

Prevalence of CSA Worldwide

Author	Year	Study	Countries	Studies	Gender distribution
Artz et al.	2016	Survey	1 (South Africa)	1	33.9% girls ^b 36.8% boys ^b
Barth, Bernetz, Heim, Trelle, & Tonia	2012	Systematic review and meta-analysis	24*	55	9% girls ^a 3% boys ^a 15% girls ^b 8% boys ^b 31% girls ^c 17% boys ^c 13% girls ^d 6% boys ^d 0 – 69% girls ^e 0 – 47% boys ^e
Ji, Finkelhor, & Dunne	2013	Meta-analysis	1 (China)	27	15.3% women ^e 13.8% men ^e
Stoltenborgh, Van Ijzendoorn, Euser, & Bakemans-Kranenburg	2011	Meta-analysis	Not specified*	217	18% women ^e 7.6% men ^e
Pereda, Guilera, Forns, & Gómez-Benito	2009	Meta-analysis	22*	100	19,7% women ^e 7.9% men ^e
Hébert, Tourigny, Cyr, MacDuff, & Joly	2009	Multivariate analysis	1	1 N = 804	22.1% women ^e 9.7% men ^e

Note. *denotes the inclusion of statistics from Africa; ^a denotes forced intercourse; ^b denotes mixed sexual abuse; ^c denotes non-contact abuse; ^d denotes contact abuse; ^e denotes total CSA

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

In a meta-analysis done by the World Health Organisation (WHO) during 2012, it was found that the CSA prevalence rate among boys and girls was the lowest in Europe with 9.2%, followed by the USA with 10.1%, Asia with 23.9% and the highest in Africa with 34.4% (Behere & Mulmule, 2013; Pereda et al., 2009). As such Ige, Ilesanmi, and Adebayo (2012) reported the prevalence in Nigeria at 25.5% among girls and 43.1% among boys. Similar statistics have been reported in Tanzania indicating 30% of boys and 26% of girls being exposed to CSA before the age of eighteen years (Kisanga, 2012). The South African Police Service (SAPS) recorded 62 649 cases of sexual abuse reported during the year 2013/2014, of which 22 781 cases were sexual offences against children and more prevalent among girls than among boys (SAPS, 2014). This figure is estimated to be even higher since only one out of nine cases of CSA is apparently reported to the police (Mathews, Jamieson, Lake, & Smith, 2014). The reason for the underreporting of CSA includes amongst others fear of victim-blaming or re-victimisation, perceived seriousness, whether an injury was incurred, attitude towards and previous experience with police and the influence of family and friends (Finkelhor, Wolak, & Berliner, 2001; Taylor & Gassner, 2010). The first representative study on the prevalence of CSA in South Africa was conducted by the Optimus foundation which indicated that 36.8% of boys and 33.9% of girls reported some form of sexual abuse in their life time (Artz et al., 2016).

1.2.3 Risk factors associated with CSA.

The prevalence of CSA globally as well as in Africa and South Africa is thus a matter of concern with several associated risk factors on an individual, family, community or societal level as reported in literature. Researchers have globally reported that the most pertinent individual risk factor includes children who were most vulnerable (e.g. withdrawn, low self-esteem, left unsupervised) and could thus be easily lured by sexual perpetrators (Elliott, Browne, & Kilcoyne, 1995; Madu & Peltzer, 2003). On a relationship level the perpetrators were mostly family members or close and trusted family friends or acquaintances (Aydin et al., 2014; Collings, 2005; Elliott et al., 1995; Foster & Hagedom, 2014; Madu & Peltzer, 2003). Family risk factors included children from single-parent families; unmet sexual needs of family members; poor communication and corporal punishment; economic dependence on partners; sexual exposure; inadequate parenting and lack of supervision (Fontes, Cruz, & Tabachnick, 2001; Foster & Hagedom, 2014; Madu & Peltzer, 2003). Lastly, community or societal risk factors include insufficient health, economic, educational and social policies; lack of social norms; role of the media; high poverty and unemployment rates and the abuse of alcohol in communities (Centers for Disease Control and Prevention, 2015; Mathews et al., 2014). The risk factors reported above thus render CSA survivors vulnerable to an array of serious long-term consequences.

1.2.4 Impact of CSA.

The profound long-term negative consequences of CSA across cultures and socio-economic strata are well-documented. The long-term effects of CSA are illustrated in Table 3 and may be categorised as mental health difficulties, intra- and interpersonal difficulties as well as sexual problems. A brief discussion of these themes will follow.

Table 3

Long-Term Effects of CSA

Category	Findings	Country	Sample	Author
Mental health difficulties	Depression	South Africa	Women	Mathews, Loots, Sikweyiya, & Jewkes, 2012
		United Kingdom	Women	Dolan & Whitworth, 2013
		United States of America	Women	Shi, 2013
	Anxiety	South Africa	Women	Mathews, Loots, Sikweyiya, & Jewkes, 2012
		United Kingdom	Women	Mathews, Abrahams, & Jewkes, 2013
		United Kingdom	Women	Dolan & Whitworth, 2013
		India	Children	Behere & Mulmule, 2013
		United States of America	Women	Shi, 2013
	Post-traumatic stress disorder (PTSD)	United States of America	Men & Women	Waseem, 2016
		Germany	Women	Priebe, Kleindienst, Zimmer, Koudela, Ebner-Priemer, & Bohus, 2013

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		South Africa	Children	Mathews, Abrahams, & Jewkes, 2013
Intra-personal difficulties	Low self-esteem	India	Women	Singh, Parsekar, & Nair, 2014
	Self-concept	United States of America	Women	Grauerholz, 2000
United Kingdom		Women	McAlpine & Shanks, 2010	
Inter-personal difficulties	Loss of interpersonal resources	United States of America	Women	Lamoureux, Palmieri, Jackson, & Hobfoll, 2012
	Lack of perceived social support	United States of America	Women	Grauerholz, 2000
	Social conflict	India	Children	Behere & Mulmule, 2013
Sexual problems	Sexual risk behaviour	United States of America	Women	Senn, Carey, & Coury-Doniger, 2012
		Canada	Women	Lacelle, Hébert, Lavoie, Vitaro, & Tremblay, 2012
	United States of America	Women	Johnsen & Harlow, 1996	
	Sexual re-victimization	United States of America	Women	Grauerholz, 2000 Johnsen & Harlow, 1996

	Sexual dysfunctions	Jamaica	Men & Women	Swaby & Morgan, 2009
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Many studies have focused on mental-health difficulties as a result of CSA (Grauerholz, 2000). CSA is thus seen to be a significant risk factor for the development of psychopathology, specifically depression, anxiety and posttraumatic stress disorder (PTSD) (Dolan & Whitworth, 2013; Mathews et al., 2014; Putman, 2003; Shi, 2013). Within South Africa, a study on PTSD indicated that half of the children who experienced CSA met the clinical criteria for anxiety and two-thirds met the criteria for PTSD, two to four weeks post-disclosure (Mathews et al., 2013).

Constant negative experiences in relationships with others, as well as feelings of shame and guilt appeared to cause CSA survivors to seriously doubt themselves. This seemed to have an effect on their self-concept and often caused them to develop a low self-esteem (Grauerholz, 2000; McAlphine & Shanks, 2010; Singh et al., 2014) and poor interpersonal competence (Behere & Mulmule, 2013; Grauerholz, 2000; Lamoureux et al., 2012). In addition, CSA survivors may often experience betrayal and trust issues due to the sexual abuse (Lamoureux et al., 2012; Maniglio, 2013; Najman et al., 2005).

A number of studies appeared to have found that CSA survivors, as adults, experience more serious sexual difficulties, including a lack of sexual responsiveness, lack of sexual satisfaction as well as sexual dysfunction (Grauerholz, 2000). This might stem from and contribute to the traumatic sexualisation associated with CSA (Finkelhor & Browne, 1985).

1.3 Contextualising the Impact of Traumatic Sexualisation

Studies often relate sexual problems in adulthood to sexual trauma experienced in childhood (Marendaz & Wood, 1999). Traumatic sexualisation alters a child's cognitive, emotional, self-related and sexual orientation to the world and thus may impact on the CSA survivor's overall functioning. It appears to distort the survivor's self-concept, sexual identity, sexuality (including sexual feelings as well as sexual attitudes), trust in others and emerging sense of safety (Finkelhor & Browne, 1985; Mullen, Martin, Anderson, Romans, & Herbison, 1994; Van der Merwe, 2009).

According to Finkelhor and Browne (1985) the impact of sexual abuse experiences can vary in terms of the severity of traumatic sexualisation. The degree of sexualisation may be influenced by: (a) the frequency of the sexual abuse; (b) the amount of force exerted by the perpetrator; (c) the amount of internal conflict and shame experienced by the victim; (d) the effort of the perpetrator to evoke sexual responses from the victim; (e) the degree to which the child is enticed to co-operate in the sexual act, and (f) the degree to which the child can comprehend the sexual act occurring (Finkelhor & Browne, 1985; Kristensen & Lau, 2011; Swaby & Morgan, 2009; Træen & Sørensen, 2008). In addition, the way in which the child responds to the sexual act physiologically as well as the child's family or supportive ecologies' reaction during or after disclosure may also influence the severity of the CSA trauma (Bloom, 2003).

The impact of traumatic sexualisation can be divided into the following two themes: *physical and cognitive*; and *psychological and social*.

1.3.1 Physical and cognitive.

According to Finkelhor and Browne (1985) sexual abuse heightens sexual awareness and sexual preoccupation or compulsive behaviour, which might be inappropriate for a specific stage of development. Consequently, the child may link self-value to their

appearance and specific body parts (Roller, Martsof, Draucker, & Ross, 2009; Wang & Heppner, 2011). In this regard, Freud's psychosexual developmental theory of 1905 proposed that persistent focus on an earlier psychosexual stage may occur due to the fact that certain issues are unresolved in a psychosexual stage, and the person will thus remain stuck in this stage until the conflict is resolved (Cherry, 2016). As such, CSA may cause feelings of guilt and confusion since perpetrators often make children believe that they've enjoyed the sexual act and may consequently feel they are responsible for the act (Culbreth, 2011). This in turn causes distress, shame and internal conflict especially regarding the child's sexual identity (Roller et al., 2009; Wang & Heppner, 2011). Marendaz and Wood (1999) found that the majority of CSA survivors who had reported sexual difficulties experienced a lack of sexual desire, and as adults, an inability to reach orgasm (Finkelhor & Browne, 1985; Kristensen & Lau, 2011).

Children often can't verbalise what they have experienced and are thus unable to make sense of it. As adults they might experience flashbacks, which are triggered by their non-verbal memory (Bloom, 2003). Associations of frightening memories regarding sexual activities may often indicate traumatic sexualisation (Finkelhor & Browne, 1985; Wang & Heppner, 2011). From childhood, people develop two integrated forms of memory. Firstly, nonverbal memory derived from kinaesthetic, auditory and visual senses and secondly, verbal memory that develops more strongly over time (Bloom, 2003). In the event of severe stress, the mind shifts to the rapid method of nonverbal memory that saves information through senses, physical sensations and strong feelings (Bloom, 2003; Dyer, Feldmann, & Borgmann, 2015). To be able to deal with trauma, the CSA survivor thus needs to verbalise the trauma which enables the brain to retrieve information, to re-organise the memories into a cognitive schema and place events into a time sequence. Without words, the traumatic past is experienced as being in the ever

present and the CSA survivor remains unable to learn from it or to cognitively make sense of the traumatic experience and so move forward in their development (Bloom, 2003; Woodiwiss, 2008; Wang & Heppner, 2011).

1.3.2 Psychological.

Survivors of CSA might experience dissociation through the disruption of the normal integration processes of consciousness, perception, memory and identity in an attempt to protect themselves against the traumatic experience (Bloom, 2003; Waseem, 2016). With repetitive traumatic experiences the CSA survivor's emotional responses diminish or separate from the traumatic experience and the accompanying feelings regarding the experience (James, 1989; Roth & Lebowitz, 1988). This may cause emotional numbness and people need to be in contact with their emotions in order to build and sustain healthy relationships.

1.3.3 Social.

Traumatic sexualisation occurs through the exchange of affection, privileges and gifts for sexual behaviour (Finkelhor & Browne, 1985). The child receives conditional love and attention from the perpetrator, which results in the child believing that they only have value as sexual objects (Roller et al., 2009). Consequently the child subconsciously learns to manipulate others in order to satisfy their needs. This learned manipulative behaviour enables the CSA survivor (who experiences difficulty in dealing with the trauma) to escape from reality often through the abuse of substances or other addictions (Timms & Connors, 2008).

Conflicting messages from the different family members and society may cause confusion in the development of sexual morality, norms and standards (Painter &

Howell, 1999). The way a person's social support system responds to disclosure may cause the child to think that they are guilty of an offence, even though they did the right thing in reporting the abuse (Kristensen & Lau, 2011). This often confuses the child and leads to trust issues and a change in their perception that the world is an unsafe place (Finkelhor & Browne, 1985; Painter & Howell, 1999; Wang & Heppner, 2011).

1.4 Conceptual Framework: Traumatic Sexualisation and CSA

Traumatic sexualisation refers to the process in which the child's healthy sexual development is redirected in such a way to make the child vulnerable to further CSA through the development of inappropriate sexual behaviour and dysfunctional intra- and interpersonal relationships (Finkelhor & Browne, 1985; James, 1989; Van der Merwe, 2009). Finkelhor and Browne (1985) on the other hand provided more specific information on how traumatic sexualisation occurs, elements that influence the severity of traumatic sexualisation as well as the impact of traumatic sexualisation on the sexual abuse survivor. The authors were the first theorists to explain traumatic sexualisation of sexual abuse survivors as part of the four traumagenic dynamics. So far, they were also the most reliable source on this topic and therefore the traumagenic dynamics framework of Finkelhor and Browne will be utilised as the preferred conceptual framework in this study.

The perpetrator often establishes traumatic sexualisation through a gradual process of causing confusion around sexual contact versus affection (Roth & Lebowitz, 1988; Wang & Heppner, 2011). The child's participation is reinforced by the provision of gifts, individual privileges or affection or by making the child feel guilty for allowing the act or previous participation (Finkelhor & Browne, 1985; Roller et al., 2009).

A distorted meaning is given to certain body parts, which often leads to the objectification of the survivor's body (Finkelhor & Browne, 1985; James, 1989; Van der Merwe, 2009). Negative sexual associations develop due to CSA and traumatic sexual experiences which often manifest in flashbacks, helplessness, avoidant or dissociative behaviour (Bloom, 2003).

The distorted sexual development often causes confusion around sexual norms that result in exploitative sexual activities, promiscuous behaviour or revictimization (Finkelhor & Browne, 1985; Van der Merwe, 2009).

1.5 Research Questions

In view of the rationale of this study, the following main research question was formulated: What is known from literature and practice about traumatic sexualisation in women survivors of CSA?

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

- What could be learned from previous studies on traumatic sexualisation in women survivors of CSA?
- What input or additional issues related to traumatic sexualisation could be identified by helping professionals such as social workers and psychologists working within the scope of CSA in practice?
- What experiences of traumatic sexualisation were reported by women survivors of CSA participating in S2T collaborative strengths-based group-intervention treatment sessions?
- What findings relating to traumatic sexualisation could further inform the global knowledge base and inform treatment practice for women survivors of CSA?

1.6 Aim and objectives of the study

The main aim of this study so as to answer the primary research question is: to explore what is known from literature and practice about traumatic sexualisation in a group of South African women, who experienced CSA, and who participated in the S2T collaborative strengths-based group-intervention programme for women survivors of CSA.

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

- To conduct a scoping literature review to identify literature and provide a summary of evidence from a variety of studies on traumatic sexualisation in women who experienced CSA.
- To present findings of the scoping literature review to helping professionals such as social workers and psychologists working within the scope of CSA in practice so as to obtain feedback on the findings of the scoping literature review and/or to identify any additional information related to traumatic sexualisation in women survivors of CSA.
- To perform QSA, using a coding framework developed from the scoping literature review findings, on a collective set of data from sixteen treatment sessions conducted with two groups of women attending the Survivor to Thriver (S2T) collaborative strengths-based group-intervention programme, over a three year period, to explore emerging reports of traumatic sexualisation in this population.
- To conduct thematic analysis of transcripts emanating from qualitative interviews with social workers and psychologists working within the scope of

CSA and of sixteen S2T collaborative strengths-based group-intervention treatment sessions.

- To contextualise findings on traumatic sexualisation with a view to propose a conceptual framework to contribute to the global knowledge base and inform future treatment practices.

1.7 Research Methodology

1.7.1 Paradigm.

The term paradigm refers to an approach to observe and measure the phenomena being studied and incorporates specific research strategies and validity procedures, to generate knowledge (Creswell & Miller, 2000; Fossey, Harvey, McDermott, & Davidson, 2002). This study utilised the constructivist paradigm through interpretive and contextualised perspectives towards reality, by providing in-depth descriptions of the themes identified (Creswell & Miller, 2000). This paradigm allows the researcher, as well as helping professionals working with survivors of CSA, to seek and understand the meaning of human action and experiences from the viewpoint of CSA women survivors (Fossey et al., 2002). A qualitative research approach is applicable to this paradigm and will subsequently be discussed.

1.7.2 Research approach.

A qualitative exploratory research approach was followed in this study. Qualitative exploratory research intends to explore the research questions and not to provide conclusive evidence, but rather to assist in bring about a better understanding of the phenomenon under study and provide a basis for further research (Creswell, 2007; Dudovskiy, 2017).

According to Creswell (2007) and Dudovskiy (2017) argue that the individual meaning attached to the complexity of a particular situation is best explored by performing qualitative studies. Thus the research approach for this study was a qualitative exploratory research approach to identify in literature, and explore by means of an empirical study, reports of traumatic sexualisation in women survivors of CSA.

This qualitative exploratory study was conducted in two phases. The first phase involved a scoping literature review of existing literature. The findings were then presented to helping professionals working within the scope of CSA (including social workers and one psychologist) by means of qualitative interviews comprising one focus-group discussion and two individual interviews. This was done in order to answer the first and second research questions.

In phase two, QSA was conducted using transcriptions from sixteen treatment sessions, conducted with two groups of women over a three-year period to explore reports of traumatic sexualisation during the S2T collaborative strengths-based group-intervention programme for South African women who had experienced CSA. In doing so, research question three was answered. The integration of findings emanating from answering research questions 1, 2 and 3 resulted in a conceptual framework which answered research question 4.

The methodology of phase 1 (scoping literature review and qualitative interviews) will subsequently be discussed, after which the methodology for phase 2 (an explanation of QSA) will be given.

1.7.3 Phase 1: Scoping literature review.

1.7.3.1 Research design.

The purpose of conducting a scoping literature review is to identify existing literature related to a specific field of study that addresses broader topics through different study designs and to then summarise and disseminate these research findings (Arksey & O'Malley, 2005). This method also contributes to identifying gaps in the literature where a scarcity of research exists and so allows for the formulation of possible recommendations for future research (Arksey & O'Malley, 2005; Peters et al., 2015).

The methodological framework designed by Arksey and O'Malley (2005) was followed to direct the process of the scoping literature review. This framework indicates six stages: (1) identifying the research question to cover the extent of the literature; (2) identifying relevant studies from various sources; (3) study selection which involves inclusion and exclusion criteria; (4) charting the data by extracting it from the included studies; (5) analysis of the data by providing a descriptive thematic analysis; and (6) consultation with stakeholders to obtain additional understandings beyond those in the literature (Levac, Colquhoun, & O'Brien, 2010). Often step six is not included in a scoping literature review. However, in this study this step was included with a view to obtain feedback and input from helping professionals such as social workers and psychologists working with women survivors of CSA. This information was obtained through qualitative interviewing, including one focus-group discussion with four social workers, and two individual interviews, one with a clinical psychologist and the other a social worker. The two individual interviews were conducted as the participants could not attend the focus-group discussion or were in a superior position to some of the participants in the focus group and as such participated during an individual interview.

1.7.3.2 Data bases and journal search for the scoping literature review.

For this scoping literature review, empirical studies on electronic databases, as well as scientific journals (Levac et al., 2010) were searched. Databases consulted included *EbscoHost (Academic Search Premiere; Arica-Wide Information; E-Journals; ERIC; PsycARTICLES; PsycINFO; SocINDEX)*, *SAePublications*, and *Science Direct (Social Sciences and Humanities)*. Academic journals that were reviewed included *Child Abuse & Neglect; Child Abuse Research in South Africa; Child Abuse Review; Journal of Child Sexual Abuse; Sexual Abuse: A Journal of Research and Treatment; and Trauma, Violence and Abuse: A Review Journal*. Additional articles were sourced from reference lists as cited in publications to ensure inclusion of all relevant studies in the scoping literature review.

Inclusion criteria

The criteria for the empirical studies included in the scoping literature review were the following: Only studies published in English between January 1985 and December 2016 reporting on traumatic sexualisation in women survivors of CSA were included. Studies that differentiated between adult female participants above the age of eighteen years as well as those studies that included males but distinguished between males and females.

Exclusion criteria

Studies on males, perpetrators, offenders, substance abuse or dependency, childbirth / maternity / parenting, HIV / other physical pathology, religion, child victims and other non-academic literature were excluded from the scoping literature review. Studies that didn't distinguish between males and female were also excluded.

Study selection process

The following Boolean phrase was used to identify studies; (**traumatic sexualization** OR **traumatic sexualisation**) AND (**child sexual abuse** OR **childhood sexual abuse**) AND (**adult women survivors** OR **adult female survivors**) NOT (**perpetrators**) NOT (**offenders**) NOT (**children**) NOT (**child victims**). The number of articles identified by using the library's electronic search facility was 54 312. After the removal of non-academic Journals, 52 790 articles were left from which the following subjects were identified; 'child sexual abuse', 'child abuse, sexual' and 'sexual abuse'. From this, 1878 articles were identified to export to Zotero 4.0 (2016), a widely used referencing management programme. In addition to this, by screening the citations from reference lists, another 130 articles were identified. After the removal of 106 duplicates, 1 471 article headings and abstracts were screened in accordance with the inclusion and exclusion criteria. A total of 174 full-text articles were downloaded and screened for eligibility, whereby 66 articles were included in the scoping literature review.

Charting the data

The extraction of data from empirical studies for the scoping literature review is referred to as the charting of data (Peters et al., 2015). The data should be extracted in a logical and descriptive summary and include all the studies used in the scoping literature review as well as be consistent with the research question (Levac et al., 2010; Peters et al., 2015). Data were extracted from the selected studies on a data-charting form to determine which data to extract (Levac et al., 2010). For purposes of the scoping literature review, only data that explained experiences of traumatic sexualisation in women survivors of CSA were mapped on the data-charting form (Addendum C). A quality assessment of studies to be included in the scoping literature

review was not needed, since a scoping literature review typically does not include a quality appraisal of studies, as in the case of a systematic review (Arksey & O'Malley, 2005; Levac et al., 2010).

1.7.3.3 Data analysis.

The six steps outlined by Braun and Clarke (2006) were followed to conduct the thematic analysis. Initially the researcher familiarised herself with the data by making notes of the abstracts and findings of each study on traumatic sexualisation in women survivors of CSA. Then initial codes were assigned manually to key ideas on traumatic sexualisation identified in the empirical studies. Thirdly, themes were identified from the studies. By reviewing the studies, fourteen sub-themes were identified. The fifth step was to define and name the different sub-themes which were categorised into themes. Then the highlights of the theme were extracted from studies to be presented within a report. This report was used to assess and review each theme as well as the coded data extracts pertaining to each theme. Initially four themes were identified and then presented to the helping professionals for further input. Thereafter the fourteen sub-themes and four themes were re-examined and reviewed by the researcher and study supervisors. Several rounds of consensus discussions during which an iterative process of working backwards and forwards between the data and literature took place and resulted in the combination of some sub-themes and renaming of themes. The sub-themes were reduced to nine and categorised into three overarching themes. The final step of the process was the writing up of the final report once the findings from the qualitative interviews had been considered. The findings were however reported separately (see Manuscript 1).

Qualitative interviews with helping professionals

Consultation with experts to gain additional understandings beyond what was found in literature (Levac et al., 2010) is the sixth step of Arksey and O'Malley's (2005) framework for the scoping literature review.

In this study two qualitative data-collection methods were applied, namely one focus-group discussion and two individual interviews (Doody, Slevin, & Taggart, 2013; Stewart & Shamdasani, 2017). The aim of the focus-group discussion and interviews was to receive feedback and input from helping professionals, working within the scope of CSA, regarding the findings of the scoping literature review and / or to discuss any additional emerging issues relating to traumatic sexualisation in CSA women survivors (Arksey & O'Malley, 2005). Initially only one focus-group discussion was planned. Some of the participants could not attend the focus-group, but indicated that they would be available for individual interviews.

Recruitment of participants: The recruitment of potential helping professionals was done by applying purposive sampling - also known as selective sampling (Gledhill, Abbey, & Schweitzer, 2008; Valerio et al., 2016). Purposive sampling is the conscious selection of specific subjects for inclusion in the study in order to ensure that the subjects will possess certain characteristics relevant to the study (Gledhill et al., 2008; Valerio et al., 2016). In this study it was helping professionals, such as social workers and psychologists with specific experience within the scope of CSA who were recruited.

In order to comply with ethical requirements, set by North-West University's Humanities Health Research Ethics Committee (HHREC), recruitment was conducted by co-opting a gatekeeper to identify potential participants to be invited to form part of the study. The gatekeeper is a social work manager at the Christian Social Council in

Centurion, Gauteng. She has thirty-two years of experience as a social worker and holds a Master's degree in forensic social work. Hence she was well-equipped to be able to be capable of identifying professionals working within the scope of CSA in Centurion. A list of helping professionals in Centurion in the Gauteng Province, working within the scope of CSA in practice and displaying sufficient experience, was compiled by the researcher by conducting a search of electronic and specific service provider databases. It was decided to include helping professionals in Centurion because it fell within the researcher's working area. This list was given to the gatekeeper for an independent selection of a group of between six and ten people on the grounds of shared characteristics relevant to the research (Crossman, 2014; Marshall & Rossman, 2016). The gatekeeper selected seven professionals from a list of twelve people who were known for their expertise in working with survivors of CSA and who met the inclusion criteria. The inclusion criteria provided to the gatekeeper were: helping professionals that had a minimum of three years' practice experience in working with CSA women survivors and were qualified as registered social workers or clinical / counselling psychologists; and worked at a trauma clinic, child protection organisation or in private practice. The gatekeeper was put into contact with an independent facilitator, Miss Marinda Henning, a Master's student in psychology at North-West University, Vanderbijlpark Campus. The gatekeeper provided the independent facilitator with the names of potential participants, that could be invited to form part of the study. The selected group was then contacted via email by the independent facilitator, who invited them to participate in the focus-group discussion or individual interview depending on their preference. From the initial invitation only two professionals responded; therefore the invitation was re-sent to the remaining sourced members.

Only four registered social workers could attend the focus-group discussion and one of the clinical psychologists indicated willingness to participate but could not attend the focus-group discussion; therefore an individual interview was arranged. Another participant who volunteered to participate, was the supervisor of some of the social workers who participated in the focus-group discussion; thus due to her authority position it was decided to exclude her from the focus-group discussion to prevent the other participants from being unduly influenced by her authority position (Dudovski, 2016). Since she had vast experience in CSA as a forensic social worker, she was also invited to participate in an individual interview. The independent facilitator sent the consent forms to the professionals who indicated their interest in participating and followed up on their willingness telephonically. Sufficient time (1 week) was allowed for participants to make a decision as to whether or not to participate. The informed consent form explained the confidential nature of and rules for participation in the research (see Addendum F for consent forms).

The participants who participated were one Black and five White participants. Participant's ages were between 30 and 50 years (average age was 40 years) and had an average of 22 years of working experience in the field of CSA.

Data collection: One focus-group discussion was conducted in English as it was the common language everyone understood and the language medium that the helping professionals use in their professional lives. The researcher, a qualified social worker with twenty years' practice experience, including conducting group work sessions in various contexts, and who often conducts interviews in English on a daily basis, is proficient in the English language and was thus competent to facilitate the discussion in English. The two individual interviews were conducted in Afrikaans as both

participants preferred to participate in Afrikaans and the researcher is Afrikaans speaking (see Addendum D for interview schedule).

The focus-group discussion was held at the researcher's office in Centurion, a central location for all four participants. Participants were remunerated for their transport costs using the Auto Mobile Association (AA) scale. The payment was done by the S2T research funding received from the National Research Foundation (NRF). Both individual interviews took place at central community locations chosen by the participants. These two participants were not remunerated for their transport, because the researcher travelled to them. Each participants received a book on CSA.

Although client confidentiality could not be guaranteed, participants who participated in the focus group were encouraged to maintain client confidentiality. Written consent to record the discussion and interviews was obtained from all the participants (NHRC, 2015). The participants were asked to think about different cases of CSA and to highlight aspects of traumatic sexualisation within these cases. Thereafter, a summary of the preliminary findings of the scoping literature review, covering traumatic sexualisation, was presented to the participants. This was followed by a discussion. The broad topics on traumatic sexualisation that were used to stimulate the discussion were: (1) aversion and avoidance; (2) confusion about sexuality and sexual norms; (3) promiscuity and compulsive sexual behaviour; and (4) re-victimisation. The participants provided valuable information on several aspects of traumatic sexualisation.

To collect the relevant data from the proposed study's focus-group discussion, the interview was digitally recorded with the consent of the professionals (Human Sciences Research Council [HSRC], 2015). Directly after the interviews the audio files were

transferred to the researcher's computer and electronically stored in an encrypted file. The digital recording device was cleared of all recordings after the transfer. The researcher signed an ethical declaration to obtain the data that were made available by the researchers of the primary study. All data were treated as being confidential, as required by the Health Professions Act 56 of 1974 (Department of Health [DoH], 2006). As such, transcriptions were stored electronically in an encrypted file.

Data analysis: With the permission of the participants, the focus-group interview and individual interviews were audio-taped and transcribed, by the researcher and anonymised by assigning participant numbers. Thematic analysis, as described earlier, was conducted where themes relating to traumatic sexualisation were identified and analysed (Braun & Clarke, 2006).

After conclusion of the data-analysis process (as explained earlier and above) a coding framework was compiled, which was issued for the first round of deductive analysis of the QSA, followed by inductive analysis of QSA as described in the next section (see Addendum G for the coding framework).

1.7.4 Phase 2: Qualitative secondary analysis (QSA).

1.7.4.1 Research design.

QSA refers to the utilisation of existing qualitative data obtained from a prior study with a view to do further research on the available data (Heaton, 2008; Irwin, 2013). Five types of analysis for existing datasets in QSA were pointed out by Heaton (2008), namely: re-analysis (the re-examining of data to confirm and validate findings of a primary study); amplified analysis (comparison or combination of two or more existing qualitative datasets for purposes of secondary analysis); assorted analysis (secondary

data analysis in conjunction with the collection and analysis of primary qualitative data for the same study); supplementary analysis (to gain a more in-depth understanding of an aspect or aspects not addressed in the original study); and supra analysis (the aim and focus of the secondary study exceed those of the original research). The latter form of analysis was used in the study, as it exceeds the original research that examined the efficacy of the S2T collaborative strengths-based group-intervention programme for women survivors of CSA. This was materialised by exploring reports of traumatic sexualisation in survivors of CSA. It went beyond the objective of the original study, namely to evaluate the benefits of a collaborative strengths-based programme for women survivors of CSA – the aim being to answer new empirical and conceptual questions (Heaton, 2008; Leech & Onwuegbuzie, 2008).

1.7.4.2 Sampling, participants and data-collection method.

Sampling and participants

Participant sampling was not required, as existing datasets were used by means of formal data sharing for the study (Heaton, 2008). The researcher therefore used two datasets comprising sixteen treatment sessions of the S2T collaborative strengths-based group-intervention programme for South African women who had experienced CSA (hereafter referred to as the primary study). Transcriptions for all sixteen treatment sessions were included for analysis. The data were coded deductively by the researcher using a coding framework deriving from phase I. Consent was obtained from the primary researchers who conducted the therapeutic sessions who also obtained consent from the participants that the data may be used for secondary analysis (Walker-Williams & Fouché, 2017). Transcripts were anonymised by the principal researchers who are also the study leaders of this study (Walker-Williams & Fouché, 2017). Ethical

clearances were obtained for the primary study, this study (Addendum J) as well as from the participants of the two groups for the re-use of data for secondary analysis (Heaton, 2008) (Addendum K).

Background information on the primary study: The S2T intervention programme

The primary study evaluated the benefits of a Survivor to Thriver (S2T) collaborative strengths-based group-intervention programme to facilitate post traumatic growth in women who had experienced CSA. The S2T collaborative strengths-based group intervention programme follows a strengths-based and supportive approach which focuses on women survivors' strengths in order to facilitate posttraumatic growth from their traumatic childhood experiences. This intervention covered four treatment outcomes (Walker-Williams & Fouché, 2017, p. 196):

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

Participants of both groups were women residing in the Gauteng province of South Africa who had experienced CSA. Inclusion criteria for the groups were: a minimum age of 18 years; disclosure of the CSA prior to joining the group; the women had

received some form of counselling (as child / adult); could understand and respond to English; and were willing to participate voluntarily and partake in the S2T collaborative group intervention sessions at a central community location. The biographical information of participants in the S2T collaborative strengths-based group-intervention programme is displayed in the Table 4.

Table 4

Biographical Information of S2T Group Members

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

Initially, with the first group, ten participants commenced with the group sessions, after which three withdrew. With the second group, eight participants commenced, after which another three withdrew. The participants had experienced contact sexual abuse and the perpetrator was known to them. In total, sixteen group treatment sessions with both groups were held with between ten and five participants over a period of three years. The transcripts of these sessions were analysed for purposes of this study.

1.7.4.3 Data analysis.

Thematic analysis was employed deductively using a coding framework developed in the first phase of the study to identify, analyse and report themes that emerged within the dataset (Braun & Clarke, 2006; Nieuwenhuis, 2011b). Firstly, during the deductive

analysis phase, sub-themes pertaining to the coding framework was identified within the dataset. Secondly, the dataset was analysed inductively to search for additional traumatic sexualisation sub-themes in addition to those listed within the coding framework. Thirdly, each theme was reviewed and discussed during consultation session with the study supervisors, to prevent the misinterpretation of data (Braun & Clarke, 2006). The findings from the scoping literature review and QSA were incorporated with the conceptual framework.

1.8 Trustworthiness

The trustworthiness of this study was established by providing comprehensive information on the study selection strategy, inclusion and exclusion criteria as well as on the analysis of data. The researcher consulted the study leaders in coding the qualitative data to verify the results of the study (Braun & Clarke, 2006). Independent coding was done by the two study leaders, follow-up by several rounds of consultation and consensus discussions with these study leaders at North-West University in order to verify the results of this study (Niewenhuis, 2011).

The QSA research design and process followed throughout the primary research study, as well as in this study, ensured the trustworthiness of evidence provided in this manuscript. This study was conducted in such a manner that the researcher's own judgment regarding the reality of traumatic sexualisation among women survivors of CSA was suspended to explore the reality experienced by the participants as evident in the existing datasets. This bracketing out or suspension of the researcher's experiences of a phenomenon is explained in Creswell (2009) as an effective manner to understand the individual's personal experiences. The authenticity of the study was ensured by linking themes to quotes from the participants (Cope, 2014). The credibility and

transferability of the data were evident in the findings of different studies on traumatic sexualisation (Bartoi & Kinder, 1998; Cope, 2014; Easton et al., 2011).

1.9 Design Map

The process of the research is illustrated in Table 5.

Table 5

Design Map

Primary research question	What is known from literature and practice about traumatic sexualisation in women survivors of CSA?	
Secondary research questions	<p>Manuscript 1 – Phase 1</p> <ul style="list-style-type: none"> ● What could be learned from previous studies on traumatic sexualisation in women survivors of CSA? ● What input or additional issues related to traumatic sexualisation can be identified by helping professionals such as social workers and psychologists working within the scope of CSA in practice? 	<p>Manuscript 2 – Phase 2</p> <ul style="list-style-type: none"> ● What experiences of traumatic sexualisation were reported by women survivors of CSA participating in S2T collaborative strength-based group-intervention treatment sessions? ● What findings relating to traumatic sexualisation could further inform the global knowledge base and inform treatment practice for women survivors of CSA?
Research design	<ul style="list-style-type: none"> ● Scoping literature review 	<ul style="list-style-type: none"> ● Qualitative secondary analysis
Sampling, participants and data-collection method	<ul style="list-style-type: none"> ● Data base & journal search ● 66 Studies selected: 15 qualitative, 47 quantitative & 4 mixed method ● Extraction of data on traumatic sexualisation through purposive sampling ● Semi-structured interviews ● Audio-recordings & transcriptions ● Focus-group discussion with 4 social workers ● Individual interviews with 1 clinical psychologist & 1 forensic social worker 	<ul style="list-style-type: none"> ● Utilised 2 datasets from the S2T intervention sessions ● In total 16 treatment sessions of women survivors of CSA

Data analysis	<ul style="list-style-type: none"> ● Thematic data analysis ● Iterative process ● Independent coding ● Consensus discussions 	<ul style="list-style-type: none"> ● Thematic data analysis ● Iterative process ● Independent coding ● Consensus discussions
Outcome	<ul style="list-style-type: none"> ● Identified 3 themes & 2 additional sub-themes of reports of traumatic sexualisation in women survivors of CSA S2T collaborative strengths-based group-intervention programme ● Developed a coding framework 	<ul style="list-style-type: none"> ● Identified 3 themes & 1 additional sub-theme of reports of traumatic sexualisation in women survivors of CSA ● Developed a conceptual framework

1.10 Ethical Considerations

An ethical application was submitted to the Humanities and Health Research Ethics Committee (HHREC) of North-West University (NWU) Vaal Triangle Campus. Permission and ethical clearance were obtained, with reference number NWU-HS-2016-0181 (Addendum I). Further ethical considerations related to the study were noted as follows.

In agreement with Mendelsohn et al. (2015), the first five steps of the scoping literature review in phase one of the study did not involve first-hand collection of data from participants as in the primary study; hence ethical clearance from HHREC of the NWU Vaal Triangle Campus was not required for the scoping literature review. However, ethical clearance for step six, to conduct qualitative interviews with helping professionals in phase one of the proposed study, as well as for the QSA in phase two was obtained from HHREC.

As mentioned earlier, recruitment of participants and facilitation of informed consent were materialised by co-opting a gatekeeper and independent facilitator as required by the Health Professions Act 56 of 1974 (DoH, 2006). With regards to the QSA in phase two, the researchers of the primary study obtained informed consent from the participants for their voluntary participation in the research and for the data obtained to be used for QSA by other researchers. Regarding secondary analysis of data, Grinyer (2009) stated that whenever consent was obtained from participants in the primary study to use data for future research, further demands on the participants to consent would be eliminated and additional anxiety would not be triggered. This is especially the case where sensitive information was shared by participants. In order to conduct the proposed study by means of secondary analysis of existing data, the researcher obtained written consent from the researchers in the primary study (Addendum K) for using the existing dataset from group 1 - 2 of S2T (2013 / 2015). Anonymity and confidentiality was ensured in the S2T groups (2013 / 2015) of which the names of participants were not mentioned in the transcripts, and the audio recordings were kept in a secure location and the data for the current study are kept confidential and stored electronically in an encrypted file as stipulated in the Health Professions Act 56 of 1974 (DoH, 2006). A venue was selected which was conducive to privacy and confidential discussions. Ground rules for the group were discussed. The researcher encouraged confidentiality by requesting that participants not share identifying details or sensitive information of clients. Although confidentiality and anonymity outside the focus-group discussion could not be guaranteed, it was strongly encouraged among the group members. The researcher drew up a confidentiality agreement to this in advance, which all participants were requested to sign. The researcher facilitated the focus-group discussion and individual interviews. Debriefing was offered to the researcher by her supervisors after

the focus group discussion and interviews. The consent forms were scanned and are kept in a separate electronically encrypted file. Hard copies of the consent forms are kept in a secure lock-up cabinet. A progress report on adherence to ethical standards was submitted to the HHREC as requested.

1.11 Summary of Findings

In total three main themes highlighting reports of traumatic sexualisation in women survivors of CSA emerged from the scoping literature review. The following main themes were identified: (1) *negative sexual association*; (2) *negative body image*; and (3) *distorted sexual development*. Over and above this, two additional sub-themes were identified within literature, namely: (1) *hiding the feminine self / body harm* (categorised under *negative body image*) and (2) *self-capacity disturbances* (categorised under *distorted sexual development*). During the qualitative interviews the above findings were also observed with one additional theme reported, namely *distorted view of males* (categorised under *distorted sexual development*).

The QSA identified all the main themes found in the scoping literature review as reported by the women survivors. The three main themes were: *negative sexual association*, *negative body image* and *distorted sexual development*. Also reports of hiding the feminine self / body harm and self-capacity disturbances emerged. However, one additional sub-theme was identified, namely *distorted view of males* and could be categorised under the main theme *distorted sexual development*.

1.12 Limitations of this Study

1.12.1 Manuscript 1.

- The scoping literature review only focused on data from women survivors of CSA.
- A more comprehensive scoping literature review on studies of both genders might provide further information on traumatic sexualisation.
- Only empirical studies written in English were included in this study. Studies conducted in other languages may also have yielded further information.
- More cultural representation within the focus-group could have enhanced the information gathered from the helping professionals working within the scope of CSA with female survivors.
- Not all helping professionals could attend the focus group discussion. Therefore individual semi-structured interviews were arranged as the inputs of a clinical psychologist and forensic social worker were considered to provide valuable information due to their vast practice experience.

1.12.2 Manuscript 2.

- The transcriptions of only two datasets were available during the finalisation of this study. More datasets could have contributed to other reports of traumatic sexualisation.
- Although the primary research study had set different objectives than did this secondary study, the information contained in the two datasets were still beneficial to the aim of identifying reports concerning traumatic sexualisation. The researcher did not participate in the collection of data during the primary study and some information was not clear in the recordings and transcriptions of the datasets. The sensitive nature of discussions contributed to this limitation.

Therefore the primary researchers assisted in clarifying certain aspects of the datasets.

1.13 Contributions of the Study

This study provided the first known summary of literature on the experiences of traumatic sexualisation reported by women survivors of CSA. It further contributes to information on traumatic sexualisation specifically experienced by South African women survivors. The results support the findings of Finkelhor and Browne's (1985) traumagenic dynamics framework with regard to traumatic sexualisation as a result of which survivors experience negative sexual associations, negative body image, and distorted sexual development. Additionally, this study identified two further sub-themes in literature not identified in Finkelhor and Browne's (1985) framework, namely *hiding the feminine self / body harm* and *self-capacity disturbances*. Furthermore, findings from the qualitative secondary analysis report an additional sub-theme under distorted sexual development, namely *a distorted view of males*.

1.14 Layout of the Study

The layout of the study is illustrated in Table 6.

Table 6

Layout of the Study

Section A	Overview of the study	
Section B	Manuscript 1, title: Traumatic sexualisation in women survivors of childhood sexual abuse: A scoping literature review	Manuscript 2, title: Reports of traumatic sexualisation in a group of women survivors of childhood sexual abuse: Qualitative secondary analysis
	Phase 1: Scoping literature review Qualitative interviews	Phase 2: Qualitative secondary Analysis (QSA)
Journal publication	Journal of Psychology in Africa	Journal of Child Sexual Abuse
Section C	Conclusion and recommendations	
Addenda		

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SECTION B

PHASE 1

PREFACE

MANUSCRIPT I: Traumatic sexualisation in women survivors of childhood sexual abuse: A scoping literature review

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

- Phase I - Scoping literature review
- Phase II - Qualitative secondary analysis

The following manuscript consists of a scoping literature review that identified and summarised literature that focused on traumatic sexualisation. Findings from qualitative interviews with helping professionals (social workers and a psychologist) who are experienced in the field of childhood sexual abuse, were integrated with this manuscript.

This part of the study was guided by two research questions:

- What could be learned from previous studies on traumatic sexualisation in women survivors of CSA?
- What input or additional issues related to traumatic sexualisation could be identified by helping professionals working within the scope of CSA in practice?

MANUSCRIPT 1

**TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF
CHILDHOOD SEXUAL ABUSE: A SCOPING LITERATURE
REVIEW**

Article instructions

Journal of Psychology in Africa – Author guidelines

Manuscripts

Manuscripts should be written in English and conform to the publication guidelines of the latest edition of the American Psychological Association (APA) publication manual of instructions for authors. Manuscripts can be a maximum of 7 000 words.

Submission

Manuscripts should be prepared in MSWord, double spaced with wide margins and submitted via email to the Editor-in-Chief at the following address:

elias.mpofu@sydney.edu.au

Before submitting a manuscript, authors should peruse and consult a recent issue of the Journal of Psychology in Africa for general layout and style.

Manuscript format

All pages must be numbered consecutively, including those containing the references, tables and figures. The typescript of a manuscript should be arranged as follows:

- Title:

this should be brief, sufficiently informative for retrieval by automatic searching techniques and should contain important keywords (preferably <13).

- Author(s) and Address(es) of author(s):

The corresponding author must be indicated. The author's respective addresses where the work was done must be indicated. An e-mail address, telephone number and fax number for the corresponding author must be provided.

- Abstract:

Articles and abstracts must be in English. Submission of abstracts translated to French, Portuguese and/ or Spanish is encouraged. For data-based contributions, the abstract should be structured as follows:

Objective – the primary purpose of the paper, Method – data source, participants, design, measures, data analysis, Results – key findings, implications, future directions and Conclusions – in relation to the research questions and theory development. For all other contributions (except editorials, book reviews, special announcements) the abstract must be a concise statement of the content of the paper. Abstracts must not exceed 150 words. The statement of the abstract should summarise the information presented in the paper but should not include references.

- Text:

(1) Per APA guidelines, only one space should follow any punctuation; (2) Do not insert spaces at the beginning or end of paragraphs; (3) Do not use colour in text; and (4) Do not align references using spaces or tabs, use a hanging indent.

- Tables and figures:

These should contain only information directly relevant to the content of the paper. Each table and figure must include a full, stand-alone caption, and each must be sequentially mentioned in the text. Collect tables and figures together at the end of the manuscript or supply as separate files. Indicate the correct placement in the text in this

form <insert Table 1 here>. Figures must conform to the journals style. Pay particular attention to line thickness, font and figure proportions, taking into account the journal's printed page size – plan around one column (82 mm) or two column width (170 mm). For digital photographs or scanned images the resolution should be at least 300 dpi for colour or greyscale artwork and a minimum of 600 dpi for black line drawings. These files can be saved (in order of preference) in PSD, PDF or JPEG format. Graphs, charts or maps can be saved in AI, PDF or EPS format. MS Office files (Word, Powerpoint, Excel) are also acceptable but DO NOT EMBED Excel graphs or Powerpoint slides in a MS Word document.

Referencing

Referencing style should follow latest edition of the APA manual of instructions for authors.

- References in text:

References in running text should be quoted as follows: (Louw & Mkize, 2012), or (Louw, 2011), or Louw (2000, 2004a, 2004b). All surnames should be cited the first time the reference occurs, e.g., Louw, Mkize, and Naidoo (2009) or (Louw, Mkize, & Naidoo, 2010). Subsequent citations should use et al., e.g. Louw et al. (2004) or (Louw et al., 2004). 'Unpublished observations' and 'personal communications' may be cited in the text, but not in the reference list. Manuscripts submitted but not yet published can be included as references followed by 'in press'.

- Reference list:

Full references should be given at the end of the article in alphabetical order, using double spacing. References to journals should include the author's surnames and

initials, the full title of the paper, the full name of the journal, the year of publication, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to books should include the authors' surnames and initials, the year of publication, full title of the book, the place of publication, and the publisher's name. References should be cited as per the examples below:

Reference samples:

Journal article

Peltzer, K. (2001). Factors at follow-up associated with adherence with adherence with directly observed therapy (DOT) for tuberculosis patients in South Africa. *Journal of Psychology in Africa*, 11(2), 165–185.

Book

Gore, A. (2006). *An inconvenient truth: The planetary emergency of global warming and what we can do about it*. Emmaus, PA: Rodale.

Edited book

Galley, K. E. (Ed.). (2004). *Global climate change and wildlife in North America*. Bethesda, MD: Wildlife Society.

Chapter in a book

Cook, D. A., & Wiley, C. Y. (2000). Psychotherapy with members of the African American churches and spiritual traditions. In P. S. Richards & A. E. Bergin (Ed.), *Handbook of psychotherapy and religiosity diversity* (pp. 369–396). Washington, DC: American Psychological Association.

Magazine article

Begley, S., & Murr, A. (2007, July 2). Which of these is not causing global warming?
A. Sport utility vehicles; B. Rice fields; C. Increased solar output. *Newsweek*, 150(2),
48–50.

Newspaper article (signed)

Landler, M. (2007, June 2). Bush's Greenhouse Gas Plan Throws Europe Off Guard.
New York Times, p. A7.

Unpublished thesis

Appoh, L. (1995). The effects of parental attitudes, beliefs and values on the
nutritional status of their children in two communities in Ghana (Unpublished
master's thesis). University of Trondheim, Norway.

Conference paper

Sternberg, R. J. (2001, June). Cultural approaches to intellectual and social
competencies. Paper presented at the Annual Convention of the American
Psychological Society, Toronto, Canada

Abstract

The primary purpose of this scoping literature review was to identify what could be learned from previous studies on traumatic sexualisation in women survivors of childhood sexual abuse (CSA) and what additional issues, if any, could be identified by a panel of helping professionals, such as social workers and psychologists working within the scope of CSA. A total of 1471 empirical studies were screened in accordance with inclusive and exclusive criteria on electronic databases as well as scientific journals. In total, 174 full-text articles were screened for eligibility, whereby 66 articles were included in the scoping literature review. Through purposive sampling six helping professionals working within the scope of CSA participated in qualitative interviews. Thematic analysis was conducted on the studies included in the scoping literature review, as well as on the transcripts of the audio recordings of the qualitative interviews. The results of this scoping literature review found three main themes that described how traumatic sexualisation presented in women survivors of CSA, namely *negative sexual association*, *negative body image* and *distorted sexual development*. These three themes support the findings of Finkelhor and Browne in their categorisation of traumatic sexualisation. However, two additional sub-themes not reported by Finkelhor and Browne (1985) were identified in the literature on women survivors of CSA, namely *hiding the feminine self / body harm* (categorised under *negative body image*) and *self-capacity disturbances* (categorised under *distorted sexual development*). During the qualitative interviews the above findings were also observed with no additional themes reported.

Keywords: childhood sexual abuse, female, survivors, traumatic sexualisation, women

2.1 Introduction

Childhood sexual abuse (CSA) is a universal epidemic with far-reaching long-term devastating effects and is well-documented in research. The studies on reported CSA in adults overall found a higher prevalence among women compared to that in men. The global prevalence rates for women were 18 – 22.1%, and 7.6 – 13.8% for men (Barth, Bernetz, Heim, Trelle, & Tonia, 2013; Hébert, Tourigny, Cyr, MacDuff, & Joly, 2009; Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh, Van IJzendoorn, Euser, & Bakemans-Kranenburg, 2011). However, this figure seems higher in Africa. As such Ige, Ilesanmi, and Adebayo (2012) reported the prevalence in Nigeria to be 25.5% among girls and 43.1% among boys. Similar statistics have been reported in Tanzania indicating 30% of boys and 26% of girls having been exposed to CSA before the age of eighteen years (Kisanga, 2012). The Optimus study, conducted nationally in South Africa, found that an alarming 36.8% of boys compared to 33.9% of girls reported some form of sexual abuse (Artz et al., 2016). They also reported that the average age at which girls first experienced CSA was fourteen years, while for boys it was fifteen years (Artz et al., 2016).

The long-term effects of CSA are known to cause mental health difficulties (e.g. depression, anxiety and post-traumatic stress disorder), intra- and interpersonal difficulties (e.g. self-esteem, trust and relational issues) as well as sexual problems (e.g. lack of sexual responsiveness, lack of sexual satisfaction as well as sexual dysfunction (Dent-Brown, 1993; Grauerholz, 2000; Kochka & Carolan, 2002; Rellini & Meston, 2011).

Finkelhor and Browne (1985) proposed a framework that claims that the experience of CSA can be explained in terms of four traumagenic dynamics which includes the area

of sexuality. These four dynamics are: (i) betrayal (due to the misuse of the trust relationship between the child and the perpetrator); (ii) powerlessness (the child feels unable to prevent or stop the abuse due to the disposition in authority); (iii) stigmatisation (due to the self-blame and secrecy surrounding the abuse); and (iv) traumatic sexualisation (as a result of the child being sexualised at an inappropriate developmental and psychological level). The latter, referring to sexuality, appears to be one of the main developmental areas affected by CSA. This may stem from and contribute to the traumatic sexualisation associated with CSA (Finkelhor & Browne, 1985). Therefore, when facing recovery, these survivors often need to redevelop their perceptions regarding sexuality.

Although much has been written in literature on these trauma-causing factors in survivors of CSA (Henning, Walker-Williams, & Fouché, 2018), a summary of studies specifically on how traumatic sexualisation is experienced by women survivors, has not been conducted. A body of research points to gender differences in response to CSA, by which women tend to internalise their experience (with mood disorders) and men tend to externalise their CSA abuse (with physical aggression or violence) (Artz et al., 2016; Beitchman et al., 1992; Gill & Tutty, 1999; Sigurdardottir, Halldorsdottir, & Bender, 2014). As such, distinguishing between how traumatic sexualisation presents in women and men is imperative in order to enhance understanding in this regard. This study therefore only focused on women but does however not discount the devastating impact on male survivors, which needs to be explored in future follow-up studies.

In summary, a study was needed to expand the knowledge concerning traumatic sexualisation in CSA women survivors so as to possibly inform treatment interventions with a view to gain a better understanding of how traumatic sexualisation is experienced

by women survivors and specifically South African women. This could potentially inform treatment programmes in supporting the CSA survivor in dealing with the challenges related to the survivor's sexual identity, sexual relationships, as well as sexual behaviour (Easton, Coohy, O'leary, Zhang, & Hau, 2011; Matorin & Lynn, 1998; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005).

Thus, the purpose of this study was twofold. Firstly, to conduct a scoping literature review to identify literature and provide a summary of evidence from a variety of studies on traumatic sexualisation in women who had experienced CSA. Secondly, to present findings of the scoping literature review to helping professionals, such as social workers and psychologists working within the scope of CSA in practice with the aim of obtaining feedback on the findings of the scoping literature review and/or to identify any additional information related to traumatic sexualisation in women survivors of CSA.

2.2 Research Questions

The research questions that guided this part of the study were:

- What could be learned from previous studies on traumatic sexualisation in women survivors of CSA?
- What input or additional issues related to traumatic sexualisation could be identified by helping professionals such as social workers and psychologists working within the scope of CSA in practice?

In the subsequent sections the methodology will be discussed followed by the findings, and discussion of the study.

2.3 Methodology

The purpose of conducting a scoping literature review is to identify existing literature related to a specific field of study that addresses broader research topics through different study designs and to then summarise and disseminate these research findings (Arksey & O'Malley, 2005). This method also contributes to identifying gaps in the literature where a paucity of research exists and so allows for the formulation of possible recommendations for future research (Arksey & O'Malley, 2005; Peters et al., 2015).

The methodological framework designed by Arksey and O'Malley (2005) was followed to direct the process of the scoping literature review. This framework indicates six stages: (1) identifying the research question to cover the extent of the literature; (2) identifying relevant studies from various sources; (3) study selection which involves inclusion and exclusion criteria; (4) charting the data by extracting it from the included studies; (5) analysis of the data by providing a descriptive thematic analysis; and (6) consultation with stakeholders to gain additional understandings beyond those in the literature (Levac, Colquhoun, & O'Brien, 2010). Often step six is not included in a scoping literature review. However in this study this step was included with a view to obtain feedback and input from helping professionals working with women survivors within the scope of CSA in practice with regard to the scoping literature review findings. This information was obtained by means of qualitative interviews. A focus-group discussion was held with four social workers. Thereafter two individual interviews were conducted with a participant who could not attend the focus group (clinical psychologist) and the other a social worker who specialises in forensic social work, but was in a superior position to some of the participants in the focus group. The individual interviews were conducted as these helping professionals' specific experiences were deemed an important contribution to the study.

2.4 Search Strategy: Scoping Literature Review

2.4.1 Data bases and journal search.

For this scoping literature review empirical studies on electronic databases, as well as scientific journals (Levac et al., 2010) were searched. Databases that were consulted included *EbscoHost (Academic Search Premiere; Arica-Wide Information; E-Journals; ERIC; PsycARTICLES; PsycINFO; SocINDEX)*, *SAePublications*, and *Science Direct (Social Sciences and Humanities)*. Academic journals that were reviewed included *Child Abuse & Neglect; Child Abuse Research in South Africa; Child Abuse Review; Journal of Child Sexual Abuse; Sexual Abuse: A Journal of Research and Treatment; and Trauma, Violence and Abuse: A Review Journal*. Additional articles were sourced from reference lists as cited in publications to ensure the inclusion of all relevant studies in the scoping literature review.

Inclusion criteria

The criteria for the empirical studies included in the scoping literature review were based on a keyword search which included: *traumatic sexualisation, traumatic sexualization, childhood sexual abuse, child sexual abuse, adult female survivors, adult women survivors*. Only studies published in English between January 1985 and December 2016 were included. Studies with adult female participants above the age of eighteen years and studies that included males but distinguished between males and females were also included.

Exclusion criteria

Studies on males, perpetrators, offenders, substance abuse or dependency, childbirth / maternity / parenting, HIV / other physical pathology, religion, child victims and other

non-academic literature were excluded from the scoping literature review. Studies that didn't distinguish between males and females were also excluded.

2.4.2 Study selection process.

The following Boolean phrase was used to identify studies; (**traumatic sexualization* OR *traumatic sexualisation**) AND (**child sexual abuse* OR *childhood sexual abuse**) AND (**adult women survivors* OR *adult female survivors**) NOT (**perpetrators**) NOT (**offenders**) NOT (**children**) NOT (**child victims**). The number of articles identified by the library's electronic search facility was 54 312. After the removal of non-academic journals, 52 790 articles were left from which the following subjects were identified; 'child sexual abuse', 'child abuse, sexual' and 'sexual abuse'. From this, 1 878 articles were identified to export to Zotero 4.0 (2016), a widely used bibliographic management programme. In addition to this, by screening the citations from reference lists, another 130 articles were identified. After the removal of 106 duplicates, 1 471 article headings and abstracts were screened in accordance with the inclusion and exclusion criteria. The total of 174 full-text articles were downloaded and screened for eligibility, whereby 66 articles were included in the scoping literature review. Below is a flow diagram of the study selection process.

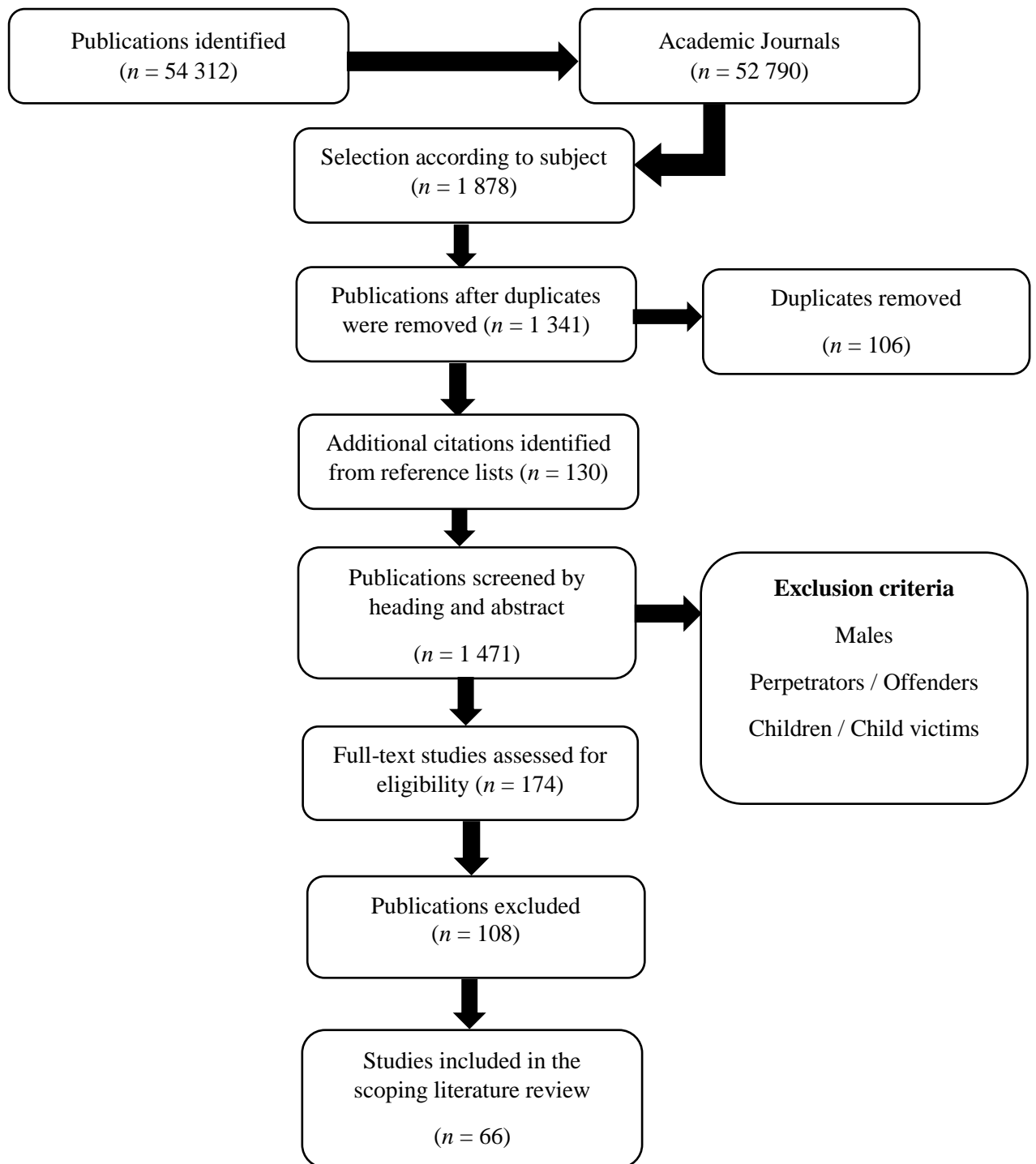


Figure 1. Flow diagram of the study selection process

2.4.3 Charting the data.

The extraction of data from empirical studies for the scoping literature review is referred to as the charting of data (Peters et al., 2015). The data should be extracted in

a logical and descriptive summary and include all the studies used in the scoping literature review, as well as be consistent with the research question (Peters et al., 2015). Data were extracted from the selected studies on a data-charting form to determine which data to extract (Levac et al., 2010). For purposes of the scoping literature review, only data that explained experiences of traumatic sexualisation in women survivors of CSA were mapped on the data-charting form (Addendum C). A quality assessment of studies to be included in the scoping literature review was not needed, since a scoping literature review typically does not include a quality appraisal of studies, as in the case of a systematic review (Arksey & O'Malley, 2005; Levac et al., 2010).

2.4.4 Data analysis – collating and summarising of results.

The six steps outlined by Braun and Clarke (2006) were followed to conduct the thematic analysis. Initially the researcher familiarised herself with the data by making notes of the abstracts and findings of each study on traumatic sexualisation in women survivors of CSA. Then initial codes were assigned manually to key ideas on traumatic sexualisation identified in the empirical studies. Thirdly, themes were identified from the studies. Through the reviewing of the studies, fourteen sub-themes were identified. The fifth step was to define and name the different sub-themes which were categorised into themes. Then the highlights of the theme were extracted from studies to be presented within a report. This report was used to assess and review each theme as well as the coded data extracts pertaining to each theme. Initially four themes were identified, then presented to the helping professionals for further input. Thereafter the fourteen sub-themes and four themes were re-examined and reviewed by the researcher and study supervisors. Several rounds of consensus discussions during which an iterative process of working backwards and forwards between the data and literature

took place and resulted in the combination of some sub-themes and renaming of themes. The sub-themes were reduced to nine and categorised into three overarching themes. The final step of the process was the writing up of the final report once the findings from the qualitative interviews had been considered. The findings of the scoping literature review, steps 1-5 as well as the qualitative interviews with the helping professionals (step 6), were reported separately (see the findings section).

2.4.5 Qualitative interviews.

Consultation with experts to gain additional understandings beyond what was found in literature (Levac et al., 2010) is the sixth step of Arksey and O'Malley's (2005) framework for the scoping literature review.

In this study two qualitative data-collection methods were applied, namely one focus-group discussion and two individual interviews (Doody, Slevin, & Taggart, 2013; Stewart & Shamdasani, 2017) to gather information about the scoping literature review findings. The aim of the focus-group discussion and interviews was to receive feedback and input from a panel of helping professionals working within the scope of CSA, regarding the findings of the scoping literature review and / or to discuss any additional emerging issues relating to traumatic sexualisation in CSA women survivors (Arksey & O'Malley, 2005). This addressed the second research question of this study, namely 'What input or additional issues related to traumatic sexualisation can be identified by helping professionals such as social workers and psychologists working within the scope of CSA in practice?'

Sampling and participants

The recruitment of potential helping professionals through purposive sampling, also known as selective sampling, was used (Gledhill, Abbey, & Schweitzer, 2008; Valerio et al., 2016). Purposive sampling is the conscious selection of specific subjects for inclusion in the study in order to ensure that the participants will possess certain characteristics relevant to the study (Gledhill et al., 2008; Valerio et al., 2016). In this study it was helping professionals, such as social workers and a psychologist with specific experience within the scope of CSA.

In order to comply with ethical requirements, set by the North-West University Humanities Health Research Ethics Committee (HHREC) recruitment was conducted by co-opting a gatekeeper to identify potential participants to be invited to form part of the study. A list of helping professionals in Centurion in the Gauteng Province, working within the scope of CSA in practice and displaying sufficient experience, was compiled by the researcher by conducting a search of electronic and specific service provider databases. It was decided to include helping professionals in Centurion, because it fell within the researcher's working area. This list was given to the gatekeeper for an independent selection of a group of between six and ten people on the grounds of shared characteristics relevant to the research (Crossman, 2014; Marshall & Rossman, 2016). The gatekeeper is a social work manager at the Christian Social Council in Centurion, Gauteng. She has thirty-two years of experience as a social worker and has a Master's degree in forensic social work. Hence she was well-equipped to identify professionals working within the scope of CSA in Centurion. The gatekeeper selected seven professionals from a list of twelve people who were known for their expertise in working with survivors of CSA and who met the inclusion criteria. The inclusion criteria provided to the gatekeeper was: helping professionals, such as social workers and clinical or counselling psychologists that had a minimum of three years' practice

experience in working with CSA women survivors and were qualified as registered social workers or clinical / counselling psychologists and worked at a trauma clinic, child protection organisation or in private practice. The independent facilitator, Miss Marinda Henning, a Master's student in psychology at the North-West University, Vanderbijlpark Campus was put into contact with the gatekeeper. The gatekeeper then provided the independent facilitator, Miss Henning, with the names of potential participants that could be invited to form part of the study. The professionals on the list were then contacted via email by the independent facilitator, who extended an invitation to them to participate in the focus-group discussion or individual interview depending on their preference. From the initial invitation only two professionals responded; therefore the invitation was resent to the remaining sourced members.

Only four registered social workers could attend the focus-group discussion and one of the clinical psychologists indicated willingness to participate but could not attend the focus-group discussion; thus an individual interview was arranged. Another participant who volunteered to participate was the supervisor of some of the social workers who participated in the focus-group discussion; thus due to her authority position it was decided to exclude her from the focus-group discussion, to prevent the other participants from being unduly influenced by her authority position (Dudovskiy, 2016). Since she had vast experience in CSA as a forensic social worker, she was also invited to participate in an individual interview. The independent facilitator sent the consent forms to the professionals who indicated their interest in participating and followed up on their willingness telephonically. Sufficient time (1 week) was allowed in order for participants to make a decision as to whether or not to participate. The informed consent form explained the confidential nature of and rules for participation in the research (see Addendum F for consent forms).

The participants who participated were one Black woman, four White women and one White male. Participants' ages were between 30 and 50 years (average age was 40 years), and had an average of 22 years of working experience in the scope of CSA.

The demographics of the professionals who attended the focus-group discussion / individual interviews are displayed in Table 7. It is important to note that, during the selection process, no limitations were set on the diversity of the group.

Table 7

Demographics of Professionals Who Attended the Focus-Group Discussion / Individual Interviews

	Gender		Race	
	Male	Female	White	Black
Social workers		5	4	1
Psychologists	1			

Data collection

One focus-group discussion was conducted in English as it was the common language that everyone understood and the language medium the helping professionals use in their professional lives. The researcher, a qualified social worker with twenty years’ practice experience, including conducting group work sessions in various contexts, and who often conducts interviews in English on a daily basis is proficient in the English language and was thus competent to facilitate the discussion in English. The two individual interviews were conducted in Afrikaans as the researcher is Afrikaans-speaking and both participants preferred to participate in Afrikaans. (Addendum G).

The focus-group discussion was held at the researcher’s office in Centurion, a central location for all four participants. Participants were remunerated for their transport costs using the Auto Mobile Association (AA) scale. The payment was done by the S2T research funding received from the National Research Foundation (NRF). Both individual interviews took place at central community locations chosen by the participants. These two participants were not remunerated for their transport, because the researcher travelled to them. Each participant received a book about CSA.

Although client confidentiality could not be guaranteed, participants who participated in the focus group were encouraged to maintain client confidentiality. Written consent to record the discussion and interviews was obtained from all the participants (Human Sciences Research Council [HSRC], 2015). The participants were asked to think about different cases of CSA and to highlight aspects of traumatic sexualisation within these cases. Thereafter, a summary of the preliminary findings of the scoping literature review about traumatic sexualisation was presented to the participants, followed by a discussion. The broad topics on traumatic sexualisation that were used to stimulate the discussion were: (1) aversion and avoidance; (2) confusion about sexuality and sexual norms; (3) promiscuity and compulsive sexual behaviour; and (4) re-victimisation. The participants provided valuable information on several aspects of traumatic sexualisation.

To collect the relevant data from the proposed study's focus-group discussion, the interview was digitally recorded with the consent of the professionals (HSRC, 2015). Directly after the interviews the audio files were transferred to the researcher's computer and electronically stored in an encrypted file. The digital recording device was cleared of all recordings after the transfer. The researcher signed an ethical declaration to obtain the data that were made available by the researchers of the primary study. All data were treated being confidential, as required by the Health Professions Act 56 of 1974 (Department of Health, 2006). As such, data / transcriptions were stored electronically in an encrypted file.

Data analysis

The focus-group interview and individual interviews were audio-taped and transcribed, with the permission of the participants, by the researcher and anonymised by assigning

participant numbers. Thematic analysis, as described earlier, was conducted where themes relating to traumatic sexualisation were identified and analysed (Braun & Clarke, 2006).

2.4.6 Trustworthiness.

The trustworthiness of this study was established by providing comprehensive information on the study selection strategy, inclusion and exclusion criteria as well as on the analysis of data. The researcher consulted the study leaders in coding the qualitative data to verify the results of the study (Braun & Clarke, 2006). Independent coding was established by verifying the similarities and differences in making comparisons across the data units (Ryan & Bernard, 2003) as well as between the studies within this research project on the traumagenic dynamics of CSA (Finkelhor & Browne, 1985).

2.5 Findings

In the following section, a summary of the findings of sixty-six studies ($N = 66$) included in the scoping literature review, will be discussed. This study reviewed the findings of forty-seven quantitative studies ($n = 47$), fifteen qualitative studies ($n = 15$) and four studies that applied a mixed method design ($n = 4$). In the subsequent section the results of the scoping literature review will be provided, namely: (1) negative sexual association, (2) negative body image, and lastly (3) distorted sexual development (Figure 2). These three themes support the findings of Finkelhor and Browne's (1985) framework in their categorisation of traumatic sexualisation. However, two additional sub-themes were identified in the literature on women survivors of CSA, namely *hiding the feminine self/body harm* (categorised under *negative body image*) and *self-capacity disturbances* (categorised under *distorted sexual development*). During the qualitative

interviews the above findings were confirmed with no additional themes being reported by helping professionals. Under each theme the qualitative interview contributions by the helping professionals working in the scope of CSA are highlighted. The different themes are displayed in Table 8.

Table 8

Themes of Traumatic Sexualisation in Women Survivors of CSA

Negative sexual associations	Negative body image	Distorted sexual development
<ul style="list-style-type: none"> ● Aversion and Avoidance ● Sexual anxiety ● Flashbacks 	<ul style="list-style-type: none"> ● Sexual self-concept ● Hiding the feminine self / Body harm 	<ul style="list-style-type: none"> ● Confusion around sexual norms ● Self-capacity disturbance ● Sexual recklessness ● Revictimisation

2.5.1 Negative sexual associations.

CSA appeared to create negative associations with sexuality (Meston & Heiman, 2000) and CSA survivors often seemed to associate touch or intimacy with distress and confusion (Easton et al., 2011; Painter & Howell, 1999).

A total of fifty studies indicated that CSA may causes negative sexual associations. The following core aspects were identified, namely: (1) sexual aversion and avoidance, (2) sexual anxiety as well as (3) flashbacks. Each of these will be discussed next.

A total of forty-five studies indicated that CSA may cause sexual aversion and avoidance, which in turn may affect the CSA survivor’s intimate relationships (Swaby & Morgan, 2009; Van Bruggen, Runtz, & Kadlec, 2006).

Sexual aversion refers to a persistent or recurrent aversion to or avoidance of all, or almost all, sexual contact with a sexual partner. This behaviour may cause distress or anxiety as well as sexual dissatisfaction (American Psychiatric Association, 2013). Sexual aversion includes avoidance and sexual anxiety.

In these regards some survivors show higher levels of *sexual avoidance* whereby survivors displayed an unwillingness to experience uncomfortable thoughts, emotions, bodily sensations or events, related to previous sexual abuse trauma, and thereby suppressed their emotions through intimacy avoidance (Batten, Follette, & Aban, 2002; Leonard, Iverson, & Follette, 2008).

Sexual anxiety (Bigras, Godbout, & Briere, 2015; Del Castillo & Wright, 2009) or anxiety in terms of attachment to their partners (Davis, Petretic-Jackson, & Ting, 2001) and the management of such anxiety posed challenges with regard to emotional intimacy (Del Castillo & Wright, 2009; Frías, Brassard, & Shaver, 2014; Meston, Rellini, & Heiman, 2006; Pistorello & Follette, 1998). Bigras et al. (2015) explained that, due to the CSA survivor's cognitive misrepresentations of their sexual self in intimate relationships, survivors may experience tension, discomfort or anxiety when thinking about sexual experiences. In addition, with regards to their sexual anxiety, women survivors of CSA may feel that they have lost control over their sexuality and this in return may cause them to be cautious rather than sensual with their partners (Bartoi & Kinder, 1998; Frías et al., 2014). Furthermore, survivors of CSA experience more difficulty with emotional expressiveness and being intimate in relationships if they had been abused at an early age and the abuse continued over a longer period of time (Pistorello & Follett, 1998). Longer exposure to CSA appeared to cause more destruction to the psycho-sexual development of the CSA survivor. According to

Merrill, Gulmond, Thomsen, and Milner (2003) the greater the severity of CSA, the greater the use of avoidant and self-abusive coping strategies by the CSA survivor. Biological father sexual abuse may be associated with stronger sexual aversion and sexual ambivalence (Noll, Trickett, & Putnam, 2003) due to the apparent conflict with social norms. Different studies indicated that multiple CSA experiences may more often lead to sexual avoidance (Rellini & Meston, 2006; Staples, Rellini, & Roberts, 2012; Vaillancourt-Morel et al., 2015) or sexual desire- and orgasm dysfunctions (Kinzl, Traweger, & Biebl, 1995; Kristensen & Lau, 2011; Sarwer & Durlak, 1996; Staples et al., 2012). Swaby and Morgan (2009) found that the older the children were at the time of the CSA, the more serious the sexual dysfunction, and difficulties to initiate and maintain relationships with their partners. In a study done by Van Bruggen et al. (2006) women with a history of CSA displayed more difficulty in managing their sexual thoughts, feelings and interactions and they reported more incongruence between their behaviour, moral standards and thoughts.

Van Bruggen et al. (2006) also found that CSA survivors reported more serious sexual concerns and poorer sexual adjustment within intimate relationships. A lower sexual self-esteem, as well as difficulty in emotional expressiveness, together with an excess or lack of control within relationships due to promiscuous behaviour or revictimisation, often poses challenges with regard to intimacy and their moral judgement (Pistorello & Follette, 1998; Van Bruggen et al., 2006).

Swaby and Morgan (2009) found that abused women experienced sexual arousal, sexual behaviour and cognition patterns similar to those of the non-abused women in their study. However, the abused participants displayed impairment in the gratification

derived from sexual acts. This may lead to sexual dysfunctions such as sexual dissatisfaction and orgasmic dysfunctions.

Flashbacks

Only five studies were found mentioning flashbacks in the context of CSA. Traumatic flashbacks can be seen as the re-emergence of a traumatic memory that is experienced as intrusive and distressing (Reavey & Brown, 2009; Wang & Heppner, 2011). Matorin and Lynn (1998) found that survivors of CSA experienced more flashbacks of the traumatic experiences as sensory areas of the body were associated with the CSA traumatic experience (Dyer, Feldmann, & Borgmann, 2015). Survivors who had flashbacks appeared to have experienced more sexual intimacy challenges, a distorted ability to feel pleasure in sexual responses as well as a distorted sense of mastery and control associated with their sexuality (Kochka & Carolan, 2002).

Reflections of the helping professionals regarding negative sexual associations

During the focus-group discussion / interviews with helping professionals similar information was shared with regards to their practice experience. Furthermore, it was added that sexual aversion and avoidance within intimate relationships appeared to be a cause of severe discomfort. In this regard a participant mentioned that a survivor *'...couldn't stand her husband. She literally said that she could pay him not to come close to her'* (Participant 3, Lines 449-454). Participant 6 further highlighted that survivors often display an *'Inability to establish any relationship and especially intimate relationships due to the sexual trauma'* (Participant 6, Line 140).

Regarding flashbacks helping professionals mentioned that: '*... every year when the time comes she would just re-experience and have flashbacks of the trauma that she went through.*' (Participant 1, Lines 36-41).

2.5.2 Negative body image.

A total of eighteen studies indicated that CSA influences the CSA survivor's attitude towards and relationship with their body and sexuality. The following aspects appear to be affected by CSA: (1) sexual self-concept and (2) hiding the feminine self / body harm.

Sexual self-concept

A total of twelve studies indicated associations between CSA and confusion around their sexual self-concept. A sexual self-concept could be defined as the way in which CSA survivors view and evaluate themselves as women and sexual beings (Roller, Martsof, Draucker, & Ross, 2009; Wang & Heppner, 2011). Sexual self-concepts are considered important cognitive mechanisms in the sexual development of women (Seehuus, Clifton, & Rellini, 2015) and may indeed predict future sexual satisfaction (Rellini & Meston, 2011). The objectification of the child's body during CSA, may cause the development of a negative sexual self-concept (Lacelle, Hébert, Lavoie, Vitaro, & Tremblay, 2012; Lemieux & Byers, 2008; Meston & Heiman, 2000; Roller et al., 2009; Wang & Heppner, 2011) and subsequently cause them to internalise that they are sexual objects. In addition, negative sexual self-concepts may lead the survivor to search for new ways of making sense of the CSA experience, and to stereotype, for example all men are the same or all men have the right to use women for sexual gratification (Roth & Lebowitz, 1988).

Literature distinguishes between how CSA affects the survivor's romantic or passionate sexual self-concept and their attractiveness sexual self-concept. Kelley and Gidycz (2015) found that adolescent sexual assault was related to a more positive romantic or passionate sexual self-concept, but a lower attractiveness sexual self-concept. As opposed to this, a study done by Meston et al. (2006) indicated that CSA survivors showed an inverse relationship between the romantic or passionate sexual self-concept; hence these survivors viewed themselves as less romantic and passionate than the non-abused group. Furthermore, a negative body image appeared to manifest in the CSA survivor's usage of language. CSA survivors are more likely to describe their bodies in negative or degrading terms (Meston & Heiman, 2000).

Hiding the feminine self / Body harm

In six studies evidence was found that CSA survivors may display more negative emotions and dissatisfaction regarding their body, compared to their non-abused counterparts (Dyer et al., 2015; Murray, MacDonald, & Fox, 2008).

Evidence of *hiding the feminine self* was found, for instance; by wearing oversized clothing or making themselves look ugly to avoid attention (Smith et al., 2010; Wang & Heppner, 2011). In addition, disconnecting from their feminine-self appeared to result in self-abusive coping strategies, such as self-mutilation, compulsive sexual behaviour or substance abuse (Murray et al., 2008; Painter & Howell, 1999; Wang & Heppner, 2011) as well as suppressed anger and compulsive eating behaviour. Studies indicated that anger due to the CSA may often be directed inwards; thus resulting in self-abusive behaviour (Painter & Howell, 1999; Wang & Heppner, 2011). Furthermore, anger may be suppressed to serve as a self-protection function for the CSA survivor; out of fear for what the perpetrator or community will do upon

disclosure, or fear regarding regrettable actions toward the perpetrator or people who didn't protect the survivor, or lastly the fear of reinforcement of feelings of helplessness or hopelessness (Roth & Lebowitz, 1988; Valdez, Lim, & Lilly, 2013; Wang & Heppner, 2011). In a study done by Smith et al. (2010) it was found that intra familial CSA may play a role in the development of compulsive eating behaviours. *Body harm* depicted in literature was evident in genital piercing, pubic tattoos or pubic scarification (Liu & Lester, 2012; Romans, Martin, Morris, & Harrison, 1998).

Reflections of the helping professionals regarding negative body image

An example of the development of a negative body image was evident in the following statement from a helping professional: *'The body image...is affected, where it causes shame regarding the body...'* (Participant 5, Lines 238-241).

Participants 2 provided an example of hiding the feminine self / body harm: *'... I had a client that became morbidly obese because so that nobody could look at her'* (Participant 2, Lines 444-445).

2.5.3 Distorted sexual development.

A total of twenty studies focussed on the distortion of sexual development. Distorted sexual development refers to the altering of the CSA survivor's sexual attitude, - skills and - behaviour from infancy to adulthood. The following developmental aspects appear to be affected by the process of traumatic sexualisation, namely: (1) confusion around sexual norms, (2) self-capacity disturbance, (3) sexual recklessness and (4) revictimisation.

Confusion around sexual norms

Twelve studies indicated associations between CSA and confusion about sexuality and sexual norms. *Confusion around sexual norms* can be seen as conditioning behaviour by the perpetrator that appears to provoke conflict about the self and interpersonal relations (Finkelhor & Browne, 1985). As a child, the CSA survivor might learn age inappropriate sexual words that are in conflict with social norms. This might lead other people to display judgemental behaviour towards the CSA survivor, which in turn affects interpersonal relationships. Research done by Rellini and Meston (2007) indicated that survivors of CSA used more sexually loaded words when writing about non-sexual topics as well as more negative emotive words when writing about non-sexual topics, compared to the non-sexually abused group.

CSA appears to distort the survivor's sexual norms regarding themselves and their intimate relationships (Painter & Howell, 1999). Confusion around themselves, regarding the reasons for the CSA was accompanied by feelings of guilt which often prevented the survivors from disclosing the abuse. Survivors of CSA might experience challenges in displaying affection or they might find it difficult to maintain boundaries due to confusion around sex versus affection. CSA survivors often were confused as children regarding the role of sex in affectionate relationships and were rewarded with affection or gifts after participation in sexual acts (Finkelhor & Browne, 1985). This confusion interfered with (1) the manner in which the survivor learned to negotiate relationships (Kochka & Carolan, 2002), (2) the development of trust issues (Frías et al., 2014; Valdez et al., 2013; Wang & Heppner, 2011) and (3) the development of control issues (Pistorello & Follette, 1998), which are often linked to sexual recklessness.

The development of dysfunctional behaviour stemming from confusion around sexual norms can manifest differently in intimate partner relationships as well as parent - child

relationships (DiLillo & Long, 1999). In the CSA survivor's intimate partner relationship, alliance protection strategies might be implemented to protect the partner relationship from a stressor that threatens the stability of the relationship dynamics (Kochka & Carolan, 2002), for example ongoing CSA within a family.

Self-capacity disturbances

With regards to self-capacity disturbances seven studies highlighted that CSA can cause self-capacity disturbances (Bigras et al., 2015; MacIntosh & Johnson, 2008; Meston et al., 2006) which affects sexual satisfaction (Rellini & Meston, 2011). Bigras et al. (2015) defines self-capacity as the extent to which individuals 'maintain a sense of personal identity and self-awareness without resorting to avoidance, sometimes referred to as affect regulation; and develop and maintain meaningful relationships with others that are not disturbed by dysfunctional behaviour or excessive preoccupation with interpersonal danger, rejection, or abandonment.' Self-capacity disturbances are recognised under two themes, namely (1) *poor interpersonal relatedness*, and (2) *poor affect regulation* (Bigras et al., 2015; Painter & Howell, 1999; Valdez et al., 2013).

Interpersonal relatedness is affected by the loss of physical and psychological boundaries, which defines the self (Roth & Lebowitz, 1988) and leaves the CSA survivors with less control over their sexual capacity (Kelley & Gidycz, 2015). With sexual abuse, affect regulation is inhibited when the child had experienced unresolved fear and this in turn inhibited functioning continuing into adulthood (MacIntosh & Johnson, 2008; Ulloa, Baerresen, & Hokoda, 2009). Fear of being overwhelmed by affect can cause hesitation in disclosure during childhood, as well as within intimate relationships during adulthood due to feelings of guilt and shame surrounding the CSA (Roth & Lebowitz, 1988).

Sexual recklessness

A total of twenty-six studies indicated associations between CSA and sexual recklessness. Sexual recklessness could be defined as heightened sexual behaviour or over-sexualisation that could cause the CSA survivor to be at risk (Najman et al., 2005; Noll et al., 2003). The following themes were identified, namely (1) *sexual preoccupation* and (2) *promiscuity*.

Six studies indicated a link between CSA and sexual preoccupation, such as excessive masturbation, increased initiation or participation in sexual games and early coitus (Noll et al., 2003).

Survivors experienced a broader range of sexual fantasies, often relating to inappropriate sexual behaviour (Briere, Smiljanich & Henschel, 1994; Meston, Heiman, & Trapnell, 1999), although Matorin and Lynn (1998) found that CSA survivors who also experience physical abuse tend to experience more intrusive thoughts about sex.

Sexual preoccupation is associated with anxiety and sexual ambivalence between sexual preoccupation and aversion was predicted by destructive coping strategies (Noll et al., 2003). CSA survivors could also be preoccupied in voluntary sexual abstinence (Lemieux & Byers, 2008).

Studies indicated that CSA survivors may experience more sexual compulsivity which in turn predicts lower couple intimacy (Vaillancourt-Morel et al., 2015). CSA is associated with survivors having more sexual partners at a younger age, but not when they're older (Najman et al., 2005). Women CSA survivors' relationships with men provides occasionally provide a means of control that causes relationships to be based on sex (Matorin & Lynn, 1998) and to become over-sexualised (Lacelle et al., 2012).

Learned sexual behaviour as well as self-destructive coping mechanisms increases the risk of compulsive sexual behaviour with multiple partners (Merrill et al., 2003).

As many as, eighteen studies indicated that CSA survivors are more likely to engage in sexual recklessness such as *promiscuity* (Lemieux & Byers, 2008; Merrill et al., 2003; Noll et al., 2003; Senn, Carey, & Coury-Doniger, 2012). In a study done by Dent-Brown (1993) it was found that survivors reported themselves as being more promiscuous. Dent-Brown (1993) argued that CSA survivors might see themselves as more promiscuous, due to the general low self-esteem reported by them. In addition, CSA survivors engage in high-risk sexual behaviour with persons other than their partners for financial benefit (Batten et al., 2002; Lacelle et al., 2012). They also have higher numbers of unsafe sexual partners (Bartoi & Kinder, 1998; Roller et al., 2009; Senn, Carey, & Coury-Doniger, 2011).

Revictimisation

Sexual revictimisation refers to the re-experience of sexual violence across different developmental periods (Van Bruggen et al., 2006). A total number of eighteen studies included in the scoping literature review indicate that survivors of CSA are at greater risk of being revictimised due to the following desensitisation to potential abusive situations and learned helplessness to act upon threatening events (Ulloa et al., 2009; Valdez et al., 2013). CSA survivors often display more tolerance to abuse within romantic relationships (Griffing et al., 2005; Valdez et al., 2013). The combination of CSA as well as physical abuse is also a strong predictor of adult victimisation (Merrill et al., 1999; Siegel & Williams, 2003; Simmel, Postmus, & Lee, 2012), while Tapia (2014) added that the severity of the physical force and self-blame plays an important role to predict repeated sexual abuse. Revictimisation through high-risk sexual

behaviour (Van Bruggen et al., 2006) and an increased risk of dating violence (Maker, Kemmelmeier, & Peterson, 2001; Ulloa et al., 2009) is explained through the learned helplessness to recognise and act upon threatening events (Ulloa et al., 2009; Valdez et al., 2013).

Reflections of the helping professionals regarding distorted sexual development

Helping professionals added that confusion around sexual norms and different roles develop within the family. Examples of such confusion are depicted in the following excerpts;

'It's been downplayed [sexual abuse] as, she imagined it. Or often it's said that she seduced him. Or you lie, it can't be, it's my dad. He will never do such things...' (Participant 6, Lines 192-194).

'I was under age. My mother was sickly'. So, in a way the child had taken over the role of the womanhood.' (Participant 6, Lines 257-258). *'...then the child start taking over the role of the mother...'* (Participant 6, Lines 309).

During the interviews the following examples were given of causing confusion regarding sex versus affection;

'...it was the only way she got attention from her father. So much so, that she got jealous of the mother. Because that was the only attention she got. The mother was depressed. That was the only attention she got. It was better than nothing.' (Participant 4, Lines 211 – 214).

Sexual recklessness was in the following quote: *'... during young adulthood, they sometimes become more sexually riotous.'* (Participant 5, Lines 280-281).

During the interviews, helping professionals mentioned the following example of revictimisation; ‘*And they always go back to the same type of [abusive]relationship.*’ (Participant 6, Line 172). ‘*But [victim would say] he came out of an abusive relationship. He’s been sexually abused.*’ (Participant 4, Lines 569-570).

2.6 Discussion

The purpose of the scoping literature review was to identify and summarise what could be learned from previous studies on traumatic sexualisation in women survivors of CSA. The results of this scoping literature review found three main themes including nine sub-themes, that described how traumatic sexualisation is experienced by women survivors of CSA, namely: (1) negative sexual association (aversion and avoidance; sexual anxiety and flashbacks), (2) negative body image (sexual self-concept and hiding the feminine self / body harm) and (3) distorted sexual development (confusion around sexual norms, self-capacity disturbances, sexual recklessness, and revictimisation). These three themes support the findings of Finkelhor and Browne (1985) in their categorisation of traumatic sexualisation. However, two additional sub-themes were identified in the literature on women survivors of CSA, namely (1) *hiding the feminine self / body harm* a (categorised under *negative body image*) and (2) *self-capacity disturbances* (categorised under *distorted sexual development*). The latter sub-themes are relevant for helping professionals in the treatment practice of CSA as well as for addressing relationship challenges stemming from traumatic sexualisation.

The majority of the studies on traumatic sexualisation were conducted in the United States of America, followed by the United Kingdom (Bigras et al., 2015; Bird, Seehuus, Clifton, & Rellini, 2014; Dent-Brown, 1993; Easton et al., 2011; Lacelle et al., 2012; Lemieux & Byers, 2008; Meston et al., 1999). From the scoping literature review it

became clear that no empirical studies were conducted or reported in Africa and more specifically South Africa. As it is not always possible to generalise knowledge from minority countries to majority countries such as South Africa. It is important to identify how traumatic sexualisation presents in South African women survivors so as to inform the global knowledge base and treatment practice. Consequently the next manuscript will deal with this.

The interviews with helping professionals, working within the scope of CSA in practice, highlighted the complexity of CSA and supported the findings from literature. Limited information was provided during discussions on sexual dysfunction, due to the sensitive nature of intimacy and sexual relationships. Under confusion regarding sexual norms, professionals added that occasionally CSA causes children to take over the sexual role of the mother, which also causes confusion in authority positions within the family. Helping professionals emphasised the reoccurrence of detrimental behaviour in going back to the same type of abusive relationships which often leads to revictimisation. This repetitive behaviour could also be seen as a form of re-enactment in an attempt to master the sexual trauma and to gain control in order to change the outcome of the trauma.

2.7 Limitations

The scoping literature review focused singularly on data from women survivors of CSA. A more comprehensive scoping literature review on studies of both genders might provide further information on traumatic sexualisation.

Only empirical studies written in English were included in this study. Studies conducted in other languages may also have yielded further information.

More cultural representation within the qualitative interviews could have enhanced information gathered from professionals working in the scope of CSA.

Not all helping professionals could attend the focus-group discussion, therefore individual interviews were arranged.

2.8 Conclusions and Recommendations

This study identified three themes of traumatic sexualisation that corresponded with Finkelhor and Browne's (1985) traumagenic dynamics framework of CSA. Now that it is known what is written in literature concerning traumatic sexualisation in women survivors of CSA it is important to also explore how it presents in practice, and more specifically in South African women. To this end, a coding framework was developed from the key findings of the scoping literature review (see Addendum H). This coding framework will be utilised in the second phase of this study (Manuscript 2).

The next manuscript reports on the findings from a qualitative secondary analysis (QSA) of two sets of transcripts of the Survivor to Thriver (S2T) collaborative strengths-based group-intervention programme.

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SECTION B

PHASE II

PREFACE

MANUSCRIPT 2: Reports of traumatic sexualisation in a group of women survivors of childhood sexual abuse: Qualitative Secondary Analysis

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

- Phase I - Scoping literature review
- Phase II - Qualitative secondary analysis

In phase I a scoping literature review was conducted and produced a summary of what has been written on traumatic sexualisation in women survivors of childhood sexual abuse (CSA) and included clinical inputs from social workers and a psychologist. The findings were then translated into a coding framework that was used to analyse the secondary data in the second phase of this study.

The manuscript which follows reports on phase II of this study and is entitled: ‘Reports of traumatic sexualisation in a group of women survivors of childhood sexual abuse: Qualitative Secondary Analysis’. In this phase existing datasets comprising of 16 treatment sessions with women survivors of CSA participating in the Survivor to Thrive (S2T) collaborative strengths-based group-intervention programme were analysed in order to explore reports of traumatic sexualisation.

This part of the study was guided by two research questions:

- What experiences of traumatic sexualisation were reported by women survivors of CSA participating in the S2T collaborative strengths-based group-intervention programme treatment sessions?

- What findings relating to traumatic sexualisation could further inform the global knowledge base and inform treatment practice for women survivors of CSA?

MANUSCRIPT 2

**REPORTS OF TRAUMATIC SEXUALISATION IN A GROUP OF
WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE:
QUALITATIVE SECONDARY ANALYSIS**

Journal of Child Sexual Abuse – Instructions for authors

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

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by author and date (Smith, 1983) and include an alphabetical list at the end of the article.

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Tables and Figures. Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

Reports of traumatic sexualisation in a group of women survivors of childhood sexual abuse: Qualitative secondary analysis

Abstract

The primary purpose of this study was to explore reports of traumatic sexualisation by women survivors of childhood sexual abuse (CSA) participating in a Survivor to Thrive (S2T) collaborative strengths-based group-intervention programme in South Africa. Qualitative secondary analysis was employed on two datasets of sixteen group sessions with between five and eight women survivors of childhood sexual abuse. The results corresponded with the three main themes on traumatic sexualisation in women survivors of CSA found in literature, namely *negative sexual association*, *negative body image* and *distorted sexual development*. However, when viewing participants' testimonies holistically, one additional sub-theme emerged, namely *distorted view of males*. Findings suggest that traumatic sexualisation causes distorted sexual developmental evident in the development of confusion around sexual norms, self-capacity disturbances, and a distorted view of males. This often manifests in sexual reckless behaviour and may increase the risk of revictimisation.

Keywords: *childhood sexual abuse, female, survivors, traumatic sexualisation, secondary data analysis, women*

3.1 Introduction

Childhood sexual abuse (CSA) is a universal epidemic with far-reaching long-term effects for those who had experienced it. The global prevalence of CSA among boys is between 3 and 17% and for girls between 8 and 31% (Barth, Bernetz, Heim, Trelle, & Tonia, 2013). The studies on reported CSA in adults found a higher prevalence among women compared to men. The global prevalence rates for women were 18 – 22.1% and 7.6 – 13.8% for men (Barth et al., 2013; Hébert, Tourigny, Cyr, MacDuff, & Joly, 2009; Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh, Van IJzendoorn, Euser, & Bakemans-Kranenburg, 2011). Surprisingly the national Optimus study conducted in South Africa found that 36.8% of boys compared to 33.9% of girls reported some form of sexual abuse (Artz et al., 2016). As such similar findings were reported in other studies performed in Africa. Ige, Ilesanmi, and Adebayo (2012) reported the prevalence in Nigeria at 25.5% among girls and 43.1% among boys and Kisanga (2012) reported statistics indicating that 30% of boys and 26% of girls had been exposed to CSA before the age of eighteen years in Tanzania.

A body of research found a high prevalence of mental health disorders (e.g. vulnerability to depression, anxiety and post-traumatic stress disorder), sexual difficulties (e.g. promiscuity and sexual aversion) and intra- and interpersonal problems (e.g. self-esteem and trust issues as well as unstable relationships) (Maniglio, 2013; Mathews, Loots, Sikweyiya, & Jewkes, 2012; Priebe et al., 2013; Walker-Williams & Fouché, 2017). In light of such long-term negative outcomes, CSA is seen as a complex trauma and consequently researchers have attempted to explain the associated trauma-causing factors of this devastating phenomenon (Allnock & Hynes, 2012). To date Finkelhor and Browne's conceptual framework detailing four traumagenic dynamics,

namely betrayal, powerlessness, stigmatisation and traumatic sexualisation have received much attention in literature (Finkelhor & Browne, 1985; Henning, Walker-Williams, & Fouché, 2018). Of the four traumagenic dynamics, traumatic sexualisation appears to be one of the main developmental areas affected by CSA (Easton, Coohy, O’leary, Zhang, & Hua, 2011; Finkelhor & Browne, 1985). Hence, when facing recovery, these survivors often have to redevelop their perceptions regarding sexuality.

Traumatic sexualisation refers to the process in which the child’s healthy sexual development is redirected in such a way to make the child vulnerable to further CSA through the development of inappropriate sexual behaviour and dysfunctional intra- and interpersonal relationships (Finkelhor & Browne, 1985; James, 1989; Van der Merwe, 2009). The perpetrator often establishes traumatic sexualisation through a gradual process of causing confusion around sexual contact versus affection. The child’s participation in the sexualisation process is reinforced by providing gifts, individual privileges or affection or by making the child feel guilty for allowing the act or previous participation (Finkelhor & Browne, 1985). A distorted meaning is given to certain body parts that often leads to the objectification of the survivor’s body (Finkelhor & Browne, 1985; James, 1989; Van der Merwe, 2009). Negative sexual associations develop due to CSA, and traumatic sexual experiences often manifests in flashbacks, helplessness, avoidant or dissociative behaviour (Bloom, 2003). The distorted sexual development often causes confusion around sexual norms that result in exploitative sexual activities, promiscuous behaviour or revictimization (Finkelhor & Browne, 1985; Van der Merwe, 2009).

A number of studies have found that as adults, CSA survivors experience sexual difficulties, including a lack of sexual responsiveness, lack of sexual satisfaction as well

as sexual dysfunction (Grauerholz, 2000; Rellini & Meston, 2011). This might stem from and contribute to the traumatic sexualisation associated with CSA (Finkelhor & Browne, 1985). Research on CSA, and specifically on traumatic sexualisation, is very complex due to the different variables in survivors, for example the onset -, duration -, and severity of sexual abuse, the relationship to the perpetrator, bystander response to disclosure, as well as the amount of effort the perpetrator invested to condition the child (Easton et al., 2011; Kelley & Gidycz, 2015; Merrill, Gulmond, Thomsen, & Milner, 2003; Senn, Carey, Vanable, Coury-Doniger, & Urban, 2007). These variables have an influence on sexual behavioural manifestations in adulthood and complicate generalisation of findings.

Several studies focussed on the link between the different forms of abuse and the effect on sexuality or sexual behaviour in adulthood (Coid et al., 2001; Lacelle, Hebert, Lavoie, Vitaro, & Tremblay, 2012). Different studies addressed how CSA affects future intimate relationships (Easton et al., 2011; Swaby & Morgan, 2009; Træen & Sørensen, 2008). Some studies have reported a relatively strong association between CSA and sexual dysfunction (Bartoi & Kinder, 1998; Bigras, Godbout, & Briere, 2015; Leonard, Iverson, & Follette, 2008; Staples, Rellini, & Roberts, 2012), while others reported limited associations and rather a dissatisfaction with their ability to manage sexual relationships (Van Bruggen, Runtz, & Kadlec, 2006). Several explanations could be given for these inconsistencies. Self-reported experiences could be affected by the survivor's relationship to the perpetrator, ongoing contact with the perpetrator, feelings of guilt / shame or the fact that they have to rely on memory (Jewkes & Abrahams, 2002; Roller, Martsof, Draucker, & Ross, 2009).

Many studies tried to explain promiscuity or compulsive sexual behaviour (Batten, Follette, & Aban, 2002; Senn, Carey, & Coury-Doniger, 2011) and the risk of revictimization (Lacelle et al., 2012; Lemieux & Byers, 2008; Tapia, 2014).

In light of the documented impact of CSA and more specifically the reported traumatic sexualisation of victims, it is undisputed that CSA survivors require specific treatment. However, limited empirical evidence is available on such treatment interventions to assist CSA survivors with problems stemming from traumatic sexualisation (Walker-Williams & Fouché, 2017; Henning et al., 2018). Research over decades found that differences occur in the impact of CSA on survivors into adulthood between males and females where women tend to internalise the experience of their CSA trauma (with e.g. mood disorders) and men tend to externalise (with e.g. physical aggression or violence) (Artz et al., 2016; Beitchman et al., 1992; Gill & Tutty, 1999; Sigurdardottir, Halldorsdottir, & Bender, 2013). Distinguishing between how traumatic sexualisation presents in women and men is imperative for enhancing an understanding and informing treatment practices in this regard.

In manuscript one a scoping literature review was conducted to provide a summary of what is known from literature about traumatic sexualisation in women survivors of CSA. It was found that traumatic sexualisation may affect the CSA survivor's sexual development and psychosexual functioning during adulthood and could manifest in aversion and avoidant sexual behaviour, a negative sexual self-concept and body harm, confusion about sexual norms and affect regulation, promiscuity and compulsive sexual behaviour and lastly make them vulnerable to revictimisation during adulthood (Bigras et al., 2015; Bird, Seehuus, Clifton, & Rellini, 2014; Easton et al., 2011; Finkelhor & Browne, 1985; Lacelle et al., 2012; Meston, Rellini, & Heiman, 2006; Noll, Trickett,

& Putnam, 2003; Painter & Howell, 1999; Vaillancourt-Morel et al., 2015; Van Bruggen et al., 2006). However, in manuscript one it was found that the majority of studies on this topic were conducted in the following world countries ($N = 66$): United States of America ($n = 42$) (Bartoi & Kinder, 1998; Staples et al., 2012); United Kingdom ($n = 7$) (Dent-Brown, 1993; Reavey & Brown, 2009) and Canada ($n = 7$) (Lacelle et al., 2012; Vaillancourt-Morel et al., 2016), New Zealand ($n = 2$) (Romans, Martin, Morris, & Harrison, 1998; Van Roode, Dickson, Herbison, & Paul, 2009), one study in each of the following countries: Netherlands (Senn, Carey, & Coury-Doniger, 2012), Germany (Dyer, Feldmann, & Borgmann, 2015), Austria (Kinzl, Traweger, & Biebl, 1995), Denmark (Kristensen & Lau, 2011), Norway (Træen & Sørensen, 2008), Australia (Najman, Dunne, Purdie, Boyle, & Coxeter, 2005), Jamaica (Swaby & Morgan, 2009) and Taiwan (Wang & Heppner, 2011). No empirical study was found exploring traumatic sexualisation in South African women.

Due to South African being a culturally rich and diverse developing country as well as characterised by poverty, unemployment and sexual crimes, the knowledge obtained from first-world countries cannot be generalised or transferred to this context.

In addition, the researcher also reported in manuscript one that the majority of empirical studies reporting on traumatic sexualisation in women survivors of CSA were conducted in the USA and other minority countries on sexual aversion, avoidance and destructive behaviour stemming from the sexual trauma (Bartoi & Kinder, 1998; Bigras et al., 2015; Dyer et al., 2015; Easton et al., 2011). However, limited research has been conducted within the South African context, specifically on how CSA affects the women survivor's sexual development and sexual functioning into adulthood.

Furthermore, little has been done to investigate women CSA survivors' reports of traumatic sexualisation and how they experience this distinctive trauma-causing factor.

Gaining access to women survivors of CSA for research purposes, so as to explore such a sensitive topic such as traumatic sexualisation, is a daunting task and brings about a multitude of ethical issues. One way of dealing with such a dilemma is by making use of existing datasets, and thus performing qualitative secondary analysis (QSA) (Heaton, 2008; Irwin, 2013). Consent was obtained from the primary researchers who conducted the therapeutic sessions who also obtained consent from the participants that the data may be used for secondary analysis (Walker-Williams & Fouché, 2017). Transcripts were anonymised by the principal researchers who are also the study leaders of this study (Walker-Williams & Fouché, 2017). Ethical clearances were obtained for the primary study and this study (Annexure I) as well as from the participants of the two groups for the re-use of data for secondary analysis (Heaton, 2008) (Annexure K).

The researcher obtained access to two datasets of treatment groups (in total 16 treatment sessions) whereby eighteen women survivors of CSA received collaborative strengths-based group-intervention treatment. Thus, the challenge due to the known secrecy surrounding this phenomenon, as well as the personal and sensitive nature of exploring sexuality difficulties from CSA survivors, was addressed by utilising QSA whereby existing data was used to provide valuable information on CSA survivors' experiences.

Understanding the effect of CSA on the sexual development of the survivor is important in order to develop programmes to support the CSA survivor in dealing with the challenges related to the survivor's sexual identity, sexual relationships and sexual behaviour (Easton et al., 2011; Matorin & Lynn, 1998; Najman et al., 2005). In addition, this study will contribute to the body of knowledge on the sexual development of the

woman CSA survivor and how this traumatic disturbance manifests in adulthood. In doing so, this will assist in informing the development of global treatment intervention programmes.

As such, the research question driving this study is: (1) what experiences of traumatic sexualisation were reported by women survivors of CSA participating in the S2T collaborative strengths-based group-intervention treatment sessions? (2) What findings relating to traumatic sexualisation could further inform the global knowledge base and inform treatment practice for women survivors of CSA?

Aim of the current study

The aim of this study was to perform QSA using a coding framework developed from the scoping literature review findings in manuscript one, on a collective set of data from sixteen treatment sessions conducted with two groups of women attending the Survivor to Thriver (S2T) collaborative strengths-based group-intervention programme. The groups were conducted over a period of three years with delayed post-testing in order to assess the benefits of the intervention programme for the participants.

In manuscript one, a scoping literature review was conducted to examine previous studies on traumatic sexualisation in women survivors of CSA. Finkelhor and Browne's (1985) traumagenic dynamics was utilised as a conceptual framework together with additional information extracted from other studies through the scoping literature review. This was done with the aim of compiling a coding framework for the implementation of the QSA. The current manuscript commences with coding framework, deriving from the findings in manuscript one, that guided the second phase of this study.

In the next section an outline of the methodology is discussed followed by the findings of the study. The manuscript concludes with limitations and recommendations for this study.

3.2 Coding Framework

As mentioned earlier, a coding framework (Addendum H) was developed from the key findings of the scoping literature review (reported in manuscript one) and used to explore reports of traumatic sexualisation in a group of women survivors attending treatment sessions of the Survivor to Thrive (S2T) collaborative strengths-based group-intervention programme. In total, three themes were identified in line with Finkelhor and Browne's (1985) traumagenic dynamics framework on traumatic sexualisation, with an additional two sub-themes that were identified in the literature. A discussion of these themes follow next.

3.2.1 Negative sexual association.

Studies indicated that CSA may causes negative sexual associations. Women survivors often develop an aversion for intimacy or avoid intimate relationships due to traumatic sexual experiences during childhood. This manifest in sexual dysfunction that is evident in intimacy disturbances, experiential avoidance, sexual anxiety, as well as sexual desire - and orgasm dysfunction (Bartoi & Kinder, 1998; Bigras et al., 2015; Kristensen & Lau, 2011; Leonard et al., 2008; Swaby & Morgan, 2009). Negative associations with certain places, - time of the year, - things or body areas may cause flashbacks (Dyer et al., 2015; Wang & Heppner, 2011; Woodiwiss, 2008). CSA creates negative associations with sexuality and associate touch and intimacy with pain and confusion (Easton et al., 2011; Meston & Heiman, 2000).

3.2.2 Negative body image.

The objectification of the child's body during CSA, may cause the development of a negative sexual self-concept (Lacelle et al., 2012; Lemieux & Byers, 2008; Meston & Heiman, 2000; Roller et al., 2009; Wang & Heppner, 2011) and the loss of physical and psychological boundaries (Roth & Lebowitz, 1988). Sexual self-concepts are seen to predict future sexual satisfaction (Rellini & Meston, 2011).

CSA may cause the survivors to display more negative emotions and dissatisfaction regarding their body (Dyer et al., 2015; Murray, MacDonald, & Fox, 2008). As such they may implement abusive or destructive survival strategies to cope with the CSA such as compulsive eating to hide the feminine self, or intentional body harm such as, body piercing / tattoos and self-abusive coping such as self-mutilation (Painter & Howell, 1999; Wang & Heppner, 2011).

3.2.3 Distorted sexual development.

CSA causes confusion around sexual norms through conditioning behaviour by the perpetrator that appears to provoke conflict regarding the self and interpersonal relations (Finkelhor & Browne, 1985). As a child, the CSA survivor might learn age inappropriate sexual words, that are in conflict with social norms. In adulthood this might manifest in the use of strong sexual words (Rellini & Meston, 2007).

CSA appears to distort the survivor's sexual norms regarding themselves and their intimate relationships (Painter & Howell, 1999). Confusion around themselves, regarding the reasons for the CSA was accompanied by feelings of guilt, which often prevented the survivors from disclosing the abuse.

Survivors of CSA might experience challenges in displaying affection or they might find it difficult to maintain boundaries due to confusion around sex versus affection. CSA survivors often were confused as children regarding the role of sex in affectionate relationships and were rewarded with affection or gifts after participation in sexual acts (Finkelhor & Browne, 1985). This confusion interfered with; (1) the manner in which the survivor learned to negotiate relationships (Kochka & Carolan 2002), (2) the development of trust issues (Frías, Brassard, & Shaver, 2014; Valdez, Lim, & Lilly, 2013; Wang & Heppner, 2011) and (3) the development of control issues (Pistorello & Follette, 1998) which are often linked to sexual recklessness.

The development of dysfunctional and inappropriate behaviour can manifest differently in intimate partner relationships as well as parent- child relationships through alliance protection strategies (Kochka & Carolan, 2002). CSA might causes self-capacity disturbances through its detrimental effect on interpersonal relatedness and affect regulation (Bigras et al., 2015; MacIntosh & Johnson, 2008; Roth & Lebowitz, 1988; Ulloa, Baerresen, & Hokoda, 2009).

Sexual recklessness such as sexual preoccupation and promiscuity often developed due to learned self-destructive coping mechanisms as a means to gain control or to deal with sexual anxiety (Lemieux & Byers, 2008; Merrill et al., 2003).

Survivors of CSA are at greater risk of being revictimised, due to desensitisation to violence as well as high-risk individuals and /or places, all stemming from their childhood (Swaby & Morgan, 2009; Valdez et al., 2013). Revictimisation through high-risk sexual behaviour and the increased risk of dating violence is explained through the lack of skill development to recognise and act upon threatening events, or through

learned helplessness as a survival mechanism (Ulloa et al., 2009; Valdez et al., 2013; Van Bruggen et al., 2006).

3.3 Methodology

This study employed a qualitative exploratory approach, with a view to gain a better understanding of the nature of traumatic sexualisation by exploring existing datasets and in so doing find answers to research questions (Dudovskiy, 2017).

Research design: Qualitative secondary analysis

Qualitative secondary analysis (QSA) is the use of existing qualitative data obtained from a prior study, in order to do further research on the available data (Heaton, 2008; Irwin, 2013). Five types of analyses for existing datasets in QSA were pointed out by Heaton (2008), namely: re-analysis (the re-examining of data to confirm and validate findings of a primary study); amplified analysis (comparison or combination of two or more existing qualitative datasets for purposes of secondary analysis); assorted analysis (secondary data analysis in conjunction with the collection and analysis of primary qualitative data for the same study); supplementary analysis (to gain a more in-depth understanding of an aspect or aspects not addressed in the original study); and supra analysis (the aim and focus of the secondary study exceed those of the original research). The latter form of analysis was used in the study, as it exceeds the original research that examined the efficacy of the S2T collaborative strengths-based group-intervention programme, by exploring reports of traumatic sexualisation in survivors of CSA. It went beyond the objective of the original study, namely to evaluate the benefits of a collaborative strengths-based group-intervention programme for women survivors of CSA, to answer new empirical and conceptual questions (Heaton, 2008; Leech & Onwuegbuzie, 2008).

3.3.1 Sampling and data collection.

Participant sampling was not required, as existing datasets were used by means of formal data sharing for the study (Heaton, 2008). The researcher therefore used two datasets comprising sixteen treatment sessions of the S2T collaborative strengths-based group-intervention programme for South African women who had experienced CSA (hereafter referred to as the primary study). Transcriptions for all sixteen treatment sessions were included for analysis. The data were coded deductively by the researcher. Consent was obtained from the primary researchers who conducted the therapeutic sessions who also obtained consent from the participants that the data may be used for secondary analysis (Walker-Williams & Fouché, 2017). Transcripts were anonymised by the principal researchers who also are the study leaders of this study (Walker-Williams & Fouché, 2017). Ethical clearances were obtained for the primary study and this study (Annexure I) as well as from the participants of the two groups for the re-use of data for secondary analysis (Heaton, 2008) (Annexure K).

Background information on the primary study: The S2T collaborative strengths-based group intervention programme

The primary study evaluated the benefits of a Survivor to Thriver (S2T) collaborative strengths-based group-intervention programme to facilitate post traumatic growth in women who had experienced CSA. The S2T collaborative strengths-based group-intervention programme follows a strengths-based and supportive approach, which focuses on women survivors' strengths in order to facilitate posttraumatic growth from their traumatic childhood experiences. This intervention covered four treatment outcomes (Walker-Williams & Fouché, 2017, p. 196):

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

Participants of both groups were women residing in the Gauteng province in South Africa, who had experienced CSA. Inclusion criteria for the groups were: a minimum age of 18 years; disclosure of the CSA; the women had received some form of counselling (as child / adult); could understand and respond to English/Afrikaans; and were willing to participate voluntarily and partake in the S2T collaborative strengths-based group-intervention sessions at a central community location. The demographics of the participants in the different groups are displayed in Table 9.

Table 9

Biographical Information of S2T Group Members

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

Initially with the first group, ten participants commenced with the group sessions, after which three withdrew. With the second group, eight participants commenced, after which also three withdrew. The participants experienced contact sexual abuse and the perpetrator was known to them. In total, sixteen group-intervention sessions with both groups were held with between five and eight participants over a period of three years. The transcripts of these sessions were analysed for the purpose of this study.

3.3.2 Data analysis.

Thematic analysis was employed deductively using a coding framework developed in the first phase of the study to identify, analyse and report themes that appear within the

dataset (Braun & Clarke, 2006). Firstly, during the deductive analysis phase sub-themes pertaining to the coding framework were identified within the dataset. Secondly, the dataset was analysed inductively to search for additional traumatic sexualisation sub-themes in addition to those listed within the coding framework. Thirdly, each theme was reviewed and discussed during consultations sessions with the study leaders to prevent misinterpretation of data (Braun & Clarke, 2006).

3.3.3 Trustworthiness.

The QSA research design and process followed throughout the primary research study as well as this study, ensured the trustworthiness of evidence provided in this manuscript. The primary researchers obtained written consent from participants in which permission was given to the researcher in this study to observe the process of the S2T collaborative strengths-based group-intervention programme. This study was conducted in such a way that the researcher's own judgment about the reality of traumatic sexualisation amongst women survivors of CSA be suspended, in order to explore the reality experienced by the participants as evident in the existing datasets. This bracketing out or suspension of the researcher's experiences of a phenomenon is explained in Creswell (2009) as an effective manner to understand the individuals' personal experiences. The authenticity of the study was ensured by the linking the themes to quotes from the participants (Cope, 2014). The credibility and transferability of the data was evident in the findings of different studies on traumatic sexualisation (Bartoi & Kinder, 1998; Cope, 2014; Easton et al., 2011).

Independent coding was done by the two study leaders through verifying the similarities and differences in making comparisons across the data units (Niewenhuis, 2011; Ryan

& Bernard, 2003) as well as between studies within this research project on the traumagenic dynamics of CSA (Finkelhor & Browne, 1985).

3.4 Ethical Considerations

Permission and ethical clearance (NWU-HS-2016-0181) was obtained from the Human Health Research Ethics Committee (HHREC) of the NWU Vaal Triangle University prior to the commencement of this study.

Written consent was obtained from the primary researchers to use the dataset of S2T collaborative strengths-based group-intervention programme treatment sessions, in which a confidentiality agreement was signed by the researcher for the re-use of these data (Addendum J). Anonymity and confidentiality of participants were ensured by the primary researchers, by assigning a unique number to each participant in the transcripts. As stipulated in the Health Professions Act 56 of 1974 (Department of Health, 2006), the audio recordings are kept in a secure location and the data for the current study are kept confidential and stored electronically in an encrypted file.

3.5 Findings

The analysis of the dataset identified three traumatic sexualisation themes corresponding to those documented in literature. These themes are: (1) *negative sexual association*, (2) *negative body image*, and (3) *distorted sexual development*. One additional sub-theme was found, namely *distorted view of males* categorised under the theme *distorted sexual development*. The findings from this study are presented below. These findings are further supported by extracts from the datasets to substantiate the evidence of traumatic sexualisation as reported by women survivors of CSA who participated in the S2T collaborative strengths-based group-intervention programme.

3.5.1 Negative sexual association.

With regards to negative sexual association all three sub-themes as in the coding framework were identified which include: (1) *sexual aversion and avoidance*, (2) *sexual anxiety*, and (3) *flashbacks*. Evidence of sexual aversion and avoidance was found in the following participant statements: Participant 1 in group 1 explained how she dissociated during sex: ‘...if my partner does initiate sex I tend to, at some point switch off...so I don’t want it... I don’t enjoy it but I do allow it’.

Participant 7 in group 1 explained how she would avoid potential intimate relationships: ‘And I know if somebody asks me, am I married, or do I have boyfriend, I would tell them I am too busy with my studies. And that is just an excuse to not tell them or have their attention.’

Sexual anxiety was evident in the following remark by participant 1 in group 1: [During sexual intercourse] ‘I was very aware of everything around me. I could basically hear the children breathing in the next room...I was so anxious.’

Flashbacks that survivors experience was clear in the testimony of the following participants: ‘...but I was just disturbed in my sleep and while awake [thinking back about the sexual abuse]. I taught myself years ago when I couldn’t sleep, you are in a white empty room, you are in a white empty room. And that worked, I could shut off my mind.’ (Participant 1 in group 1); ‘...tot jy daai flashbacks kry en drome kry [of the sexual abuse], dan beseef jy daar’s geen manier dat jy dit opmaak nie’ (till you get those flashbacks and dreams, then you realise there is no way that you could make it up) (Participant 2 in group 1); ‘...because each and every Christmas I feel like that’ [sexual abuse happened over Christmas time] and it comes back to haunt me (Participant 4 in

group 1); *'And then there is the refusal to have sex and avoid intimacy so as to prevent the flashbacks...'* (Participant 3 in group 2).

3.5.2 Negative body image.

The following two sub-themes as included in the coding framework explain negative body image, namely: (1) *negative sexual self-concept* and (2) *hiding the feminine self/body harm*.

The impact of CSA that causes a negative sexual self-concept was displayed in the following comments from two participants: Participant 5 in group 2 stated: *'...I feel like men, some men, see me as a sexual object...'* In the words of Participant 7 in group 1: *'I'm just good to be used.'*

Participant 5, in group 1 reflected self-blame: *'...what is it in that body [my body] that attracts men, so that they could abuse it.'* The objectification of the survivor's body was furthermore highlighted in the following statement by participant 7: *'...I feel like a sex object, that's what I've been for a long time... my sexuality was there but I did not enjoy it with men...as if it was gone...'* (Participant 7 in group 1).

The inability to accept one's feminine self and body is depicted in the following excerpt: *'I am able now to look into the mirror not in disgust, but in pride... I can look at my face in the mirror and put on makeup, but the rest of my body ... I'm still disgusted with it... I don't know, I can't touch it'* (Participant 7 in group 1).

Body harm was illustrated by the following remarks: *'I decided not to cut myself, because it's terrible. So I just had sleeping tablets'* (Participant 7 in group 1); *'...to the point where I start hurting myself, cutting myself...using destructive coping mechanisms, like uhm, I used drugs...'* (Participant 1 in group 2); *'...I didn't eat for*

about a week and a half, nothing...I think I just punished myself... but I can't feel better if I don't look after myself' (Participant 7 in group 1).

Hiding the feminine self was an additional sub-theme identified within scoping literature review. Due to the negative body image, the CSA survivor develop ways to avoid things that remind them of the CSA, for example their body or certain parts of their body. Evidence of the hiding of the feminine self was illustrated in the following remarks: '*Sodra ek 'n aantal gewig verloor dan sit ek dit weer aan ... Jy wil nie so mooi lyk dat jy mense uitlok om na jou te kyk nie.*' (when I lose a certain amount of weight, then I gain the weight again ... You don't want to look that beautiful that you tempt people to look at you.) (Participant 2 in group 2); '*Iets waaroor ek baie bly is, is ek het begin om korter klere te dra. Dit was vir my nogal erg gewees, want ek het geweier om my lyf te wys...And I'm not afraid to wear shorter skirts, I'm not afraid to show my legs, not afraid to show my arms, I have my neck open.*' (Something that I'm glad about is, I started to wear shorter clothing. It was bad for me, because I refused to show my body) (Participant 2 in group 1).

3.5.3 Distorted sexual development.

The distortion of sexual development can be grouped under the following four sub-themes: (1) *confusion around sexual norms*; (2) *self-capacity disturbances*; (3) *sexual recklessness* and (4) *revictimisation*. An additional sub-theme was found within the dataset, namely: *distorted view of males* and will also be discussed.

Confusion around sexual norms was illustrated in the following statements: '*I uhh, discussed it with my partner how I have trust issues, but we did not go into it...it's more than what I thought it was... I thought it was, you know, you go out, someone cheats on you, that it's just that, but it's way more than that. That is what I've realised...I can say*

something about being with someone who is really good to you, who really loves you. I would refuse to marry that man because I believed in my mind, fifty years old, that if I marry him, he will change and abuse me (Participant 1 in group 1); *‘...instead of helping me they wanted to help the family, and like the message my grandma gave me was that if word came out, I would actually be destroying my family, so if I did something about it, if maybe he and his wife divorced or the family knew about it, it would be on my shoulders’* (Participant 2 in group 2).

The following statement by participant two suggests a self-capacity disturbance: *‘...it is actually very shocking...the abuse is so strong...as a person you really become...oppressed emotionally’* (Participant 2 in group 1). Another example of affect dysregulation is: *‘And if I speak about what happened, I kind of shut down and kind of regurgitate it, so I don’t put any emotion into it’* (Participant 3 in group 2). Difficulty with interpersonal relatedness was evident in the following remarks: *‘...I told him I’m not comfortable around males...’* (Participant 5 in group 2); *‘...all my relationships ended up with not talking to each other or I did something bad’* (Participant 4 in group 2).

Sexual recklessness was evident in statements of sexual preoccupation and promiscuity. An example of sexual preoccupation is evident in the following statements: *‘...I will go over it in my head’* (Participant 7 in group 1); *‘How am I going to stop thinking about sex or when am I going to, or how am I going to be a woman, like a woman. It just played over and over in my head’* (Participant 7 in group 1).

The following participant didn’t understand the promiscuous behaviour as indicated in the following remarks: *‘But I also wanted to know if boys will still accept me as someone special. As a young adult, I used to go out and try to see which of the men in*

clubs or pubs would be interested in me... that was a destructive way of coping but I was still searching for myself... I took them home as well, and...we had sex...and...that was never a pleasure for me it was self-destructive’ (Participant 7 in group 1). Control derived from promiscuous behaviour was evident in the following statement: ‘*...I had been very promiscuous, and if I sum up all the guys that I have slept with... I would say three out of everybody else was people I was dating, the rest was just sex. And I did it because I wanted to take back control*’ (Participant 5 in group 2).

Revictimisation was a reality for several participants. Evidence of the lack of skills to recognise threatening events due to desensitisation is displayed in the following remarks: ‘*I was raped and I got married to the person and I realised ... only after I got divorced that I was raped because I didn’t perceive it as wrong, what he did to me...and I got pregnant...I know I said get off me and no he wouldn’t, but I was sixteen years old, and I didn’t even go to my parents again*’ (Group 1, Participant 1, age 50); ‘*It happened at the age of six and then it happened again later on when I was about eight..*’ (Participant 4 in group 2); ‘*It happened at age ten, it was five different people*’ (Participant 2 in group 2).

In addition, reports of a *distorted view of males* were found as an additional sub-theme. Distortion in the view of males develop where the CSA survivor often experience contradicting emotions around the perpetrator’s attitude towards them, family member’s response to the disclosure and confusion to understand their own response to the abuse in allowing it versus resisting it, especially where the perpetrator was more caring, supportive and kind towards the survivor in comparison to the other family members, resulting in more sexualisation. This contradicting emotions causes feelings of guilt.

The following remark indicates the distorted view of males where the survivor as a child asked her stepfather for support to prevent his sons from abusing her, and then he starts to abuse her. She doesn't understand how the sexual abuse of her stepfather then became an achievement for her: *'And I felt very important because this old man who was actually my dad...he is doing it now so I'm getting acceptance even more than I used to...and it was fine...a father is supposed to be like that, he had to do it, so to prepare you for your, uhm, marriage...'* (Participant 6 in group 1). Another example of this distortion is: *'I was raped and I got married to the person and I realised ... only after I got divorced that I was raped because I didn't perceive it as wrong, what he did to me'* (Participant 1 in group 1).

Participant 2 in group 2 highlighted the distorted view of males through confusion around God as a protective figure versus the male figure who hurt them: *'It is so difficult you know because we view God as a male figure, and a male figure hurt us.'*

3.6 Discussion

The objective of this QSA was to explore emerging reports of traumatic sexualisation in women survivors who participated in the S2T collaborative strengths-based group-intervention programme. Results from the deductive analysis corresponded with the results found in manuscript one and one additional sub-theme emerged categorised under the theme of *distorted sexual development*, namely *distorted view of males*.

A conceptual framework flows from this study incorporating findings from manuscript one and two (as illustrated in Figure 2).

The sub-themes highlighted in red suggest new contributions to the knowledge base as it expands on Finkelhor and Browne's (1985) traumagenic dynamic framework. This

conceptual framework provides and answer the final research question and may further inform the global knowledge base and treatment practice for women survivors of CSA.

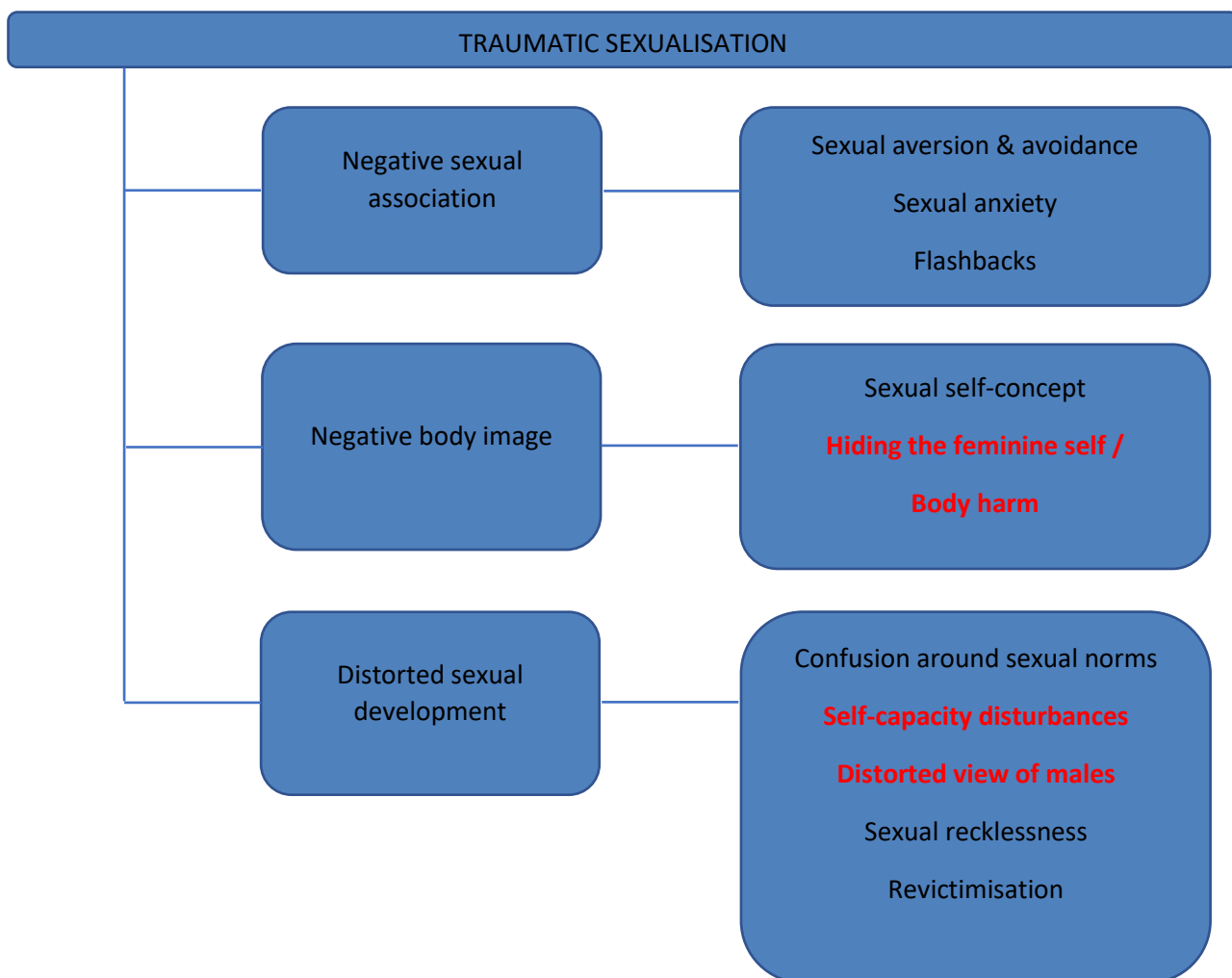


Figure 2. Conceptual framework

Traumatic sexualisation causes negative sexual associations that consequently leads to the development of aversion to intimacy or to ways to avoid intimacy due to sexual anxiety. Similar to the findings in literature, participants in this study displayed strategies not to get involved in intimate relationships or if they do get involved in long term relationships, to then avoid intimacy. Ways to deal with sexual anxiety were to

avoid initiate intimacy, then 'to switch off' (Participant 1 in group 1). This behaviour highlights the impaired gratification derived from intimacy that CSA survivors often experience as well as difficulty with emotional intimacy. Flashbacks also appeared to distort the participants' ability to feel pleasure in sexual responses (Kochka & Carolan, 2002).

The current study confirms that CSA influences the survivor's attitude and relationship to their body and sexuality. Through several remarks from participants within both groups, it was evident that the CSA survivor's sexual self-concept often is affected in such a way that the survivor feeling like a sexual object. Literature also distinguished between the survivor's romantic or passionate sexual self-concept and the attractiveness self-concept. Evidence of these different self-concepts were not found within the datasets, due to the content of the S2T collaborative strengths-based group-intervention programme. Wearing oversized clothing or making themselves look ugly to avoid attention (Wang & Heppner, 2011) was evident in participants' remarks about the type of clothing they choose to wear and issues regarding weight control. Disconnection from their feminine self, appeared to result in body harm such as self-mutilation and substance abuse.

Distorted sexual development in which the CSA survivors' sexual attitude, skills and behaviour are altered manifested in confusion around sexual norms. Evidence of this confusion was displayed by participants' remarks on family members that expected them to keep quiet about the sexual abuse and how it affected their relationships due to the development of trust issues. Self-capacity disturbances were recognised through participant remarks of poor affect regulation, which leads to non-disclosure of the abuse or the suppression of emotions surrounding the sexual abuse. Challenges with

interpersonal relatedness that causes the loss of physical and psychological boundaries became evident in participants' remarks concerning sexual recklessness such as promiscuity. In this study no evidence of sexual recklessness was found for financial gain, as emphasized in literature. Several examples of revictimisation were raised by participants. Evidence of desensitisation to high-risk or abusive situations was described by a participant through her remark that she didn't realise that she was raped, only after she got divorced. Additionally, within this study another sub-theme was identified that wasn't specifically identified as such within literature, namely *distorted view of males* (categorised under the theme *distorted sexual development*). This distorted view of males causes contradicting emotions as well as trust and betrayal issues in CSA survivors due to challenges with regards to understanding how males in positions of authority, who were supposed to protect them, then abused them (Henning et al., 2018).

3.7 Limitations of the Study

The transcriptions of only two datasets were available during the finalisation of this study. The other datasets could contribute to more reports of traumatic sexualisation. Although the primary research study had set objectives different from those of this secondary study, the information contained in the two datasets were still beneficial to identify reports of traumatic sexualisation. The researcher did not participate in the collection of data during the primary study and some information was not clear in the recordings and transcriptions of the datasets. The sensitive nature of discussions contributed to this limitation. Therefore the primary researchers assisted in clarifying certain aspects of the datasets.

3.8 Recommendations

This study contributes a conceptual framework which can potentially contribute to the global knowledge base on CSA. Furthermore, from the findings of this study it is evident that traumatic sexualisation severely affects women survivors of CSA, which makes them vulnerable to further revictimisation. Hence it is recommended that programmes focusing on the treatment of survivors be developed. Further empirical research with larger studies on males and females are thus recommended.

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SECTION C

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

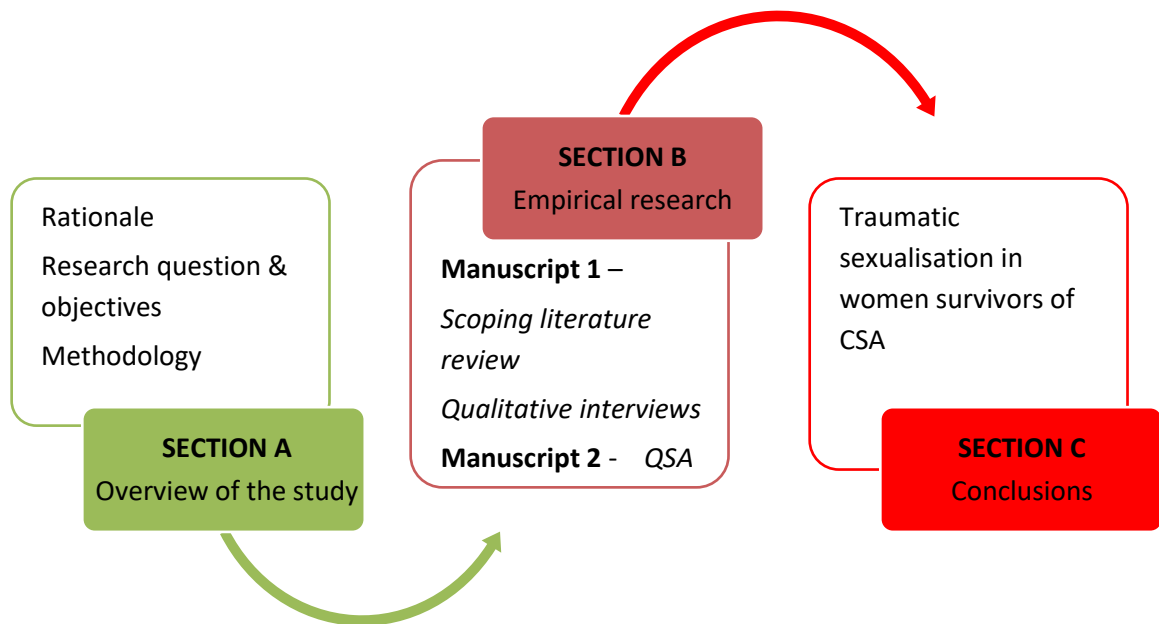


Figure 3. Unfolding of the study

4.1 Introduction

This qualitative exploratory research study aimed at exploring what is known from literature and practice about traumatic sexualisation and at identifying reports of traumatic sexualisation in women survivors of CSA. The objectives for this study were: (1) to conduct a systematic scoping literature review to identify literature and provide a summary of evidence from a variety of studies on traumatic sexualisation in women who had experienced CSA; (2) to present findings of the scoping literature review to helping professionals, such as social workers and psychologists, working within the scope of CSA in practice, in an endeavour to obtain feedback on the findings of the scoping literature review and to identify any additional information related to traumatic sexualisation in women survivors of CSA; (3) to conduct thematic content analysis of transcripts emanating from qualitative interviews with helping professionals working within the scope of CSA; (4) to perform QSA on datasets of two S2T groups of treatment sessions with women survivors of CSA over a three-year period, in order to explore emerging reports of traumatic sexualisation in this population; and (5) to contextualise findings on traumatic sexualisation so as to propose a conceptual framework that could contribute to the global knowledge on traumatic sexualisation in women and to inform future S2T treatment practice.

By means of the scoping literature review, evidence in literature was identified and summarised on traumatic sexualisation in women survivors of CSA. This was followed by discussions on traumatic sexualisation with helping professionals, working within the scope of CSA, to establish whether any additional factors related to traumatic sexualisation were evident in practice not indicated in literature. The QSA on the two

sets of data explored reports of traumatic sexualisation in women survivors who participated in the S2T collaborative strengths-based group-intervention programme.

The purpose was to assess correlations between findings in literature and two datasets.

An overview of the conclusions will follow, as well as the limitations and recommendations emanating from this study.

4.2 Research Questions Reconsidered

The current study was guided by the main research question and four secondary research questions, as illustrated in Figure 4.

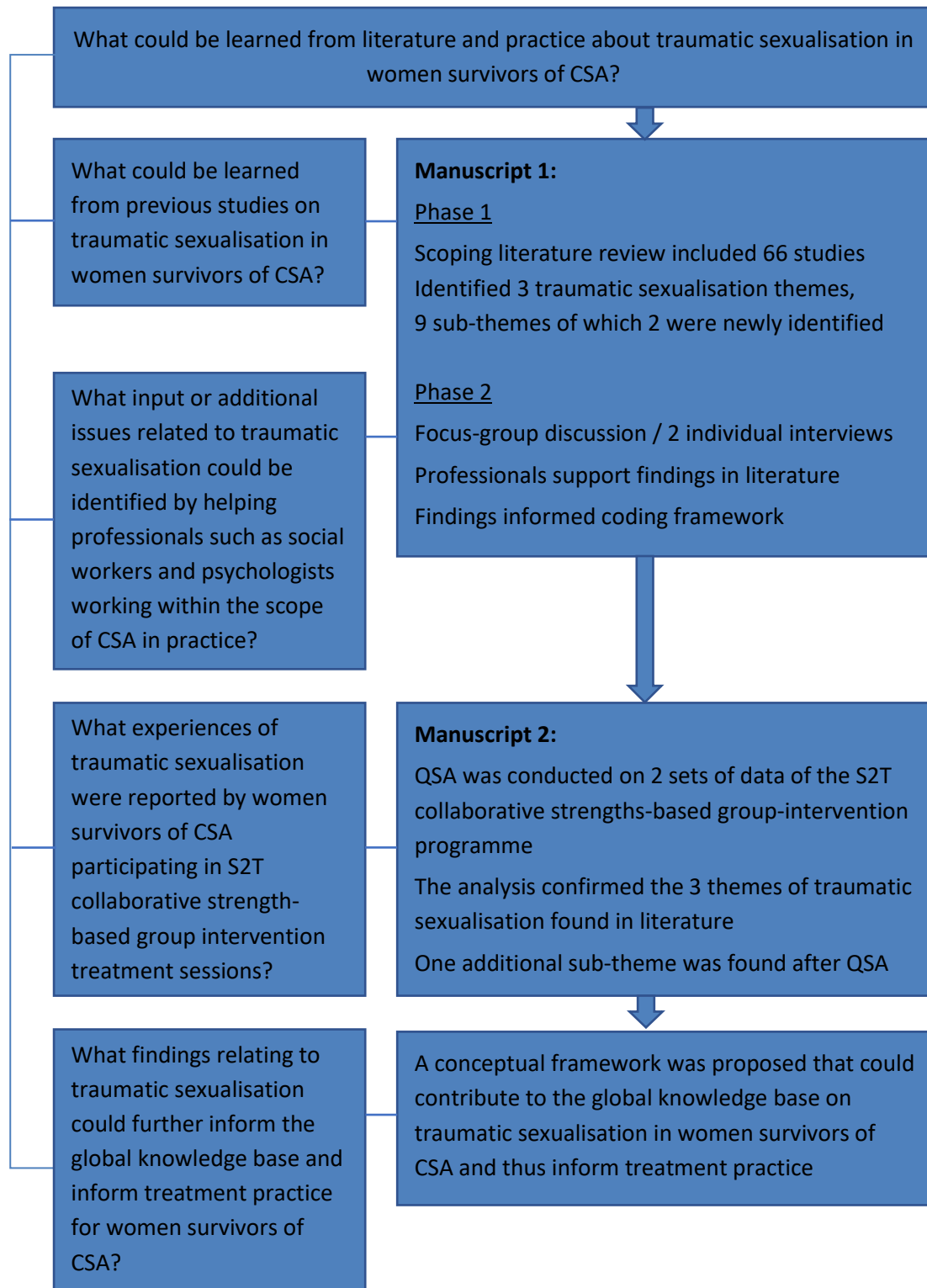


Figure 4. Research questions reconsidered

4.3 Conclusions Emanating from this Study

4.3.1 Manuscript 1.

Manuscript 1 reported on the results of the scoping literature review conducted with the aim of identifying and summarising the findings from literature on traumatic sexualisation (Addendum C). The results of the scoping literature review support the findings of Finkelhor and Browne (1985) in their seminal traumagenic framework on traumatic sexualisation. A total of three themes were identified to explain traumatic sexualisation, namely: (1) *negative sexual association*; (2) *negative body image*; and (3) *distorted sexual development*. However, within the literature two additional sub-themes were identified to explain the detrimental effect of traumatic sexualisation on the survivors' development and behaviour, namely: *hiding the feminine self/body harm* (categorised under *negative body image*) and *self-capacity disturbances* (categorised under *distorted sexual development*).

Hereafter qualitative interviews comprising one focus-group discussion and two semi-structured interviews were conducted with a total of six helping professionals working within the field of CSA with women who experienced CSA with the purpose of obtaining input and/or identify any additional emerging themes of traumatic sexualisation. During these qualitative interviews the above indicated findings were confirmed with no additional themes being reported by helping professionals.

4.3.2 Manuscript 2.

The results of the QSA on two datasets of the S2T collaborative strengths-based group-intervention programmes corresponded with the three main themes found in the scoping literature review on traumatic sexualisation in women survivors of CSA. These three

themes were: *negative sexual association*, *negative body image* and *distorted sexual development*. However, one additional sub-theme was found, namely *distorted view of males*, which could be categorised under the main theme *distorted sexual development*.

4.3.3 Overall conclusion.

The overall conclusion drawn from this study is that the changes caused by traumatic sexualisation in the CSA survivors' psycho-sexual development cause on-going life-long challenges for the survivors. The secrecy surrounding CSA as well as people's responses to disclosure enhances the survivors' confusion regarding their own sexual self-concept, sexual norms as well as emotions experienced regarding the abuse. From this study it becomes evident that survivors had developed coping skills manifesting in behaviour aimed at protecting them from further harm.

4.4 Personal Reflection

I became interested in post graduate studies on trauma after my life changed instantly after the death of my spouse and my mother who sustained a head injury during an armed robbery. On this road to find meaning in life changing events, I discovered the S2T collaborative strengths-based group-intervention and research programme that's been making a vast difference in the lives of women who had experienced CSA and related traumas.

Through the study I became aware of the immense challenges survivors of CSA have to face day by day due to this devastating trauma. The secrecy surrounding CSA and therefore the lack of support survivors experience, coupled with the confusion caused by this experience, makes this a unique trauma that affects all aspects of the survivor's life.

Additional, I realised the complexity of CSA and how it affects different systems (individual, family, community, legal) that makes it extremely complicated to prevent and treat.

What surprised me was the development in technology, during the last few years, to utilise in research and how it affects researchers as well as the quality of research, for example the usage of referencing management programmes such as Zotero (Zotero 4.0, 2016), that saved me an immense amount of time on referencing.

The effectiveness of strengths-based intervention and education were demonstrated through the S2T collaborative strengths-based group intervention and research programme, and I shall apply it in future ventures.

4.5 Limitations of this Current Study

The limitations presented by each manuscript are as follows:

4.5.1 Manuscript 1.

The scoping literature review only focused on data from women survivors of CSA. A more comprehensive scoping literature review on studies of both genders might provide further information on the process of traumatic sexualisation. Only empirical studies written in English were included in this study which may have limited the studies found in literature.

More cultural representation within the focus-group / individual interviews may have enhanced the information gathered from the helping professionals working in the field of CSA.

Not all helping professionals could attend the focus-group discussion; thus individual interviews were arranged for those individual helping professionals.

4.5.2 Manuscript 2.

The transcriptions of only two data sets from the S2T collaborative strengths-based group-intervention programme were available during the finalisation of this study. More datasets may have contributed to further reports of traumatic sexualisation. Although the primary research study had different objectives than did this secondary study, the information contained in these datasets were still beneficial to the aim of identifying themes concerning traumatic sexualisation. The researcher did not participate in the collection of the data during the primary study and some information was not clear in the recordings and transcriptions of the data set. The sensitive nature of discussions contributed to this limitation, consequently the primary researchers assisted in clarifying certain aspects of the datasets.

4.6 Contribution of this Study

To the researcher's knowledge, this study provided the first summary of reports of traumatic sexualisation in women survivors of CSA. The findings support and extend Finkelhor and Browne's (1985) seminal framework on traumatic sexualisation due to which survivors experience negative sexual associations, a negative body image as well as a distortion in their sexual development - resulting in intimacy challenges for the rest of their lives. Over and above this, two additional sub-themes emerged during the scoping literature review, namely *hiding the feminine self/body harm* and *self-capacity disturbances*, which appeared to affect the psycho-sexual development and behaviour of CSA survivors. This can inform treatment practice in the identification of CSA. From the findings of the QSA, a third sub-theme of traumatic sexualisation was identified

that wasn't specifically identified as such within literature, namely *distorted view of males*.

4.7 Recommendations for Future Research

This study focused on reports of traumatic sexualisation in women survivors of CSA. Further research on traumatic sexualisation in males is necessary to contribute to the global knowledge base in this specific gender so as to inform treatment practice. Limited research exists on traumatic sexualisation in survivors of CSA; therefore additional research to support the findings of this study will be beneficial.

It is recommended that the findings from this study be incorporated into existing intervention programmes (such as the S2T collaborative strengths-based group-intervention programme) so as to assist CSA survivors in understanding the challenges related to recovery with regards to traumatic sexualisation.

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Addendum A

PROTOCOL - SCOPING REVIEW	
Research question	What could be learned from previous studies on traumatic sexualisation in adult women survivors of Childhood Sexual Abuse (CSA)?
Search strategy	<ul style="list-style-type: none"> ▪ Key terms for search includes: Traumatic sexualisation, Traumatic sexualization, Child sexual abuse, Childhood sexual abuse, Adult women survivors, Adult female survivors ▪ Coverage of the search: Only published articles between 1985 and 2016 will be utilized in the scoping review, because the term traumatic sexualisation was only created by Finkelhor and Brown during the eighties. The scoping review will only cover articles published in English. Articles in other languages will be excluded due to the costs and time constraints involved in the translation of articles. The databases that will be utilized to find research evidence are; EbscoHost (Academic Search Premiere, Africa-Wide Information, E-Journals, ERIC, PsycArticles, PsycINFO, SocINDEX), SAePublications and Science Direct (Social Science and Humanities). Academic journals that will also be reviewed include: Child Abuse and Neglect, Child Abuse Research in South Africa, Child Abuse Review, Journal of Child Sexual Abuse, Sexual Abuse: A Journal of Research and Treatment, and Trauma, Violence and Abuse: A Review Journal. Additional articles as cited in bibliographies of studies found through the database searches will also be utilized. Duplicated articles will be removed.
Study selection and applying inclusion and exclusion criteria	<p>Inclusion criteria: Female survivors of CSA Full text empirical studies Academic Journals</p> <p>Exclusion criteria: Male survivors of CSA Sexual offenders / perpetrators of CSA Substance abuse / dependency and CSA Childbirth / Maternity / Parenting and CSA HIV and CSA Physical pathology and CSA Religion and CSA Child victims / children Non-academic literature</p>
Charting the data	Thematic content analysis
Organizing, summarising and reporting the results	The selected studies will be summarized alphabetically according to themes and sub-themes
Consultations with experts	Focus group discussion with experts in the field of CSA Individual interviews with experts who can't attend the focus group
Limitations	The scoping review does not appraise the quality of evidence. It provides a narrative or descriptive account of available research. The scoping review includes findings from a range of different research methods and study designs.

Addendum B

Identified database and studies for the scoping review

DATA BASE	KEY TERMS	EXCLUSION CRITERIA	STUDIES SELECTION PROCESS
<p>EbscoHost <i>Academic Search Premiere</i> <i>Arica-Wide Information E-Journals</i> <i>ERIC</i> <i>PsycARTICLES</i> <i>PsycINFO</i> <i>SocINDEX,</i></p> <p>SAePublications</p> <p>Science Direct <i>Social Sciences and Humanities.</i></p> <p>Academic journals <i>Child Abuse & Neglect</i> <i>Child Abuse Research in South Africa</i> <i>Child Abuse Review</i> <i>Journal of Child Sexual Abuse</i> <i>Sexual Abuse: A Journal of Research and Treatment; and</i> <i>Trauma</i> <i>Violence and Abuse: A Review Journal</i></p>	<p>(*child sexual abuse* OR *childhood sexual abuse*) AND (*traumatic sexualisation* OR *traumatic sexualization*) AND (*adult women survivors* OR *adult female survivors*) NOT (*perpetrators*) NOT (*offenders*) NOT (*children*) NOT (*child victims*)</p>	<p>Males Perpetrators, Offenders Substance abuse or dependency Childbirth / maternity / parenting HIV / other physical pathology Religion Child victims Non-academic literature</p>	<p>Key terms 54 312 studies</p> <p>Academic Journals 52 790 studies</p> <p>Subject Child sexual abuse Child abuse, sexual Sexual abuse 1 878</p> <p>Publications after duplicates removed 1 341</p> <p>Additional citations 130</p> <p>Publications screened by title and abstract 1 471</p> <p>Full studies assessed 174</p> <p>Studies included in the scoping review 66</p>

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						<ul style="list-style-type: none"> - Higher numbers of unsafe sexual partners - Irresponsible sexual behaviour
2	<p>Batten, S.V., Follette, V.M. & Aban, I.B. (2001)</p> <p><i>Experiential avoidance and high-risk sexual behaviour in survivors of child sexual abuse</i></p>	<p>Reno USA</p>	<p>Quantitative</p> <p>Self-report questionnaires</p> <p>Undergraduate</p> <p>Females (N = 257)</p> <p>CSA (n = 71)</p> <p>Age (M = 20)</p>	<p>Abused until adolescence (18 years)</p> <p>No indication of perpetrator or severity</p> <p>Distinguish between CSA and physical abuse</p>	<p>Negative sexual association</p> <p>Distorted sexual development</p>	<p><i>Aversion & avoidance</i></p> <ul style="list-style-type: none"> - Higher levels of experiential avoidance (style of responding to private events through a process in which a person is unwilling to experience negatively evaluated private events, such as thoughts / feelings / memories through reduction / numbness / alleviation of the experience) <p><i>Sexual recklessness</i></p> <p>High-risk sexual behaviour with persons other than their primary partners</p>
3	<p>Bigras, N., Godbout, N. & Briere, J. (2015)</p> <p><i>Child sexual abuse, sexual anxiety, and sexual</i></p>	<p>Canada, USA</p>	<p>Quantitative study</p> <p>Multivariate analysis of variance</p> <p>Path analysis</p> <p>Questionnaires</p>	<p>Abused until adolescence</p> <p>Severity;</p> <p>Sexual touching (n = 42)</p> <p>Oral contact (n = 13)</p> <p>Penetration (n = 24)</p>	<p>Distorted sexual development</p>	<p><i>Self-capacity disturbance</i></p> <p>CSA cause lasting alterations in;</p> <ul style="list-style-type: none"> - interpersonal relatedness - identity

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	<i>satisfaction: The role of self-capacities</i>		Participants (N = 302) Women (n=257) Men (n=45) Age (>18 yrs.)		Negative sexual association	<ul style="list-style-type: none"> - affect regulation (act of trying to change one's emotional attitude or disposition) <i>Aversion & avoidance</i> - CSA impact negatively on sexual functioning - CSA related to sexual anxiety - Decreased sexual satisfaction Through its association with reduced self-awareness and and to be involved in difficult interpersonal relationships
4	Bird, E.R., Seehuus, M., Clifton, J. & Rellini, A.H. (2014) <i>Dissociation during sex and sexual arousal in women with and without a history of childhood sexual abuse</i>	New York USA	Quantitative Questionnaires and Interviews Women with CSA (n = 37) Women without CSA (n = 22)	Abused before 16 years Severity; Penetration	Negative sexual association	<ul style="list-style-type: none"> <i>Aversion & avoidance</i> - Women with history of CSA experience greater frequency - Dissociation may mediate The relationship between CSA and sexual arousal difficulties - Women without CSA who depersonalized during sex with a partner was associated with lower sexual arousal functioning - Both with and without CSA groups more derealization during sex was associated with higher sexual arousal

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						functioning
5	Briere, J., Smiljanich, K. & Henschel, D. (1994) <i>Sexual fantasies, gender, and molestation history</i>	USA	Quantitative; Questionnaires; University students (N = 314) Males (n = 107) Females (n = 207)		Distorted sexual development	<i>Confusion about sexual norms</i> Sexually abused women reported more fantasies of being sexually forced in than women without a history of sexual abuse
6	Camuso, J. & Rellini, A.H (2010) <i>Sexual fantasies and sexual arousal in women with a history of childhood sexual abuse</i>	USA	Internet-based survey n = 60 female CSA survivors n = 120 women with no history of CSA	Abused before the age of 14 years Severity; Fondling Forced intercourse Oral sex Anal sex	Negative sexual association	<i>Aversion & avoidance</i> CSA group did not report more degrading and violent sexual fantasies than the women without a history of CSA. greater frequency of conventional fantasies (sex with one's partner, sex in unusual positions, oral sex) was associated with greater sexual arousal for both groups
7	Coid, J., Petruckevitch, A., Feder, G., Chung, W., Richardson, J. &	UK	Quantitative Cross-sectional survey Questionnaires	Abused before the age of 16 years Severity; Unwanted sexual intercourse (n = 88)	Distorted sexual development	<i>Revictimisation</i> -CSA substantially increases the risk of re-victimisation in adulthood

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	Moorey, S. (2001) <i>Relation between childhood sexual abuse and physical abuse and risk of revictimisation in women: a cross-sectional survey</i>		Women (N = 1207) Unwanted sexual intercourse in childhood (n = 88) Unwanted sexual activities but not intercourse (n = 116) Physically abused (n = 48) All 3 forms of abuse (n = 17) Age (M = 37.2)	Unwanted sexual activities, but not intercourse (n = 116)		- Women who experienced multiple childhood abuse are at most risk of adult revictimisation
8	Davis, J.L. Petretic-Jackson, P.A. & Ting, L. (2001) <i>Intimacy dysfunction and trauma symptomatology: Long-term correlates of</i>	South Carolina USA	Quantitative Regression analyses Questionnaires Women (N = 315) CSA (n = 58) Physical abused (n = 35)	Abused until adolescence Severity; Only participants who indicated contact experiences was included	Negative sexual association	<i>Sexual anxiety</i> Women who experienced multiple abuse reported greater fear of intimacy Greater anxiety in terms of attachment to their partners were reported by participants who experienced severe CSA Fear of intimacy was positively associated with;

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	<i>different types of child abuse</i>		Both (n = 22) Non abused (n = 200) Age Abused (M = 21.05) Non abused (M = 19.46)			<ul style="list-style-type: none"> - multiple abuse - psychological maltreatment - sexual concerns - dissociation - defensive avoidance
9	Del Castillo, D.D. & Wright, M.O. (2009) <i>The perils and possibilities in disclosing childhood sexual abuse to a romantic partner</i>	Ohio	Qualitative Interviews Women (n = 7) Age (>18)	Abused during childhood Severity; Fondling (n = 2) Digital penetration (n – 2) Penetration and / or Incest (n = 3) Multiple perpetrators (n = 4) Disclosed (n = 5)	Negative sexual association	<p><i>Sexual anxiety</i></p> <ul style="list-style-type: none"> - Difficulty in the management of anxiety that emotional intimacy and sexual activity generate - Women felt they give off signs of having been abused that lead to troubling intrapersonal and interpersonal dynamics - Fear disclosure due to risk of stigmatization <p><i>Disclosure & support</i></p> <p>The amount of control the CSA survivor had over the timing of the disclosure appeared crucial to how she felt about the disclosure experience</p>

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						Women reported that how they felt the romantic partner's response to disclosure was initially supportive, but later feel that the romantic partner was lacking in genuine understanding and therefore would question the romantic partner's support. Women conveyed a need for ongoing support after disclosure
10	Dent-Brown, K. (1993) <i>Child sexual abuse: Problems for adult survivors</i>	UK	Qualitative Factor analysis Clients (N = 36) CSA (n = 18) Non abuses (n = 18) Age: CSA (M = 31.5) Non abused (M = 39.1)	Abused during childhood	Negative sexual association Negative sexual association Distorted sexual development	<i>Aversion & avoidance</i> - Sexual dissatisfaction - Need to please others <i>Flashbacks</i> Experience; - nightmares - flashbacks - gaps in memory <i>Sexual recklessness</i> Survivors reported themselves as being more promiscuous, but in

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						<p>this study the rate of sexual contact was identical to the control group</p> <p>Survivors see themselves as more promiscuous, perhaps due to general low self-esteem reported</p>
11	<p>DiLillo, D & Long, P.J. (1999)</p> <p><i>Perceptions of couple functioning among female survivors of child sexual abuse</i></p>	<p>Columbia USA</p>	<p>Quantitative Questionnaires</p> <p>College women with CSA (n = 51) Without CSA (n = 91)</p> <p>Age (M = 20)</p>	<p>Abused until adolescence (18 years)</p> <p>Severity;</p> <p>CSA survivors had to experience physical contact to be included in the study</p>	<p>Distorted sexual development</p>	<p><i>Confusion around sexual norms</i></p> <p>Survivors of CSA reported significantly less relationship satisfaction, poorer communication, and lower levels of trust in their partners</p>
12	<p>Dyer, A.S., Feldmann, R.E. & Borgmann, E. (2015)</p> <p><i>Body-related emotions in posttraumatic stress disorder following childhood sexual abuse</i></p>	<p>Germany</p>	<p>Quantitative Questionnaires</p> <p>Females (N = 97)</p>	<p>Abused until adolescence</p>	<p>Negative sexual association</p>	<p><i>Flashbacks</i></p> <ul style="list-style-type: none"> - CSA participants reported more areas of their body to be associated with traumatic experiences - Areas associated with highly negative emotions (shame, guilt, anger, disgust) were the pubic area, the buttocks and inner thighs

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			<p>PTSD after CSA (n = 23)</p> <p>Borderline Personality Disorder (n = 25)</p> <p>Both PTSD and BPD (n = 22)</p> <p>Control (n = 27)</p> <p>Age (M = 32.8)</p>		<p>Distorted sexual development</p>	<p>- Specific body area's may act as a trigger for traumatic - and aversive memories</p> <p><i>Self-capacity disturbance</i></p> <p>-Body-related anger is more closely connected to suppressed anger or anger directed towards themselves</p> <p>- CSA participants show significant higher negative emotions regarding their body</p>
13	<p>Easton, S.D., Coohy, C., O'Leary, P., Zhang, Y., & Hua, L. (2011)</p> <p><i>The effect of childhood sexual abuse on psychosexual functioning during adulthood</i></p>	USA	<p>Quantitative</p> <p>Secondary analysis</p> <p>Semi-structured telephone interviews</p> <p>General Estimating Equation</p> <p>CSA adults (N = 165)</p> <p>Females (n = 133)</p> <p>Males (n = 32)</p>	<p>Abused during childhood</p> <p>Severity;</p> <p>Participants had to indicate the</p> <ul style="list-style-type: none"> - frequency - incest - amount of abusers - injuries 	Negative sexual association	<p><i>Aversion & avoidance</i></p> <p>Psychosexual functioning affected when survivors were;</p> <ul style="list-style-type: none"> - older when they were first abused - abused by different perpetrators - injured during the abuse - abused by family members <p>Older children, who understood what was happening to them during the time of the abuse, were more likely than younger children to have problems with;</p> <ul style="list-style-type: none"> - touch during adulthood - fear of sex, especially if they were injured during CSA

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						- being dissatisfied with sex
14	Feinauer, L.L (1989) <i>Sexual dysfunction in women sexually abused as children</i>	USA	Quantitative Mixed method CSA women (N = 57)	Abused until adolescence Severity; Age at time of abuse (M = 7.8) Perpetrators known (n = 54) Frequency – more than weekly (n = 28) Intercourse attempted / completed (n = 42)	Negative sexual association	<i>Aversion & avoidance</i> Orgasm was experienced by 63% of CSA women Significant interaction among these women's ability to be; - An orgasmic, sexual esteem And - Adjustment to the sexual abuse Physical discomfort was experienced by 56% of this population 36% reported challenges in their intimate relationship and needed sex therapy
15	Frías, T.T., Brassard, A. & Shaver, P.R. (2014). <i>Childhood sexual abuse and attachment insecurities as predictors of</i>	Canada	Quantitative Questionnaires French Canadian women (N = 807) CSA (n = 116)	Abused until adolescence	Negative sexual association	<i>Aversion & avoidance</i> A sense of betrayal stemming from CSA predisposes a women to; - Attachment related avoidance (but not anxiety) - Which in turn predisposed her to extradyadic involvement - Evade emotional intimacy - Remain relatively independent of romantic partner

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	women's own and perceived-partner extradyadic involvement		Non-abused (n = 691) Age (M = 22.83)			- Lack of trust
16	Griffing, S., Ragin, D.F., Morrison, S.M., Sage, R.E., Madry, L., & Primm, B.J. (2005) <i>Reasons for returning to abusive relationships: effects of prior victimization</i>	USA	Quantitative Mixed method Females (N = 104) CSA survivors (n = 34) Non CSA survivors (n = 70) Age (M = 26.61)	Abused until adolescence Severity; Multiple perpetrators (n = 6) Abused "many times" (n = 58) Abused "few times" (n = 12) Abused before age of 7 years (n = 45) Perpetrator known (n = 70)	Distorted sexual development	<i>Revictimisation</i> CSA survivors reported a greater number of past separations Decisions to return to an abusive relationship were more than twice as much influenced by emotional attachment to the batterer CSA survivors were more likely to underestimate their vulnerability to return to an abusive relationship and affect long-term decisions to separate from the abusive partner permanently Economic reasons for returning to an abusive partner were the same between the CSA survivors and the control group
17	Kelley, E.L. & Gidycz, C.A. (2015) <i>Differential relationships</i>	Athens, USA	Quantitative Questionnaires Women (N = 710)	Abused during childhood Severity; Rape (n = 22)	Distorted sexual development Negative sexual association	<i>Self-capacity disturbance</i> CSA was related to; - Lower control sexual self-esteem <i>Aversion & avoidance</i>

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	<i>between childhood and adolescent sexual victimization and cognitive – affective sexual appraisals</i>		<p>None CSA (n = 664)</p> <p>CSA (n = 46)</p> <p>None ASA (n = 416)</p> <p>Both CSA & ASA (n = 29)</p> <p>Age (M = 18.93)</p>	<p>Abused during adolescence</p> <p>Severity;</p> <p>Complete rape (n = 54)</p> <p>Attempted rape (n = 130)</p>	Negative body image	<p>Adolescent sexual assault was related to;</p> <ul style="list-style-type: none"> - Greater erotophilia (approach tendencies toward sexual stimuli) or erotophobia (avoidance tendencies toward sexual stimuli) <p><i>Sexual self-concept</i></p> <ul style="list-style-type: none"> - More positive romantic / passionate sexual self-schema - Lower attractiveness sexual self-esteem
18	<p>Kinzi, J.F., Traweger, C. & Biebl, W. (1995)</p> <p><i>Sexual dysfunctions: Relationship to childhood sexual abuse and early family experiences in a non-clinical sample</i></p>	Austria	<p>Quantitative</p> <p>Questionnaires</p> <p>Female university students (N = 202)</p> <p>CSA (n = 44)</p> <p>Age (M = 22)</p>	<p>Abused until adolescence</p> <p>Severity;</p> <p>Perpetrator</p> <ul style="list-style-type: none"> - Immediate family (n = 9) - Extended family (n = 8) - Acquaintance (n = 14) - Stranger (n = 13) <p>Number of sexual assaults</p> <ul style="list-style-type: none"> - Two or more (n = 26) 	Negative sexual association	<p><i>Aversion & avoidance</i></p> <ul style="list-style-type: none"> - More sexual desire- and orgasm disorders report by victims of multiple CSA - Incest were significantly related to any kind of sexual disorder - Women with orgasm disorders more often reported inadequate sex education compared to women with no sexual dysfunction or another sexual dysfunction

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19	<p>Kochka, P. & Carolan, M. (2002)</p> <p><i>Alliance protection: The influence of childhood sexual abuse memories on couple dynamics</i></p>	USA	<p>Case & cross-case analyses</p> <p>Qualitative & quantitative study</p> <p>Interviews</p> <p>Questionnaires</p> <p>n = 6 women</p> <p>n = 3 therapists</p>	<p>Abused between 4 – 15 years</p> <p>Severity;</p> <p>Multiple perpetrators (n = 5)</p> <p>Incest (n = 6)</p>	<p>Negative sexual association</p> <p>Distorted sexual development</p>	<p><i>Flashbacks</i></p> <p>Sexual intimacy problems</p> <p>Sexual dysfunction</p> <p>Distort ability to feel pleasure in Her sexual response</p> <p>Distort sense of mastery & Control that is associated with sexuality</p> <p>Ambivalence about sex</p> <p><i>Confusion around sexual norms</i></p> <p>Interferes with normal attachment & the manner to negotiates relationships</p> <p>Sexually acting out</p> <p>“Alliance protection”</p>
20	<p>Kristensen, E. & Lau, M. (2011)</p> <p><i>Sexual function in women with a history of intrafamilial childhood sexual abuse</i></p>	Denmark	<p>Quantitative</p> <p>Mixed method</p> <p>Cross sectional study design;</p> <p>Clinical interviews & self-administered questionnaires</p> <p>CSA women (N = 158)</p>	<p>Abused during childhood</p> <p>Intrafamilial abuse with physical contact</p>	<p>Negative sexual association</p>	<p><i>Aversion & avoidance</i></p> <ul style="list-style-type: none"> - Unsatisfied with current sexual life - Uncomfortable with physical endearments - Unsatisfied with their body - Orgasmic problems - Women who did not have a trustful adult during childhood had more sexual problems

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					Negative sexual association	<p><i>Sexual pain disorders</i></p> <ul style="list-style-type: none"> - Dyspareunia (pain in genitals or lower abdomen in connection with coitus or other sexual stimulation) - Vaginismus (muscle spasms in vagina so that the penis can't be inserted)
					Negative body image	<p><i>Sexual self-concept</i></p> <p>Women who were dissatisfied with their bodies were significantly more dissatisfied with their sexual life</p>
					Negative sexual association	<p><i>Childhood physical abuse</i></p> <ul style="list-style-type: none"> - More sexual problems - Not comfortable with physical endearment - General psychological distress - <i>Flashbacks</i> in sexual situations
21	Lacelle, C., Hebert, M., Lavoie, F., Vitaro, F., &	Canada	Quantitative study Questionnaires	Abused until adolescence Severity were measured through questions;	Negative body image	<p><i>Sexual self-concept</i></p> <p>Negative sexual self-concept</p>

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	<p>Tremblay, R.E. (2012)</p> <p><i>Child sexual abuse and women's sexual health: The contribution of CSA severity and exposure to multiple forms of childhood victimization</i></p>		<p>Interviews</p> <p>Regression analyses</p> <p>N = 889 young women</p> <p>n = 275 no victimization</p> <p>n = 73 CSA only</p> <p>n = 147 any single victimization other than CSA</p> <p>n = 187 cumulative victimization other than CSA</p> <p>n = 69 CSA with single victimization</p> <p>n = 138 CSA with cumulative victimization</p>	<ul style="list-style-type: none"> - Exhibitionism - Touching / fondling - Penetration / attempted penetration 	<p>Negative sexual association</p> <p>Distorted sexual development</p>	<p><i>Aversion & avoidance</i></p> <p>Sexual problems</p> <p><i>Sexual recklessness</i></p> <p>Sexual risky behaviour</p> <p>"Over-sexualization" of relationships</p> <p><i>Revictimisation</i></p> <p>Multiple forms of victimisation</p>
22	<p>Lemieux, S.R. & Byers, E.S. (2008)</p> <p><i>The sexual well-being of women who have</i></p>	Canada	<p>Quantitative</p> <p>Questionnaires</p> <p>Female university students (n = 270)</p>	<p>Abused during childhood (before 16 years)</p> <p>Severity;</p> <ul style="list-style-type: none"> - Fondling (n = 41) - Penetration / attempted penetration (n = 166) 	<p>Negative sexual association</p> <p>Distorted sexual development</p>	<p><i>Aversion & avoidance</i></p> <p>Fondling was not associated with adverse sexual outcomes</p> <p>Sexual penetration was associated with;</p>

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						Higher levels of relationship violence associated with lower levels of sexual functioning
24	Liu, C.M. & Lester, D. (2012) <i>Body modification sites and abuse history</i>	USA	Quantitative study Online questionnaires Participants (N = 4 690) Men (n = 2078) Women (n = 2581) Sexually abused women (n = 524) Age: 6 – 24 years	Abused during childhood	Negative body image	<i>Body harm</i> Body modification Genital piercing Pubic tattoos Pubic scarification
25	MacIntosh, H.B. & Johnson, S. (2008) <i>Emotionally focused therapy for couples and</i>	Canada	Qualitative Thematic analysis Audio-taped sessions – couple therapy Couples (N = 10)	Abused until adolescence	Distorted sexual development	<i>Self-capacity disturbance</i> - CSA struggles with affect dysregulation, hypervigilance and self-capacities

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	<i>childhood sexual abuse survivors</i>		<p>CSA female survivors (n = 10)</p> <p>Age: CSA (M = 40.50) Non-CSA (M = 43)</p>			
26	<p>Maker, A.M., Kemmelmeier, M. & Peterson, C. (2001)</p> <p><i>Child sexual abuse, peer sexual abuse, and sexual assault in adulthood: A Multi-Risk Model of Revictimization</i></p>	USA	<p>Quantitative Multi-Risk Model</p> <p>Women (N = 131)</p> <p>CSA (n = 11)</p> <p>PSA (n = 11)</p> <p>ASA (n = 26)</p> <p>ASA & CSA (n = 21)</p> <p>ASA & PSA (n = 15)</p> <p>None (n = 42)</p> <p>Age (M = 22.2)</p>	<p>Abused before 16 years</p> <p>Severity of abuse was measured</p>	Distorted sexual development	<p><i>Revictimization</i></p> <p>CSA occurring before the age of 16 years was the only predictor of later sexual assault among severity of CSA, number of CSA perpetrators, and age at onset of CSA</p>

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27	<p>Matorin, A.I. & Lynn, S.J. (1998)</p> <p><i>The development of a measure of correlates of child sexual abuse: The Traumatic Sexualization Survey</i></p>	<p>Athens USA</p>	<p>Quantitative Surveys</p> <p>Undergraduate females (N = 540)</p> <p>CSA (n = 99)</p> <p>Physical abuse (n = 44)</p> <p>Both (n = 43)</p> <p>Non-abused (n = 265)</p>	<p>Abused during childhood</p> <p>Severity;</p> <ul style="list-style-type: none"> - Penetration (n = 10) - Attempted penetration (n = 10) - Fondling (n = 16) - Incest (n = 13) 	<p>Negative sexual association</p> <p>Negative sexual association</p> <p>Distorted sexual development</p>	<p><i>Sexual anxiety</i></p> <p>The scale measured the following factors;</p> <p>Avoidance and fear of sexual and physical intimacy</p> <p>Similar results in all the groups</p> <p><i>Flashbacks</i></p> <p>CSA women and physically abused women reported more;</p> <ul style="list-style-type: none"> - frequent intrusive thoughts about sex than non-abused women - Flashbacks and preoccupation with sexual issues <p><i>Sexual recklessness</i></p> <p>CSA women scored higher than the control group indicating the fulfilment of social and personal needs such as acceptance, self-confidence and intimacy. This factor also indicates behaviour such as building relationships with men on sex</p>
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						<ul style="list-style-type: none"> - CSA women may have distorted views of their sexuality and the role it plays in relationships with men - More dysfunctional sexual behaviour
28	<p>Merrill, L.L., Gulmond, J.M., Thomsen, C.J., Milner, J.S. (2003)</p> <p><i>Child sexual abuse and number of sexual partners in young women: The role of abuse severity, coping style and sexual functioning</i></p>	California	<p>Quantitative Questionnaires</p> <p>Females (N = 5 226)</p> <p>CSA (n = 547)</p> <p>Age (M = 19.27)</p>	<p>Abused until adolescence</p> <p>Severity;</p> <ul style="list-style-type: none"> - Intercourse (64%) - Force / threats (62%) - Father / Stepfather (21%) - More than 1 perpetrator (26%) - More than 5 incidents (53%) 	<p>Negative sexual association</p> <p>Distorted sexual development</p>	<p><i>Aversion & avoidance</i></p> <p>The greater the severity of CSA, the greater the use of both avoidant and self-destructive coping strategies</p> <p><i>Sexual recklessness</i></p> <p>Self-destructive coping in response to CSA was positively associated with;</p> <ul style="list-style-type: none"> - Dysfunctional sexual behaviour - Number of sex partners <p>CSA survivors who initially cope with abuse in self-destructive ways may be prone to continue use of self-destructive coping strategies, like;</p> <ul style="list-style-type: none"> - Engaging in dysfunctional sexual behaviour - Having sex with multiple partners

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						Greater severity abuse, reported greater use of avoidant & self-destructive coping strategies
29	Merrill, L.L., Newell, C.E., Thomsen, C.J., Gold, S.R., Milner, J.S., Koss, M.P., & Rosswork, S.G. (1999) <i>Childhood abuse and sexual revictimization in a female navy recruit sample</i>	USA	Quantitative Questionnaires Females (N = 1887) Child Physical Abuse (n = 755) CSA (n = 740) Age (M = 20.57)	Abused during childhood Severity; - Raped (35%) - Attempted rape (8%)	Distorted sexual development	<i>Revictimisation</i> CSA women were 5.12 times more likely to have been raped than women with no history of CSA CSA in comparison to CPA is a much stronger predictor of rape Women who had experienced both CSA and CPA were at greater risk of revictimization
30	Meston, C.M., Heiman, J.R., & Trapnell, P.D. (1999) <i>The relations between early abuse and adult sexuality</i>	UK	Quantitative Questionnaires Undergraduates (N = 1032) Males (n = 376) Females (n = 656)	Abused before the age of 18 years Severity of abuse was measured	Distorted sexual development	<i>Sexual recklessness</i> In this study sexual abuse was associated with; - more lavish sexual attitudes and behaviour, as demonstrated by a higher frequency of intercourse and masturbation, - a greater range of sexual fantasies, - more sexual experience,

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						<ul style="list-style-type: none"> - engagement in unrestricted sexual behaviour <p><i>Revictimisation</i></p> <p>CSA increased risk of sexual revictimization as adults</p>
31	<p>Meston, C.M. & Heiman, J.R. (2000)</p> <p><i>Sexual abuse and sexual function: An examination of sexually relevant cognitive processes</i></p>	USA	<p>Quantitative</p> <p>Mixed method</p> <p>Sexually abused women (n = 61)</p> <p>Control group (n = 57)</p>	<p>Abused until adolescence</p> <p>Severity;</p> <p>Abuse during childhood</p> <ul style="list-style-type: none"> - Forced intercourse (24%) - Oral-genital sexual relations (34%) - Fondling (47%) - Acquaintance (24%) - Family member (72%) - Stranger (4%) <p>Abuse during adolescence</p> <ul style="list-style-type: none"> - Forced intercourse (37%) - Oral-genital sexual relations (24%) - Fondling (37%) - Acquaintance (28%) - Family member (40%) - Stranger (7%) - Dating partner (25%) 	Negative body image	<p><i>Sexual self-concept</i></p> <p>Sexually abused women were more likely than the non-abused women to;</p> <ul style="list-style-type: none"> - describe themselves in negative terms - to give a positive meaning to sexual behaviour words - Sexually abused women and non-abused women did not differ in how they compartmentalized positive / negative self-information - CSA shape a women's world view and frame of reference - Created negative associations with sexuality - CSA women describe themselves in negative terms

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32	<p>Meston, C.M., Rellini, A.H., & Heiman, J.R. (2006)</p> <p><i>Women's history of sexual abuse, their sexuality, and sexual self-schemas</i></p>	USA	<p>Quantitative Questionnaires</p> <p>Female survivors (n = 48)</p> <p>Female control participants (n = 71)</p> <p>Age (21 – 40 years)</p>	<p>Abused before the age of 16 years</p> <p>Severity was measured</p>	<p>Negative body image</p> <p>Negative sexual association</p>	<p><i>Sexual self-concept</i></p> <p>CSA survivors;</p> <ul style="list-style-type: none"> - See themselves as less romantic and passionate - Showed an opposite relationship between romantic / passionate sexual self-schemas - Experience distress during sexual arousal - Symptoms of depression and anxiety was independent from negative sexual affect
33	<p>Murray, C.D., MacDonald, S. & Fox, J. (2008)</p> <p><i>Body satisfaction, eating disorders and suicide ideation in an Internet sample of self-harmers reporting and not reporting childhood sexual abuse</i></p>	Man- chester UK	<p>Quantitative On line web questionnaires</p> <p>Participants (N = 113)</p> <p>Female (n = 104)</p> <p>Male (n = 9)</p> <p>Age (M = 19.92)</p>	<p>Abused during childhood</p>	<p>Negative body image</p>	<p><i>Body harm</i></p> <p>Self-harmers with a history of CSA scored higher on measures of;</p> <ul style="list-style-type: none"> - Body dissatisfaction <p><i>Hiding the feminine self</i></p> <ul style="list-style-type: none"> - Eating disorders

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34	<p>Najman, J.M., Dunn, M.P., Purdie, D.M, Boyle, F.M., & Coxeter, P.D. (2005)</p> <p><i>Sexual abuse in childhood and sexual dysfunction in adulthood: An Australian population-based study</i></p>	Austria	<p>Quantitative Mixed method</p> <p>CSA;</p> <p>Male (n = 859) Female (n = 898)</p> <p>Age (>18 years)</p>	<p>Abused during childhood</p> <p>Severity;</p> <ul style="list-style-type: none"> - Fondling (n = 75) - Oral sex (n = 97) - Vaginal sex (n = 96) - Attempted vaginal sex (n = 91) 	<p>Negative sexual association</p> <p>Distorted sexual development</p>	<p><i>Aversion & avoidance</i></p> <p>CSA had a greater impact on the self-reported sexual functioning of women in comparison to men</p> <p>CSA appears to lead to impaired sexual functioning</p> <p>Impaired sexual functioning has been associated with reduced emotional and physical pleasure derived from sex</p> <p><i>Sexual recklessness</i></p> <p>CSA is associated with obtaining more sexual partners at a younger age, but not when she is older</p>
35	<p>Noll, J.G., Trickett, P.K. & Putnam, F.W. (2003)</p> <p><i>A prospective investigation of the impact of childhood sexual abuse on the</i></p>	Washing- ton USA	<p>Quantitative Longitudinal, prospective study Mixed method Cross sectional analyses</p> <p>CSA women</p>	<p>Abused to the age of 16 years</p> <p>Abused by known perpetrator</p> <p>Support received upon disclosure</p>	Negative sexual association	<p>Aversion & avoidance</p> <ul style="list-style-type: none"> - Sexual aversion was linked to childhood sexual behaviour difficulties - Sexual ambivalence (simultaneous sexual preoccupation and sexual aversion) was associated with pathological dissociation - Greater sexual ambivalence and sexual aversion was associated

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	<i>development of sexuality</i>		(n = 77) Comparison women (n = 89) Age (M = 20.41)		Distorted sexual development	with biological father sexual abuse <i>Sexual recklessness</i> Sexual preoccupation was predicted by anxiety Abused participants experienced; - Increased sexual preoccupation - First voluntary intercourse at a younger age - Birth control issues resulting in teen pregnancies
36	Painter, S.G. & Howell, C.C. (1999) <i>Rage and women's sexuality after childhood sexual abuse: A Phenomenological study</i>	Atlanta USA	Qualitative Guided interview method Women (N = 7) Age (>18 years)	Abused during childhood Severity discussed during interviews	Distorted sexual development Negative body image	<i>Revictimisation</i> - Patterns of abuse are recreated - Becoming involved with abusive relationships - Externalized rage is unacceptable <i>Sexual self-concept</i> Triggered when; - Felt dehumanized

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						<ul style="list-style-type: none"> - Boundaries violated - Viewed as a sexual object - Felt not permitted to control their sexual experiences <p><i>Body harm</i></p> <p>Displayed through;</p> <ul style="list-style-type: none"> - Anger directed inward (self-harm) - Re-enactment behaviour <p><i>Aversion & avoidance</i></p> <ul style="list-style-type: none"> - Associate intimacy with pain and confusion - Connect adult sexual experiences with rage
					Negative sexual association	
					Distorted sexual development	<p><i>Confusion around sexual norms</i></p> <p>Develop distrust</p> <p>Taught them new way to think about;</p> <ul style="list-style-type: none"> - themselves

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						<ul style="list-style-type: none"> - intimate relationships - trust and safety
37	<p>Pistorello, J. & Follette, V.M. (1998)</p> <p><i>Childhood sexual abuse and couples' relationships: Female survivors' reports in therapy groups</i></p>	Reno	<p>Qualitative Interviews</p> <p>Analyse therapy videotapes</p> <p>Female survivors (n = 55)</p> <p>Age (M = 33)</p>	<p>Abused during childhood</p> <p>Severity;</p> <ul style="list-style-type: none"> - Penetration (50%) <p>Abused by;</p> <ul style="list-style-type: none"> - Father (32%) - Stepfather (29%) - Brother (11%) - Other family member (10%) - Acquaintance (9%) - Unknown (9%) 	Distorted sexual development	<p><i>Self-capacity disturbances</i></p> <p>Survivors experience difficulties with;</p> <ul style="list-style-type: none"> - emotional communication and intimacy - Low emotional expressiveness - An excess or lack of control within the relationship - Discussing aspects of the abuse history - To tolerate emotional closeness <p>CSA survivors having difficulty discussing emotions and being intimate in relationships had be abused at an earlier age and for a longer period of time</p> <p>Issues of control were more likely to be discussed by group member who thought that a non-perpetrating parental figure was</p>

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						aware of the ongoing abuse and did not intervene
38	Reavey, P. & Brown, S.D. (2009) <i>The mediating role of objects in recollections of adult women survivors of child sexual abuse</i>	UK	Qualitative Interviews Analytic approach CSA women (n = 11)	Abused during childhood	Negative sexual association	<i>Flashbacks</i> Recollections have to negotiate issues of incidence and intentionality in the past as well as the potential contribution made by non-human participants, e.g. objects and spaces.
39	Rellini, A.H. & Meston, C.M (2006) <i>Psychophysiological sexual arousal in women with a history of child sexual abuse</i>	Texas, USA	Qualitative Interviews Women (N = 28) CSA (n = 8) PTSD (n = 10) Control (n = 10)	Abused during childhood	Negative sexual association	<i>Sexual anxiety</i> CSA survivors displayed higher baseline Sympathetic Nervous System (SNS) activity, that plays a role in female physiological sexual arousal Excessive SNS activity may have a detrimental effect on physiological sexual arousal
40	Rellini, A.H. & Meston, C.M. (2011)	Burlington USA	Quantitative Mixed method	Abused before the age of 16 years Severity; Touching or penetration of genitals	Negative sexual association	<i>Aversion & avoidance</i> - CSA survivors reported negative affect prior to sexual stimuli leading to lower sexual satisfaction

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	<i>Sexual self-schemas, sexual dysfunction, and the sexual responses of women with a history of childhood sexual abuse</i>		Women (N = 96) Women with history of CSA (n = 48) Without (n = 48)			- Sexual self-schemas affects sexual satisfaction
41	Rellini, A.H. & Meston, C.M. (2007) <i>Sexual desire and linguistic analysis: A comparison of sexually abused and non-abuse women</i>	USA	Qualitative Mixed method - Questionnaires - Picture essay - Linguistic analysis Women with CSA history (n = 27) Women with no history of CSA (n = 22)	Abused during childhood	Negative body image Negative sexual association	<i>Sexual self-concept</i> - In comparison to the control group, women with a history of CSA used more negative emotions words when writing about sexual topics, but not non-sexual topics - CSA women used more sex words when writing about the non-sexual topics - The frequency in the usage of body and sex words in the sexual texts were positively linked to levels of sexual desire function. This association was not different between CSA women and the control group - A history of CSA remained an independent predictor of levels of sexual desire dysfunction

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					Negative sexual association	<i>Aversion & avoidance</i> - Women avoid intimate relationships - Fearful and distrustful of men - Negative sexual effects
43	Romans, S.E., Martin, J.L., Morris, E.M. & Harrison, K. (1998) <i>Tattoos, childhood sexual abuse and adult psychiatric disorder in women</i>	New Zealand	Cross-sectional study Interviews Personality Diagnostic Questionnaires Women (N = 354) Tattooed women (n = 10) Non-tattooed women (n = 344) Women with CSA (n = 173)	Abused before the age of 16 years	Negative body image	<i>Hiding the feminine self / body harm</i> Tattoos in women are statistically linked to CSA, and to later psychopathology in some women
44	Roth, S. & Lebowitz, L. (1988)	Durham USA	Qualitative Interviews	Abused in childhood and / or adolescence and / or adulthood Known and unknown perpetrators	Distorted sexual development	<i>Self-capacity disturbances</i> Overwhelming affect; - Loss of sense of self (feeling of being out of control of one's life)

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	<i>The experience of sexual trauma</i>		Women (n = 7)	Vaginally or orally raped by perpetrator	Negative body image	<ul style="list-style-type: none"> - Loss of boundaries that defines the self (physical and psychological boundaries violated) <p>Helplessness is likely to be present due to the elimination of the victim's choice in the act</p> <p>Rage might be suppressed due to;</p> <ul style="list-style-type: none"> - Fear of the perpetrator - Fear for the consequences of their actions should they express feelings of rage - Feelings of helplessness and loss of control - Fear of being overwhelmed by affect that might lead to hesitation to disclose - Suppression of these feelings are associated with dissociation, the usage of defence mechanisms and self-blame <p><i>Feeling like a sexual object</i></p> <p>Loss of basic operating schemas leads the individual to search for new ways to make sense of their experience</p>
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						May lead to destructive paradoxes e.g. I am an object, men have the right to use me
45	Sarwer, D.B. & Durlak, J.A. (1996). <i>Childhood sexual abuse as a predictor of adult female sexual dysfunction: A study of couples seeking sex therapy</i>	Chicago USA	Quantitative Interviews Discriminant function analyses Married women (N = 359) Sexually abused (n = 73) Sexually non-abused (n = 286) Sexual dysfunction (n = 182) Age (M = 40.51)	Abused until adolescence	Negative sexual association	<i>Aversion & avoidance</i> Of the 73 sexually abuse women; - 46 (63%) had a sexual dysfunction - 27 (37%) diagnosed with Hypoactive sexual desire disorder (HSDD) - 15 (21%) orgasmic disorder - 4 (5%) vaginismus or dyspareunia - 27 (37%) no dysfunction diagnosed Of the 286 non-abused women; - 136 (47%) had a sexual dysfunction - 97 (34%) diagnosed with HSDD - 19 (6.6%) orgasmic disorder - 20 (7%) vaginismus or dyspareunia - 150 (52%) no dysfunction diagnosed Sexual penetration during childhood specifically associated

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						with sexual dysfunction in women survivors of CSA
46	Schloretdt, K.A. & Heiman, J.R. (2003) <i>Perceptions of sexuality as related to sexual functioning and sexual risk in women with different types of childhood abuse histories</i>	Washington USA	Quantitative Structural Analysis of Social Behavior Model Questionnaires Women (N = 148) CSA (n = 26) CSA & Physical abuse (n = 44) None (n = 78) Age (21 – 40 years)	Abused during childhood Severity; - More than one perpetrator (43%) - Perpetrator parent / step parent (34.6%) - Perpetrator other family member (23.1%) - Intercourse (19.1%)	Negative sexual association Distorted sexual development	<i>Aversion & avoidance</i> Women with abuse histories Reported more negative affect (e.g. fear, anger, disgust) during sexual arousal <i>Sexual recklessness</i> More lifetime vaginal intercourse Partners in comparison to Non-abused women
47	Seehuus, M., Clifton, J. & Rellini, A.H. (2015) <i>The role of family environment and multiple forms of childhood abuse in the shaping of</i>	USA	Quantitative Cross-sectional study Heterosexual women (n = 417) Age (18 – 25 yrs.)	Abused during childhood	Distorted sexual development	<i>Aversion & avoidance</i> Affected by; - family dynamics - type of childhood abuse Mediated by; - Sexual self-schemas - Romantic relationship quality

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	<i>sexual function and satisfaction in women</i>				Negative body image	<i>Sexual self-concept</i> Important cognitive mechanism in the sexual development of women
48	Senn, T.E., Carey, M.P., Venable, P.A., Coury-Doniger, P. & Urber, M. (2007) <i>Characteristics of sexual abuse in childhood and adolescence influence sexual risk behaviour in adulthood</i>	New York USA	Quantitative Questionnaires Participants (N = 1177) Women (n = 534) Men (n = 643)	Abused before the age of 13 years Severity were measured	Distorted sexual development	<i>Sexual recklessness</i> CSA participants involved in penetration and/or force; -Reported more adult sexual risk behaviour - higher amount of lifetime Partners - higher number of previous STI diagnoses - Women abused with penetration, regardless of whether the abuse involved force, reported the most episodes of sex trading
49	Senn, T.E., Carey, M.P., & Coury-Doniger, P. (2012) <i>Mediators of the relation between childhood sexual abuse and</i>	Netherlands	Quantitative Computerized survey Behavioural simulations Women (N = 481)	Abused during childhood	Distorted sexual development	<i>Sexual recklessness</i> - Sexual risk behaviour in adulthood - Traumagenic dynamics model constructs better mediated the relation between CSA and the number of sexual partners - The traumagenic dynamics

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	<i>women's sexual risk behaviour: a comparison of two theoretical frameworks</i>		CSA women (n = 216)			model and the information-motivation-behavioural skills model constructs did not differ in their ability to mediate the relation between CSA and unprotected sex
50	Senn, T.E., Carey, M.P., & Coury-Doniger, P. (2011) <i>Self-defining as sexually abused and adult sexual risk behaviour: Results from a cross-sectional survey of women attending an STD clinic</i>	USA	Quantitative Mixed method Interviews Questionnaires Women recruited from a STD Clinic (N = 481) CSA (n = 206) Age (M = 27.5)	Abused before the age of 13 years Severity were measured	Distorted sexual development	<i>Sexual recklessness</i> CSA women reported more; <ul style="list-style-type: none">- Traumatic sexualisation- More trust of a partner- More powerlessness- Less sexual guilt- More episodes of unprotected sex- More sex partners- Greater likelihood of sex trading
51	Siegel, J.A. & Williams, L.M. (2003) <i>Risk factors for sexual victimization of women: results</i>	USA	Qualitative Interviews Prospective study Women (N = 496) CSA (n = 206)	Abused before the age of 13 years Severity of abuse was measured	Distorted sexual development	<i>Revictimisation</i> The combination of CSA and adolescent abuse were associated with a much Greater risk of adult sexual Victimization than other women

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	<i>from a prospective study</i>					
52	<p>Simmel, C., Postmus, J.L. & Lee, I. (2012)</p> <p><i>Sexual revictimization in adult women: examining factors associated with their childhood and adulthood experiences</i></p>	USA	<p>Quantitative; Univariate and multivariate analyses; Interviews</p> <p>Adult women (n = 234) Age (M = 36)</p>	<p>Abused during childhood</p> <p>Severity of abuse was measured</p> <p>After disclosure, no action was taken (50%)</p>	Distorted sexual development	<p>Revictimisation</p> <p>CSA experience associated with;</p> <ul style="list-style-type: none"> - Children's decisions to disclose - In adult revictimization experiences - Adulthood disclosure about re-victimization only when there was no action taken upon disclosure as a child
53	<p>Smith, H.A., Markovic, N, Danielson, M.E., Matthews, A., Youk, A., Talbott, E.O., Larkby, C. & Huges, T. (2010)</p> <p><i>Sexual abuse, sexual orientation, and obesity in women</i></p>	USA	<p>Quantitative</p> <p>Multiple logistics regression analyses</p> <p>n = 392 heterosexual women n = 475 lesbian women</p>	<p>Abused until adolescence</p> <p>Severity of abuse was measured</p>	Negative body image	<p><i>Hiding the feminine self</i></p> <p>Lesbian women may be at greater risk of obesity than heterosexual women</p> <p>Intra-familial CSA – regardless of sexual orientation – play a role in the development of obesity</p>

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54	<p>Staples, J., Rellini, A.H. & Roberts, S.P. (2012)</p> <p><i>Avoiding experiences: Sexual dysfunction in women with a history of sexual abuse in childhood and adolescence</i></p>	USA	<p>Qualitative</p> <p>Questionnaires</p> <p>With CSA history (n = 32)</p> <p>Without (n = 22)</p> <p>Age</p> <p>With CSA history (M = 30.25)</p> <p>Without (M = 27.6)</p>	<p>Abused before the age of 16 years</p> <p>Severity of abuse was measured</p>	<p>Negative sexual association</p> <p>Distorted sexual development</p>	<p><i>Aversion & avoidance</i></p> <p>The greater the severity of sexual abuse, the stronger the negative relationship between avoidance and orgasm function</p> <p>Avoidant behaviour (e.g. substance abuse, dissociation, emotional suppression) would negatively affect orgasm functioning</p> <p><i>Sexual recklessness</i></p> <ul style="list-style-type: none"> - More severe CSA histories have on average more lifetime partners - High frequency of sexual activities can coexist with a tendency to avoid interpersonal connectedness and to use avoidance behaviours
55	<p>Stephenson, K.R., Pulverman, C.S. & Meston, C.M. (2014)</p> <p><i>Assessing the association</i></p>	USA	<p>Quantitative study</p> <p>Questionnaires – Self-report instruments</p> <p>N=238</p>	<p>Abused before the age of 16 years</p> <p>Severity of abuse was measured</p>	<p>Negative sexual association</p>	<p><i>Aversion & avoidance</i></p> <p>Women with CSA exhibited stronger associations between perceived sexual compatibility with partners and sexual communication</p> <p>Exhibited weaker associations</p>

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	<i>between childhood sexual abuse and adult sexual experiences in women with sexual difficulties</i>		CSA women (n=134) Non-sexually abused women (n=104)			between perceived sexual compatibility and personal concern regarding sexual difficulties CSA produced a larger effect on sexual satisfaction than sexual function
56	Swaby, A.N. & Morgan, K.A.D. (2009) <i>The relationship between childhood sexual abuse and sexual dysfunction in Jamaican adults</i>	Jamaica	Qualitative Questionnaires Adults (n = 100) Females (n = 70) Males (n = 30) Abused females (n = 35) Abused males (n = 15) Age (M = 23)	Abused until adolescence	Negative sexual association	<i>Aversion & avoidance</i> - Sexual disruption - More dysfunction in intimate relationships - Abused and non-abused groups experienced similar sexual arousal, sexual behaviour and cognition - Impairment in the gratification derived from sexual acts in the abused group - Impaired overall sexual satisfaction - Older children suffer greater sexual dysfunction than younger at the time of abuse - Quality and frequency of orgasms decreases as the age of the abuse victim increases

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						<p>- Older children, when abused, have greater difficulties in their ability to initiate and maintain relationships with their partners</p> <p><i>Sexual anxiety</i></p> <p>- Experience difficulty in sexual climax / orgasm that often result in anxiety and feelings of guilt</p> <p><i>Revictimisation</i></p> <p>- CSA survivors more likely to Experience sexual abuse repeatedly</p>
57	<p>Tapia, N.D. (2014)</p> <p><i>Survivors of child sexual abuse and predictors of adult re-victimization in the United States: A forward logistic</i></p>	USA	<p>Quantitative</p> <p>Prospective study – Secondary analyses</p> <p>Interviews</p> <p>CSA women (n = 114)</p> <p>Comparison women (n = 60)</p>	<p>Abused before the age of 12 years</p> <p>Severity measured through;</p> <ul style="list-style-type: none"> - Perpetrator was a relative - Penetration - Force involved - Self-blame 	Distorted sexual development	<p><i>Revictimisation</i></p> <p>Self-blame & severity in terms of physical force / penetration in childhood predict adult revictimisation</p>

TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

	<i>regression analysis</i>					
58	Træen, B., & Sørensen, D. (2008) <i>A qualitative study of how survivors of sexual, psychological and physical abuse manage sexuality and desire</i>	Norway	Qualitative study Interviews N = 22 Women (n = 18) Men (n = 4)	Abused until adolescence	Negative sexual association	<i>Aversion & avoidance</i> - Lack of self-appreciation and shame affects intimacy & sexual desire - Sexual development and early perception of self and body, seems to influence the way an adult experiences sexual desire - Reduced sexual desire - Intimacy problems - Negative sexual affect during sexual arousal Feelings of shame for being who one is, feeling shame for sex and for the subsequent intimacy problem shame causes Learn love and emotional intimacy are connected to the possibility of being rejected, therefore fear for intimacy developed
59	Ulloa, E.C., Baerresen, K., & Hokoda, A. (2009)	California USA	Quantitative Questionnaires	Abused before the age of 18 years Severity of abuse was measured	Distorted sexual development	<i>Revictimisation</i> Women who reported CSA were more likely to report experiences of dating violence

TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

	<i>Fear as a mediator for the relationship between child sexual abuse and victimization of relationship violence</i>		College women (N = 327) Age (M = 19.64)			<p>The skills needed to cope with threatening / frightening events are not learned and are therefore less accessible in threatening situations</p> <p>CSA was found to be positively associated with fear in dating relationships and with dating violence victimization, fear was associated with dating violence victimization, and the effect of CSA on dating violence victimization scores was reduced after controlling for fear</p> <p><i>Self-capacity disturbance</i></p> <p>Functioning is inhibited when a child has experienced unresolved fear and this inhibited functioning tends to continue into adulthood</p>
60	Vaillancourt-Morel, M., Godbout, N., Labadie, C. Runtz, M. & Sabourin, S. (2015)	Canada	Quantitative Questionnaires Path analyses and structural equation analyses	Abused during childhood	Negative sexual association Distorted sexual development	<p><i>Aversion & avoidance</i></p> <p>CSA was associated with more sexual avoidance</p> <p><i>Sexual recklessness</i></p>

TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

	<i>Avoidant and compulsive sexual behaviours in male and female survivors of childhood sexual abuse</i>		Adults (N = 686) CSA women (n = 137) CSA men (n = 130)			CSA was associated with more sexual compulsivity which in turn predicted lower couple adjustment
61	Vaillancourt-Morel, M., Godbout, N., Sabourin, S., Briere, J., Lussier, Y, & Runtz, M. (2016) <i>Adult sexual outcomes of child sexual abuse vary according to relationship status</i>	Canada	Quantitative Questionnaires Participants (N = 1475) Women (n = 760) Men (n = 273) CSA women (n = 163) CSA men (n = 59) Age (M = 27.5)	Abused until adolescence Participants reported abuse by; - Family member (n = 153) - Non-family member (n = 27) - Unknown (n = 20) Severity of abuse; - Fondling / touching (n = 124) - No physical contact (n = 22) - Oral sex (n = 32) - Penetration (n = 40)	Negative sexual association Distorted sexual development	<i>Aversion & avoidance</i> CSA was associated with more sexual avoidance <i>Sexual recklessness</i> CSA was associated with more sexual compulsivity, which in turn predicted lower couple adjustment

TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

62	<p>Valdez, C.E., Lim, B.H., Lilly, M.M. (2013)</p> <p><i>"It's going to make the whole tower crooked": Victimization trajectories in IPV</i></p>	USA	<p>Qualitative study Mixed method Thematic analyses</p> <p>Women (N = 50)</p> <p>Intimate partner victimization (IPV) women (n = 23)</p> <p>Age (M = 32)</p>	<p>Abused during childhood Abused by known perpetrator</p>	Distorted sexual development	<p><i>Revictimisation</i></p> <p>Due to;</p> <ul style="list-style-type: none"> - Learned pattern of abuse and violence stemmed from childhood - Survivors held problematic interpersonal schemas - Internalized a negative view of others - Mistrusting other people - Tolerating abuse within their romantic relationships <p>Negative interpersonal schemas learned in childhood and carried over into romantic relationships contribute to;</p> <ul style="list-style-type: none"> - Sense of learned helplessness - Tolerance of abuse by a romantic partner <p>Emotional trauma in childhood lead to internalized feelings of guilt. An internalized negative view of self in conjunction with a fear of loneliness may have made many of these women vulnerable to tolerating the physical abuse at the hands of a romantic partner</p>
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TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

						<p>behaviours and are less satisfied with their ability to manage their sexual relationships</p> <p>Women with a history of CSA do not indicate higher levels of dysfunctional or uncommitted sexual behaviours when compared to women without a history of CSA</p>
64	<p>Van Roode, T., Dickson, N., Herbison, P. & Paul, C. (2009)</p> <p><i>Child sexual abuse and persistence of risky sexual behaviours and negative sexual outcomes over adulthood: Findings from a birth cohort</i></p>	New Zealand	<p>Quantitative Longitudinal study Questionnaires</p> <p>Women (n = 465) Men (n = 471)</p>	<p>Abused until adolescence Severity; Contact CSA (30.3%)</p>	Distorted sexual development	<p><i>Sexual recklessness</i></p> <p>For abused women increased rates in the following were observed;</p> <ul style="list-style-type: none"> - Number of sexual partners - Unhappy pregnancies - Abortion - Sexually transmitted infections <p>The profound early impact of CSA for women appears to lessen with age</p>
65	<p>Wang, Y. & Heppner, P.P. (2011)</p>	Taiwan	<p>Qualitative Mixed method</p>	<p>Abused before the age of 12 years Abused by known perpetrator</p>	Negative sexual association	<p><i>Aversion & avoidance</i></p> <p>CSA survivors indicated the following;</p>

TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

	<p><i>A qualitative study of childhood sexual abuse survivors in Taiwan: Toward a transactional and ecological model of coping</i></p>		<p>CSA females (N = 10) Age (20 – 39 years)</p>	<p>Non-disclosure or negative experiences upon disclosure Severity between fondling and forced intercourse</p>	<p>Negative body image Distorted sexual development Distorted sexual development</p>	<ul style="list-style-type: none"> - Hyper-arousal - Difficulty concentration - Psychosomatic symptoms - Flashbacks - Inability to recall certain aspects - Feeling detachment - Low self-esteem - Poor body images - Felt bodies were physical damaged - Negative evaluation of themselves - Difficulty with emotion regulation - Self-blame - Feeling helplessness, hopelessness <p><i>Confusion around sexual norms</i></p> <ul style="list-style-type: none"> - Trust issues affecting relationships - Difficulty in establishing relationships - Isolation - Trying to please others - Attempting to avoid conflict - Sexual difficulties - Difficulty with authority figures - Fear and anger towards perpetrators - Struggles with forgiveness
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TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

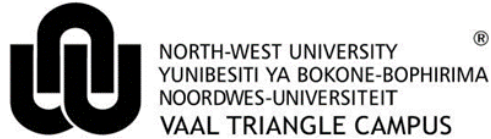
					Negative body image	<p><i>Hiding the feminine self / body harm</i></p> <ul style="list-style-type: none"> - Intentional self-sabotaging behaviour (making themselves look ugly, getting poor grades to avoid male attention) - Tension reduction or distracting coping strategies with self-harm consequences (self-mutilation, bingeing, compulsive sex)
66	<p>Woodiwiss, J. (2008)</p> <p><i>'Compulsary sexuality': a guide to healing?</i></p>	UK	<p>Qualitative study</p> <p>Mixed method</p> <p>N = 16 Women</p>	<p>Abused during childhood</p> <p>Severity;</p> <p>Continuous memories (n = 5)</p> <p>Recovered memories (n = 6)</p> <p>False memories (n = 5)</p>	Negative sexual association	<p><i>Aversion & avoidance</i></p> <p>Sexual difficulties, including lack of interest, was present with most of the participants</p> <p>Where discourse around sex and sexuality was present, the issue was complex and reflected not only their need to make sense of their lives up to the present, but also to negotiate a future in which they may include or exclude sexual relationships</p>

TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

						<p><i>Flashbacks</i></p> <p>Participants, including those without memories of childhood sexual abuse, uses ideas promoted in self-help literature to explain sexual difficulties they've experienced</p>
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Addendum D

Focus group schedule



TRAUMATIC SEXUALISATION IN FEMALE SURVIVORS OF CHILDHOOD SEXUAL ABUSE

Ina Theunissen

Master Social Work student at North West University (Vaal Triangle)

PROGRAMME

Welcoming:	Tea / Coffee
	Sign attendance register / claim forms for traveling
Opening:	Introduction by researcher
	Focus group participant's introduction
Discussion:	Overview of research project
	Aim of focus group discussion
	Ground rules
	Presenting the findings of the scoping review
	Participant reflections on findings
Closing:	Summary of discussion
	Closing statements
	Refreshments

Addendum E

Focus group questions

FOCUS GROUP INTERVIEW QUESTIONS

RESEARCH TOPIC

Reports of traumatic sexualisation in a group of female survivors of childhood sexual abuse.

RESEARCH OBJECTIVE

To present the findings of the scoping review to a panel of professionals, in order to obtain feedback on the findings as well as to identify any additional information on traumatic sexualisation in survivors of childhood sexual abuse.

INTERVIEW QUESTIONS

- Please take some time to think of 2 or 3 specific clients where you had to provide treatment to adult survivors of childhood sexual abuse.
- Please highlight what issues stood out about these specific clients.

Researcher present findings of the scoping review.

- Given the findings of the literature study, what experiences of traumatic sexualisation was reported by your clients?
- What worked for your clients to overcome challenges relating to traumatic sexualisation?
- Is there any additional information relating to traumatic sexualisation and childhood sexual abuse that you have observed in practice?

Addendum F

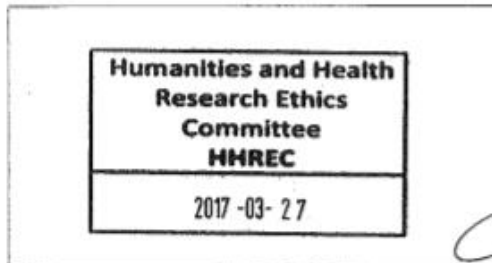
Focus group consent form



PO Box 1174, Vanderbiljpark
South Africa, 1900

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

27 March 2017



C. van Eeden

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM FOR FOCUS GROUP

TITLE OF THE RESEARCH PROJECT: Reports of traumatic sexualisation in a group of female survivors of childhood sexual abuse.

REFERENCE NUMBERS: NWU-HS-2016-0181

RESEARCHER: Ina Theunissen

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

CONTACT NUMBER: 072 8654 504

SUPERVISOR: Prof Ansie Fouché

CO-SUPERVISOR: Dr Hayley Walker-Williams

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

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

This letter is to inform you about the purpose of the study and what the expectations would be if you should agree to participate. If you have any questions, please feel free to direct

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CvE

them to the researcher. It is important that you understand what this research is about and what your involvement would entail prior to giving your informed consent.

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

This study has been approved by the Humanities and Health Research Ethics Committee (HHREC) of the Faculty of Humanities of the North-West University (NWU-HS-2016-0181) and will be conducted according to the ethical guidelines and principles of the International Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council.

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

What is the research study all about?

The main aim of the study is to explore traumatic sexualisation as reported by a group of South African women, who experience CSA, and who participated in a group intervention programme for women survivors of CSA. The findings could serve to inform further S2T treatment outcomes.

This study has five objectives:

- To conduct a systematic scoping review to identify available literature and provide a summary of evidence from a variety of studies on traumatic sexualisation in women who experienced CSA.
- To present findings of the scoping review to a panel of professionals working within the framework of CSA, in order to obtain feedback on the findings of the scoping review and to identify any additional information on traumatic sexualisation in female adult survivors of CSA.
- To perform qualitative secondary analysis (QSA) on a collective set of data from treatment sessions conducted with two groups of women over a three year period, to explore reports of traumatic sexualisation in this population.
- To conduct thematic content analysis of transcriptions emanating from a focus group discussion with professionals working within the scope of CSA and three S2T treatment sessions.
- To contextualise findings on traumatic sexualisation in order to inform future S2T treatment practice.

Why have you been invited to participate?

You were identified by Mrs Petro Fourie, as a knowledgeable professional working within the scope of CSA. You are invited because you have a minimum of three to five years practice experience in working with CSA survivors, are a qualified clinical psychologist or social worker working in private practice or for a child protection organisation, and can communicate in English.

What will your participation entail?

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The focus group discussion will be held 9:00 on Thursday, May 18, 2017 at 106A Tortelduif street, Wierda Park, Centurion. Only one focus group discussion of approximately two hours will be held.

The focus group will be conducted in English. You will be presented with the findings of a scoping review (literature study) and asked for feedback on the findings of the scoping review and to identify any additional information related to traumatic sexualisation from your practice experience. You will also be requested to consent to the discussion being digitally recorded.

You will be requested not to disclose any personal details of your clients. Confidentiality will be encouraged during the sharing of sensitive information from your practice experience with others in the group. Though the limits to confidentiality and anonymity outside the group discussion cannot be guaranteed, but will be strongly encouraged. You will be asked to indicate your agreement with these rules in writing.

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

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

Who will have access to the data?

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

What will happen to the data?

All data and identifying information will be kept confidential, as required by the Health Professions Act 56 of 1974 (Department of Health, 2006). Your participation and identity will be kept confidential. Your name and any identifying information will be removed from the transcript of the focus group and your contributions will be identified by a numbered code. After the focus interview is transcribed, you will receive a copy of the transcript. You will then be granted the opportunity to correct any misinformation and add information if you wish.

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

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

How will you know about the findings?

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

3

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Q.F.

Is there anything else that you should know or do?

- If you have any questions or would like more information, you may contact the researcher at tel no 072 8654 504 or via email at ina.theunissen@outlook.com
- You may contact the chair of the Humanities and Health Research Ethics Committee, Prof Chrizanne van Eeden at tel no 016 910 3441 or chrizanne.vaneeden@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher. Or you can leave a message for Chrizanne with Ms Daleen Claasens at tel no 016 910 3441.
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

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

I declare that:

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

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

.....
Signature of participant

.....
Signature of witness

(Please note that should you not have working printing / scanning / faxing facilities to return the signed consent form, then you are welcome to sign it on the day of the focus group discussion. Then just indicate that you will be able to attend the focus group.)

- You may contact me again Yes No

4

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CVF.

- I would like a summary of the findings of this research Yes No

The best way to reach me is:

Name & Surname: _____

Postal Address: _____

Email: _____

Phone Number: _____

Cell Phone Number: _____

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

Name & Surname

Phone/ Cell Phone Number /Email

Declaration by person obtaining consent

I (*name*) declare that:

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

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

.....
Signature of person obtaining consent

.....
Signature of witness

CvF

Addendum G

Summary of the focus group discussion and individual interviews

FOCUS GROUP / INDIVIDUAL INTERVIEWS

THEME	SUB-THEME	FOCUS GROUP / INDIVIDUAL INTERVIEWS RESPONSE
Negative sexual association	Aversion & avoidance	<p>“And it is very difficult if the marital partner isn’t involved in all this. If he doesn’t start to understand the whole thing. With this lady I was working with, I mean by the grace of God she had a very very understanding husband, but he needed to be educated, almost like around effects of sexual abuse and why is she.” (Transcription 1, Participant 3, Lines 374-378)</p> <p>“...any sexual trauma affects the perception of intimacy.” (Transcription 2, Participant 5, Lines 169-170)</p> <p>“And self-awareness, specifically intimate relationships, sexual relationships are affected.” (Transcription 2, Participant 5, Lines 240-241)</p> <p>“...these people’s inability to maintain intimate relationships, ...also normal relationships, ... with the opposite gender.” (Transcription 3, Participant 6, Lines 133-136)</p> <p>“Inability to establish any relationship and intimate relationship.” (Transcription 3, Participant 6, Line 140)</p>
	Flashbacks	<p>“After that it was so severe to a point that every time when the date, cause she still could remember the date like round about just after New Year’s. So, every time that the date approaches she just have severe headaches, she black out, she gets very sick. So every year when the time comes she would just re-experience I would think the trauma that she went through.” (Transcription 1, Participant 1, Lines 36-41)</p> <p>“...where there was direct trauma, a threat to a person’s integrity or physical safety, will it happen.” (Transcription 2, Participant 5, Lines 293-295)</p>
Negative body image	Feelings like a sexual object / Sexual self-concept	<p>“The body image...is affected, where it causes shame regarding the body. And self-awareness...” (Transcription 2, Participant 5, Lines 238-241)</p>

TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

	<p>Hiding the feminine self / body harm</p>	<p>“... I had a client that became morbidly obese because then nobody can look at her.” (Transcription 1, Participant 2, Lines 444-445)</p> <p>“This client of mine also had the tendency of we thought in a stage of therapy that she’s going into a lesbian relationship, because she got so attached to another women, because she felt safe in that relationship. And we thought it could go into that being almost like a lesbian thing, because she couldn’t stand her husband. She literally said that she could pay him not to come close to her.” (Transcription 1, Participant 3, lines 449-454)</p>
<p>Distorted sexual development</p>	<p>Confusion around sexual norms</p>	<p>“...that it has a destructive, negative effect where the person confuses intimate relationships. And does not know how to maintain or define relationships. Specifically, when it comes to intimacy and sexuality.” (Transcription 2, Participant 5, Lines 132-136)</p> <p>“...she has trust issues, she has rejection issues...” (Transcription 1, Participant 3, Line 40)</p> <p>“And every time they take the blame on themselves...” (Transcription 3, Participant 6, Lines 176-177)</p> <p>“And with this girl he also promises things. We’ll go, ‘gaan ry karretjies’, if we do this. Then the whole family will benefit and go on an outing. And if you don’t then we would do that.” (Transcription 1, Participant 4, Lines 207-209)</p> <p>“...it was the only way she got attention from her father. So much so, that she got jealous of the mother. Because that was the only attention she got. The mother was depressed. That was the only attention she got. It was better than nothing.” (Transcription 1, Participant 4, Lines 211 – 214)</p> <p>“...he’s now busy with the grooming process.” (Transcription 3, Participant 6, Line 290)</p> <p>“It’s been downplayed as, she imagined it. Or often it’s said that she seduced him. Or you lie, it can’t be, it’s my dad. He will never do such things...” (Transcription 3, Participant 6, Lines 192-194)</p> <p>“I was under age. My mother was sickly. So, in a way the child had taken over the role of the women hood.” (Transcription 3, Participant 6, Lines 257-258)</p> <p>“...then the child start taking over the role of the mother...” (Transcription 3, Participant 6, Lines 309)</p> <p>“... the child seduced him. You can’t belief the child ...” (Transcription 3, Participant 6, Line 361)</p>
	<p>Self-capacity disturbances</p>	<p>“Inability to establish any relationship and intimate relationship.” (Transcription 4, Participant 6, Line 140)</p>

TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

	<p>Sexual recklessness</p>	<p>“I talk about compulsive behavior. It is also sometimes there, sometimes it is total dependent behavior. Or anti-social behavior or avoidance behavior. So, I see obsessive compulsive behavior.” (Transcription 2, Participant 5, Lines 282-284)</p> <p>“So, then he goes through this phase where he is at a younger age sexually ripe.” (Transcription 2, Participant 5, Lines 278-279)</p> <p>“And then during young adulthood, that they sometimes become more sexually riotous.” (Transcription 2, Participant 5, Lines 280-281)</p>
	<p>Revictimisation</p>	<p>“But he came out of an abusive relationship. He’s been sexually abused.” (Transcription 1, Participant 4, Lines 569-570)</p> <p>“And they always go back to the same type of relationship.” (Transcription 3, Participant 6, Line 172)</p> <p>“And the mom said she beliefs it, but she still loves her husband. But he came out of an abusive relationship. He’s been sexually abused.” (Transcription 1, Participant 4, Lines 568-570)</p>

Addendum H

QSA coding framework

CODE	DESCRIPTION
Negative sexual association	
Aversion & avoidance	<ul style="list-style-type: none"> • Intimacy disturbances (difficulty to recognize what is satisfying or unsatisfying within intimate relationships), • Sexual avoidance (being distant with a partner or terminate the relationship when the partners expects intimacy / physical relationship), • Attachment related avoidance (insecure relationships / keep relationships superficial), • Challenges with emotional intimacy (difficulty feeling attached and open to one’s partner), • Negative perceptions of intimate relationships (all men are the same / labelling others / feeling uncomfortable and unable to maintain close love filled relationships), • Difficulty in managing sexual thoughts, feelings and interactions (poor emotional regulation around sexual matters), • Associate tough or intimacy with pain and confusion (avoid intimacy), • Distort ability to feel pleasure in sexual responses (can’t reach a climax),
Sexual anxiety	<ul style="list-style-type: none"> • Fear of distress associated with intimacy (avoiding intimacy), • Feeling apprehensive or fearful about having sex,
Flashbacks	<ul style="list-style-type: none"> • Areas of the body associated with traumatic experiences (e.g. touching of the inner thigh is associated with CSA / cause uncomfortable feelings), • Body areas associated with highly negative emotions (e.g. referral to breasts), • Negative associations with certain places, certain time of the year),
Negative body image	
Feeling like a sexual object / sexual self-concept	<ul style="list-style-type: none"> • Objectification of a person (feeling disrespected as a women or like a sexual object to be used), • Negative sexual self-concept (feeling dirty or damaged or that everyone can see that they’ve been sexually abused / feeling like damaged goods),

	<ul style="list-style-type: none"> • Sexual self-schemas predicted sexual satisfaction (feeling dissatisfied with sexual relationships and unable to form lasting connections with partners), • Negative emotions and dissatisfaction regarding their body, • Describe themselves in negative terms (I am only good for ..., people don't like me because ..., I attract ...), • Use more sexual words (boobs),
<p>Hiding the feminine self / body harm</p>	<ul style="list-style-type: none"> • Anger due to abuse directed inwards through self-harm behaviour (self-mutilation marks on the arm, over – or under-weight), • Anger / rage suppression to serve as self-protection (un-assertiveness), • Development of obesity (my partner / I have an issue with my weight), • Intentional self-harm behaviour by making themselves look ugly to avoid attention (wear oversized clothing), • Eating disorders (referral to weight issues or indicate an obsession with weight), • Scarification of the body (mentioning that this tattoo is a reminder of ...), • Tension reduction or distracting coping strategies with self-harm consequences life self-mutilation, substance abuse (referral to ... I use to drink a lot of sleeping tables ..., I use to cut myself ...),
<p>Distorted sexual development</p>	
<p>Confusion around sexual norms</p>	<ul style="list-style-type: none"> • Altered view on intimate relationships and what's been considered to be safe (negative view of others / unhealthy boundaries and poor anxious attachment in relationships), • Trust issues with people in general (general distrust in relationships), • Negative perception of men (stereotyping men / generalizing that all men are bad or will hurt), • Rewards / gifts to negotiate relationships or influence behaviour (my partner doesn't love me, because he never gives me ..., think love is an exchange of gifts), • Control and boundary issues (if I am not in control bad things will happen / overcompensate by controlling as they could not control things as

	<p>children / my mother never ..., / she / he blamed me for ...),</p>
<p>Self-capacity disturbances</p>	<ul style="list-style-type: none"> • Interpersonal relatedness affected by the loss of physical and psychological boundaries (experience relationship problems), • Learned helplessness due to the elimination of choice in the act – as a child (feel like damaged goods and therefore stay in the victim role), • Self-blame (take responsibility for other people’s actions / feel responsible for others), • Affect regulation is inhibited with the experience of unresolved fear (fear causes an over-reaction), • Fear of being overwhelmed by affect (use defense mechanisms to protect themselves), • Hesitation to disclose CSA to intimate partner out of fear for rejection • Experience negative sexual affect during sexual arousal (difficulty achieving arousal due to negative emotional reactions), • Lack of self-appreciation and shame affects intimacy and sexual desire (negative referrals to the self or self-blaming),
<p>Sexual recklessness</p>	<ul style="list-style-type: none"> • Sexual ambivalence between sexual preoccupation and aversion (involvement in several intimate relationships or avoiding intimate relationships- /insecure to form attachments), • Voluntary sexual abstinence (avoiding relationships with the opposite sex), • Sexual compulsivity – lower couple adjustment (extra-marital relationships / promiscuous), • Younger at first voluntary intercourse (age of voluntary intercourse earlier than the norm), • More sexual partners at a younger age (boasting over sexual achievements), • More lifetime sexual partners (boasting over sexual achievements), • Multiple sexual partners (number of sexual partners), • Incongruence between sexual behaviour, moral standards and thoughts (feelings of guilt), • Distort sense of mastery and control associated with sexuality (finding themselves in high risk situations due to the way they dress / people they associate with),

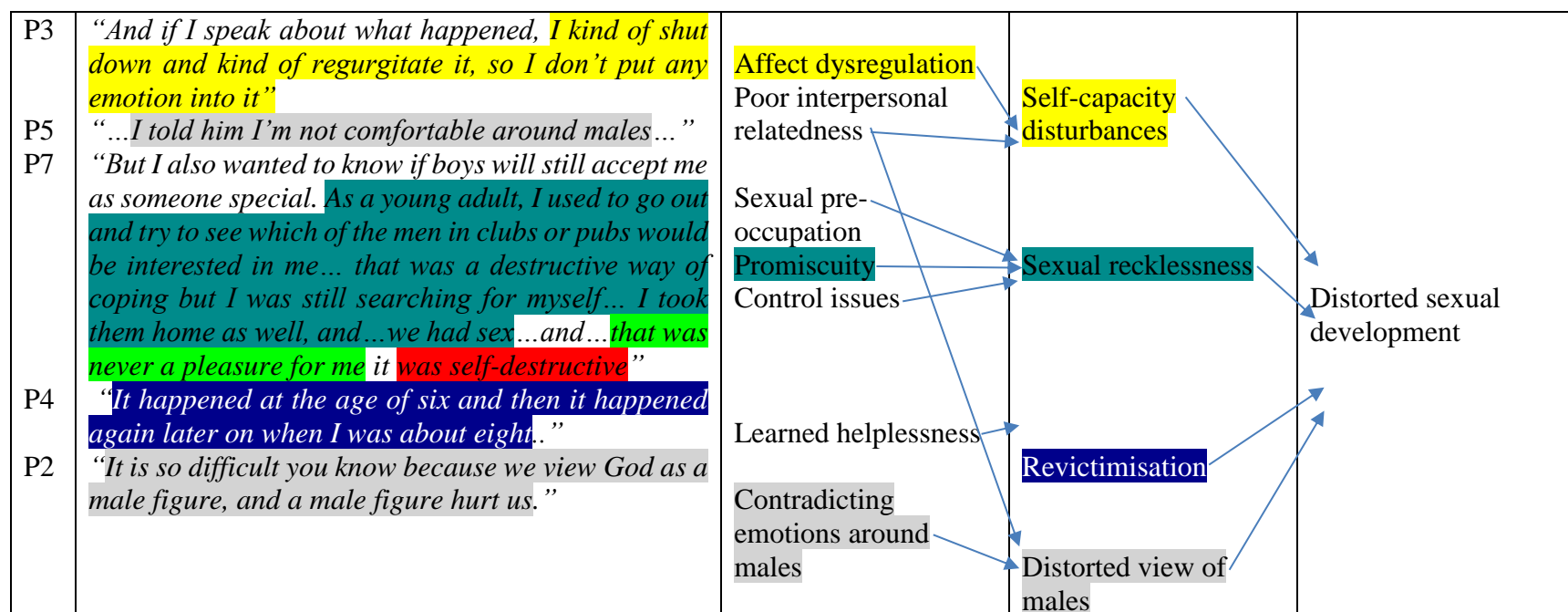
	<ul style="list-style-type: none"> • Dysfunctional sexual behaviour (with high risk people or having unprotected sex), • More likely to become teen mothers (age of first pregnancy earlier than the norm or non-abused cohorts), • Lower birth control efficacy (lack of birth control), • Control issues, • High risk sexual behaviour with persons other than their partners for financial benefit (spoiling in return for sexual favors- / compensation for being a sexual object / self-destructive through sexual revictimization), • Episodes of sex trading and STI's (sexually promiscuous and self-destructive),
<p>Revictimisation</p>	<ul style="list-style-type: none"> • Tolerance to emotional and / or physical abuse in romantic relationships (being in an abusive intimate relationship), • Combination of CSA and physical abuse – strong predictor of adult revictimisation (continued involvement in bad relationships leading to a similar pattern of abuse), • Lack of skills to recognize threatening events due to desensitisation (I couldn't tell him, being passive and submissive in the relationship...),

Addendum I

Example of the coding process

Data from the S2T collaborative strengths-based treatment sessions	Open codes	Axial codes	Themes
<p>P1 “...if my partner does initiate sex I tend to, at some point switch off...so I don’t want it... I don’t enjoy it but I do allow it”.</p> <p>P7 “And I know if somebody asks me, am I married, or do I have boyfriend, I would tell them I am too busy with my studies. And that is just an excuse to not tell them or have their attention”.</p> <p>P1 “I was very aware of everything around me. I could basically hear the children breathing in the next room...I was so anxious”.</p> <p>P3 “And then there is the refusal to have sex and avoid intimacy so as to prevent the flashbacks...”</p>	<p>Challenges with emotional intimacy</p> <p>Impaired gratification from sexual act</p> <p>Sexual desire dysfunction</p> <p>Sensory areas of the body associated with abuse</p>	<p>Aversion</p> <p>Avoidance</p> <p>Sexual anxiety</p> <p>Flashback</p>	<p>Negative sexual association</p>
<p>P7 “...I feel like a sex object, that’s what I’ve been for a long time... my sexuality was there but I did not enjoy it with men...as if it was gone...”.</p> <p>P7 “I decided not to cut myself, because it’s terrible. So I just had sleeping tablets”</p>	<p>Feeling like a sexual object</p> <p>Self-mutilation</p> <p>Compulsive behaviour</p>	<p>Sexual self-concept</p> <p>Hiding the feminine self / body harm</p>	<p>Negative body image</p>
<p>P1 “I uhh, discussed it with my partner how I have trust issues, but we did not go into it...it’s more than what I thought it was... I thought it was, you know, you go out, someone cheats on you, that it’s just that, but it’s way more than that. That is what I’ve realised...I can say something about being with someone who is really good to you, who really loves you. I would refuse to marry that man because I believed in my mind, fifty years old, that if I marry him, he will change and abuse me”</p>	<p>Trust issues</p> <p>Conflict with self & interpersonal relations</p>	<p>Confusion around sexual norms</p>	<p>Distorted sexual development</p>

TRAUMATIC SEXUALISATION IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE



Addendum J

Ethics approval certificate



ETHICS APPROVAL CERTIFICATE OF PROJECT

Based on approval by the Humanities and Health Research Ethics Committee (HHREC) on 03/01/2016, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby approves your project as indicated below. This implies that the NWU-IRERC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Report of traumatic sexualisation in a group of female survivors of childhood sexual abuse																													
Project Leader/Supervisor: Prof A Fouche & Dr H Walker-Williams																													
Student: Theunissen, CJ																													
Ethics number: <table border="1"><tr><td>N</td><td>W</td><td>U</td><td>-</td><td>HS</td><td>-</td><td>2</td><td>0</td><td>1</td><td>6</td><td>-</td><td>0</td><td>1</td><td>8</td><td>1</td></tr><tr><td colspan="4">Institution</td><td colspan="4">Project Number</td><td colspan="2">Year</td><td colspan="4">Status</td></tr></table>	N	W	U	-	HS	-	2	0	1	6	-	0	1	8	1	Institution				Project Number				Year		Status			
N	W	U	-	HS	-	2	0	1	6	-	0	1	8	1															
Institution				Project Number				Year		Status																			
Application Type: N/A																													
Commencement date: 2017-01-03	Expiry date: 2020-01-03	Risk: <table border="1"><tr><td>Medium</td></tr></table>	Medium																										
Medium																													

Special conditions of the approval (if applicable):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HHREC (if applicable).
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HHREC. Ethics approval is required BEFORE approval can be obtained from these authorities.

General conditions: While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following: <ul style="list-style-type: none">• The project leader (principle investigator) must report in the prescribed format to the NWU-IRERC via HHREC:<ul style="list-style-type: none">- annually (or as otherwise requested) on the progress of the project, and upon completion of the project- without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.- Annually a number of projects may be randomly selected for an external audit.• The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the HHREC. Would there be deviation from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.• The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-IRERC via HHREC and new approval received before or on the expiry date.• In the interest of ethical responsibility the NWU-IRERC and HHREC retains 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 project;- 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:<ul style="list-style-type: none">- any unethical principles or practices of the project are revealed or suspected,- it becomes apparent that any relevant information was withheld from the HHREC or that information has been false or misrepresented,- the required annual report and reporting of adverse events was not done timely and accurately,- new institutional rules, national legislation or international conventions deem it necessary.• HHREC can be contacted for further information via Daleen.Claasens@nwu.ac.za or 018 210 3441

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

Yours sincerely

Prof LA Du Plessis
Digitally signed by
Prof LA Du Plessis
Date: 2017.01.12
08:46:32 +02'00'

Prof Linda du Plessis
Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

Addendum K

Confidentiality agreement



PO Box 1174, Vanderbijlpark
South Africa, 1900

School of Behavioural Science
Psychology Department
Tel: (016) 016 910 3416
Cell: 082 496 4105
Email: Hayley.williams@nwu.ac.za
Date: 28 September 2016

Dear Mrs Ina Theunissen

MA Student Confidentiality Agreement

This study, *The Benefit of a Survivor to Thrive (S2T) Strengths-Based Group Intervention Programme for Women Who Experienced Childhood Sexual Abuse* (Ethical Clearance Number: NWU-00041-08-A1), is being undertaken by Dr Hayley Walker-Williams and Prof Ansie Fouché at North-West University, Vanderbijlpark Campus.

The study focuses on the implementation of a strengths-based group intervention programme for women who experienced childhood sexual abuse.

You will have access to the transcriptions of the recorded S2T group treatment sessions (group one – three) for which participants have provided their written consent. These will be made available once your proposal has been approved by the Optentia's committee for advanced degrees and ethical clearance has been obtained.

I, CJ Theunissen (name of MA student), agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g. transcripts) with anyone other than Dr Hayley Walker-Williams and Prof Ansie Fouché;
2. Keep all research information (biographical questionnaires and transcripts) in any form or format secure while it is in my possession;
3. Return all research information in any form or format to Dr Hayley Walker-Williams and Prof Ansie Fouché when I have completed the research tasks.

MA student:

CJ Theunissen
Mrs Ina Theunissen


(signature)

6/10/2016
(date)

H. J. Walker-Williams
Dr Hayley Walker-Williams

H. J. Walker-Williams
(signature)

2016-09-28.
(date)

Ansie Fouché
Prof Ansie Fouché

Ansie Fouché
(signature)

2016/09/28
(date)

If you have any questions or concerns about this study, please contact:

Dr Hayley Walker-Williams
Psychology Subject Group
School of Behavioural Sciences
North-West University, Vanderbijlpark Campus
Building 7- 119
Hayley.williams@nwu.ac.za
016-910 3416

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

Addendum K

Consent to use the S2T data set



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

PO Box 1174, Vanderbijlpark
South Africa, 1900

School of Behavioural Science
Psychology Department
Tel: (016) 016 910 3416
Cell: 082 496 4105
Email: Hayley.williams@nwu.ac.za
Date: 28 September 2016

Dear Mrs Theunissen

CONSENT TO USE TRANSCRIPTIONS OF S2T TREATMENT SESSIONS (GROUP 1 – 3):

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

NWU ETHICAL CLEARANCE NUMBER: NWU 00041-08-A1

PRINCIPAL INVESTIGATOR: Dr Hayley Walker-Williams

CO-INVESTIGATOR: Prof Ansie Fouché

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

CONTACT NUMBER: 016 9103416 / 0169103428

We hereby grant permission to Mrs Ina Theunissen (identity number: 7406140025083) a prospective MA student in the above research project and consent to the following:

- To have access to the transcriptions of the recorded S2T group treatment sessions for groups one to three for which group participants have provided their written consent. Access will be made available once her proposal has been approved by the Optentia's committee for advanced degrees and ethical clearance has been obtained.
- To make use of the above transcriptions for qualitative secondary data analysis for the purpose of her proposed MA study.

Conditions for consent:

- Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g. transcripts) with anyone other than Dr Hayley Walker-Williams and Prof Ansie Fouché;
- Keep all research information (biographical questionnaires and transcripts) in any form or format secure while it is in my possession;
- Return all research information in any form or format to Dr Hayley Walker-Williams and Prof Ansie Fouché when I have completed the research tasks;
- The data will be treated confidentially and kept in a lock up facility;
- The data will be treated with sensitivity.

H.J. Walker-Williams

Dr H.J. Walker-Williams

Ansie Fouché

Prof A. Fouché

H Walker-Williams

Signature

[Signature]

Signature

28/09/2016

DD MM YYYY

28/09/2016

DD MM YYYY