Shame and Psychosocial Intervention Experiences of Women Survivors of Child Sexual Abuse from Minoritized Racial and Ethnic Groups

Rusan Lateef

School of Social Work, McGill University, Montreal

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Abstract

Child sexual abuse (CSA) is a persistent social problem that affects children from all sociodemographic backgrounds worldwide. CSA has devastating consequences for survivors, which can persist throughout their lives if not addressed. A common detrimental consequence of CSA is shame, a complex social, self-conscious emotion that concerns the whole self. Shame is often alleviated with the support of psychosocial interventions. The overall purpose of this thesis is to explore how women survivors of CSA from minoritized racial and/or ethnic groups experience shame and psychosocial interventions related to the CSA, with a specific focus on the intersection of racial, ethnic, and gender identities. This thesis is comprised of three manuscripts that contribute to the current literature by providing an enhanced understanding in these areas. The first manuscript is a scoping review of empirical research that has been published in the past 30 years (1994-2024) that has investigated or produced findings related to shame following CSA among survivors across the lifespan. The scoping review covered a sample of 101 studies and discussed trends in demographic profiles of participants included and methodologies used in these studies. The results of the scoping review revealed that shame is a common outcome of CSA, shame increases the risk of other negative outcomes, is a deterrent to CSA disclosures, and is a critical aspect of the CSA recovery process for CSA survivors across the lifespan. The findings also revealed that survivor characteristics may influence how shame is experienced, and groups that are marginalized in the literature, including CSA survivors from minoritized racial and ethnic groups. The second and third manuscripts are both qualitative studies that used interpretative phenomenological analysis to better understand the shame and psychosocial interventions experiences, respectively, of 10 women CSA survivors who identified with minoritized racial and/or ethnic groups. Both studies were informed by intersectionality theory

and were based on analyses of in-depth semi-structured interviews with the participants. The second manuscript centered on the following research question: How do the intersecting social identities of women survivors of CSA, and particularly the intersection of race, ethnicity, and gender, impact their experiences of shame? The analysis resulted in three Group Experiential Themes: 1) internalized shame tied to intersectional identity; 2) intra-familial reinforcement of shame and silence; and 3) maintenance of shame through systemic racism. The third manuscript centered on the following research question: How do women survivors of CSA from minoritized racial and/or ethnic groups experience psychosocial interventions? The following three Group Experiential Themes resulted from the analysis that signified identity-driven influences on the quality of their experiences: 1) survivor-counselor shared social identities facilitate authentic expression and connection; 2) racial dynamics and microaggressions in counseling lead to detrimental impacts; and 3) counselor cultural competence and humility are perceived as priorities. The findings of the two empirical studies highlighted how the intersectional social identities of women survivors of CSA, particularly the intersection of gender, race, and ethnicity, shaped important aspects of their CSA and recovery experiences, including shame and their experiences with psychosocial interventions. The three manuscripts together point to the need to prioritize inclusion and diversity in CSA research, to disrupt the longstanding practice in sexual violence research of conceptualizing phenomenon largely based on the voices of those in socially privileged positions. Practice, research, and social implications and directions for future research are discussed in each manuscript and the final chapter of this thesis.

Résumé

L'abus sexuel des enfants est un problème social persistant qui touche des enfants de tous les milieux sociodémographiques dans le monde entier. Ces abus ont des conséquences dévastatrices pour les personnes survivantes, qui peuvent persister tout au long de leur vie s'ils ne sont pas pris en charge. L'une des conséquences néfastes les plus courantes des abus sexuels commis sur des enfants est la honte, une émotion sociale complexe, qui concerne l'ensemble de la représentation de soi. La honte peut toutefois être atténuée par des interventions psychosociales. L'objectif général de cette thèse est d'explorer la manière dont les femmes survivantes d'abus sexuels sur mineurs appartenant à des groupes raciaux et/ou ethniques minorisés vivent la honte et les interventions psychosociales liées à l'abus sexuel sur mineurs, en mettant l'accent sur l'intersection des identités raciales, ethniques et sexospécifiques. Cette thèse est composée de trois manuscrits qui contribuent à la littérature actuelle en apportant une meilleure compréhension dans ces domaines. Le premier manuscrit est un examen de la portée des recherches empiriques publiées au cours des 30 dernières années (1994-2024) qui ont étudié ou produit des résultats liés à la honte à la suite d'abus sexuels dans l'enfance chez les personnes survivantes à tous les stades de la vie. L'examen exploratoire a porté sur un échantillon de 101 études et a examiné les tendances des profils démographiques des participants et participantes inclus et des méthodologies utilisées dans ces études. Les résultats de l'examen exploratoire révèlent que la honte est une conséquence courante de la violence sexuelle, qu'elle augmente le risque d'autres conséquences négatives, qu'elle dissuade de divulguer la violence sexuelle et qu'elle est un aspect essentiel du processus de rétablissement des personnes survivantes de la violence sexuelle à tous les stades de la vie. Les résultats révèlent également que les caractéristiques des personnes survivantes peuvent influencer la façon dont la honte est ressentie,

et les groupes qui sont marginalisés dans la littérature, y compris les personnes survivantes d'abus sexuels durant l'enfance issues de groupes raciaux et ethniques minorisés. Les deuxième et troisième manuscrits sont tous deux des études qualitatives qui ont utilisé l'analyse phénoménologique interprétative pour mieux comprendre les expériences de honte et d'interventions psychosociales, respectivement, de 10 femmes survivantes d'abus sexuel durant l'enfance qui se sont identifiées à des groupes raciaux et/ou ethniques minorisés. Les deux études s'appuient sur la théorie de l'intersectionnalité et sur l'analyse d'entretiens semi-structurés approfondis avec les participantes. Le second manuscrit est centré sur la question de recherche suivante : Comment les identités sociales croisées des femmes ayant survécu aux abus sexuels, et en particulier l'intersection de la race, de l'ethnicité et du sexe, influencent-elles leurs expériences de la honte ? L'analyse a permis de dégager trois thèmes: 1) la honte intériorisée liée à l'identité intersectionnelle ; 2) le renforcement intrafamilial de la honte et du silence ; et 3) le maintien de la honte par le biais du racisme systémique. Le troisième manuscrit est centré sur la question de recherche suivante : Comment les femmes survivantes d'abus sexuel durant l'enfance issues de groupes raciaux et/ou ethniques minorisés vivent-elles les interventions psychosociales ? L'analyse a permis de dégager les trois thèmes suivants, qui témoignent de l'influence de l'identité sur la qualité de leur expérience: 1) les identités sociales communes entre les survivants et les intervenants facilitent l'expression authentique et la connexion ; 2) les dynamiques raciales et les microagressions dans l'intervention ont des effets néfastes ; et 3) la compétence culturelle et l'humilité des intervenants sont perçues comme des priorités. Les résultats des deux études empiriques mettent en évidence la façon dont les identités sociales intersectionnelles des femmes survivantes des abus sexuels durant l'enfance, en particulier l'intersection du genre, de la race et de l'ethnicité, façonnent des aspects importants de leurs expériences de rétablissement, y compris

la honte et leurs expériences avec les interventions psychosociales. Les trois manuscrits soulignent la nécessité de donner la priorité à l'inclusion et à la diversité dans la recherche les abus sexuels, afin de rompre avec la pratique de longue date de la recherche sur la violence sexuelle, qui consiste à conceptualiser le phénomène en se basant largement sur les voix de ceux qui occupent des positions socialement privilégiées. Les implications pour la pratique, la recherche, et les politiques sociales, ainsi que les orientations de la recherche future sont discutées dans chaque manuscrit et dans le dernier chapitre de la thèse.

Acknowledgements

It is my pleasure to take this opportunity to express my gratitude and acknowledge everyone who has contributed to the completion of this dissertation and my doctorate program. First and foremost, I would like to thank my doctoral supervisor Dr. Delphine Collin-Vézina for her invaluable support throughout my doctoral journey. I appreciated your flexibility in making the time to meet with me throughout my dissertation planning and writing process and providing useful feedback on the different components of this dissertation. Your support, encouragement, advice, insights, problem-solving abilities, and continuously calm and friendly demeanor were very much appreciated at every step of my doctoral journey.

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I would like to thank the women who participated in my dissertation research. Their willingness to share their stories with me and enthusiasm to specifically bring attention to the experiences of CSA survivors from minoritized racial and ethnic groups were central to the success of this dissertation. I honor their stories and will continue to focus on bringing attention to the experiences of CSA survivors from marginalized groups throughout my academic career.

Finally, I would like to thank my research funding body, the Social Sciences and Humanities Research Council of Canada, whose financial contribution through a Joseph-Armand Bombardier Canada Graduate Scholarship allowed me to centre my attention on my thesis.

Contribution to Original Knowledge

All three manuscripts provide distinct contributions to the CSA knowledge base. The first manuscript advanced the state of knowledge surrounding shame and CSA by means of a scoping review. Through its broad inclusion of research published between 1994 to 2024 on CSA survivors of all ages, this scoping review is the most updated, comprehensive review of the empirical research on shame among CSA survivors that currently exists.

The second and third manuscripts were based on original data collected for the purpose of this thesis. They highlighted the voices of 10 women CSA survivors who identified with minoritized racial and/or ethnic groups, focusing specifically on how their intersectional identities influenced their experiences of shame related to CSA in the second manuscript, and psychosocial interventions received for CSA in the third manuscript. Both manuscripts were informed by intersectionality theory, which has limitedly been used as a theoretical framework to guide empirical research with CSA survivors, despite being suggested as a necessary framework to understand sexual violence against racially minoritized women by foundational intersectional scholars such as Kimberlé Crenshaw.

The second manuscript is the first known study to apply intersectionality to qualitatively examine shame from the perspectives of adult CSA survivors, as well as the first study to qualitatively explore shame among adult CSA survivors from minoritized racial and ethnic groups. The findings of this study included detailed accounts from CSA survivors that revealed how shame following CSA can be shaped by their intersectional identities and the interactions between various systems of oppression. Their accounts are elaborated through three themes that demonstrated that internalized shame is tied to intersectional identity, shame and silence are

reinforced within families, and the shame of CSA survivors from minoritized racial and ethnic groups is maintained through systemic racism.

The third manuscript is the first known study to apply intersectionality to examine the psychosocial intervention experiences and identity-related preferences of CSA survivors who identify with minoritized racial and ethnic groups. It is also the first known study to qualitatively explore how intersectional identities can influence psychosocial intervention experiences specifically within the CSA context. The detailed accounts of CSA survivors resulted in three themes that demonstrated their experiences and identity-related preferences, which have important clinical implications that have the potential to enhance the psychosocial intervention experiences of women CSA survivors who identify with minoritized racial and ethnic groups.

Contribution of Authors

The manuscripts in this dissertation were first authored by me (Rusan Lateef), and co-authored by Dr. Delphine Collin-Vézina, Dr. Ramona Alaggia, and Dr. Heather MacIntosh. After a review of the existing literature through my comprehensive exam, I developed the plan for the three manuscripts that were included in this thesis, including formulating the research questions and conceptual frameworks for all manuscripts. The plan was reviewed and approved by my three committee members and co-authors on the manuscripts, Dr. Delphine Collin-Vézina, Dr. Ramona Alaggia, and Dr. Heather MacIntosh. I engaged in further consultation with Dr. Delphine Collin-Vézina to finalize additional details during the writing process, as needed.

Manuscript 1, the scoping review, was conceptualized and conducted by me. As the first author, I was responsible for conducting the search, systematically reviewing each study, extracting the data from each study and analyzing the results according to the Arksey and O'Malley (2005) five-stage framework. I wrote the full first draft of the manuscript. I received feedback on the draft from each of my three committee members. I incorporated their feedback, which led to the current version of the manuscript presented in this thesis.

With regards to Manuscripts 2 and 3, I developed the research study that led to the findings presented in these two manuscripts, including selecting the methodology and theoretical framework, preparing the recruitment materials, and developing the interview guide. I conducted all the participant interviews and completed the data analyses for both manuscripts. As the first author on both manuscripts, I completed a full first draft of both manuscripts. Dr. Delphine Collin-Vézina provided guidance throughout this process, as needed. Dr. Delphine Collin-Vézina, Dr. Ramona Alaggia, and Dr. Heather MacIntosh reviewed and provided feedback on

the completed drafts of both manuscripts. Their feedback was incorporated into the manuscripts, leading to the current versions of the manuscripts presented in this thesis.

Co-authorship on this thesis is in accordance with McGill's Graduate and Postdoctoral Studies Thesis Guidelines. Manuscript 1 has been submitted for publication in *Child and Youth Services Review*. Manuscript 2 has been submitted for publication to *Psychology of Women Quarterly* and it is currently under review. Manuscript 3 is ready for publication submission.

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List of Abbreviations

CSA: child sexual abuse

IPA: interpretative phenomenological analysis

PTSD: post-traumatic stress disorder

CBT: cognitive behavioral therapy

Introduction

Child sexual abuse (CSA) is a worldwide and longstanding issue with global prevalence estimates ranging from 3 to 17% for boys and 8 to 31% for girls in international meta-analyses, although it is commonly speculated that these numbers are an underestimation of actual CSA prevalence rates (Barth et al., 2013; Pan et al., 2021; Stoltenborgh et al., 2011). Among a nationally representative sample of 18- to 28-year-old individuals in the United States (US), Finkelhor and colleagues (2024) recently found that the inclusion of online sexual abuse into the calculation of prevalence rates for CSA raised the overall prevalence rate from 13.5 % to 21.7 %, with the rate increasing from 19.8 % to 31.6 % for females and from 6.2 % to 10.8 % for males. With increased internet usage across the globe, recent data presents that there has been a rise in the scale and methods of online child sexual exploitation and abuse worldwide (WeProtect Global Alliance, 2023). This highlights CSA as an enduring and seemingly growing issue that warrants continued scholarly attention.

In Canada, a social survey reported that almost one in 10 (7.8%) Canadians have experienced CSA, including 12% of women and 3.7% of men (Heidinger, 2022). Canadian statistics indicated that between 2017 to 2021, there was an increase in police-reported sexual interference[1] incidents, with a 21.44% increase between 2020 and 2021 (Statistics Canada, 2023b). The most recently available statistics indicate that there has been a 168% increase in reporting of sexual violations against children between 2012 and 2022 (Statistics Canada, 2023a). It seems this increase is largely attributable to incidents of luring a child via computers (Department of Justice, 2019) and a sharp increase in cases brought to the attention of the

[1] "Sexual interference" is the legal term for child sexual abuse offences in Canada and is defined in the Criminal Code of Canada as "every person who, for a sexual purpose, touches, directly or indirectly, with a part of the body or with an object, any part of the body of a person under the age of 16 years."

authorities following the #MeToo social media movement (Statistics Canada, 2018). With respect to the two Canadian provinces captured in this thesis, first, in Quebec, 14.9% of girls and 3.9% of boys among a sample of 8194 youth reported experiencing CSA (Hébert et al., 2019). Second, in Ontario, 22.1% of girls and 8.3% of boys among a sample of 1928 youth reported experiences of CSA (MacMillan et al., 2013). These statistics are consistent with research, which has consistently found higher rates of CSA among females compared to males across the world (Assink et al., 2019; Stoltenborgh et al., 2011).

Beyond females, there are other groups that are at a higher risk of CSA. A review of the CSA research literature found that children who were female, living in low-income households and neighborhoods, had a disability, and in retrospective studies lesbian women had a greater risk for CSA (Clayton et al., 2018). Moreover, a Canadian study found that among 282 Indigenous Canadians, 35% of males, 50% of females, and 57% of transgender and gender non-conforming participants reported CSA, and children who had a family member who went to a residential school were at higher risk of CSA (Helmus & Kyne, 2023). On this note, through a review of the literature published between 1989 to 2007, Collin-Vézina et al. (2009) found a CSA prevalence rate of 25-50% among Indigenous adults across Canada. Clearly, these reported CSA prevalence rates for Indigenous children are higher than both global and Canadian CSA prevalence rates.

What these groups have in common is that they are all socially marginalized. A group of people are considered marginalized when they are deemed less important and relegated to a secondary or powerless position in society, or excluded due to discrimination and oppression, based on their social identities. The groups mentioned to be at a higher risk of CSA represent

different types of oppressions including sexism, classism, ableism, heterosexism, and racism, with more than one of these factors possibly relevant for the same child (Helmus & Kyne, 2023).

Marginalization in research could be understood as the relative exclusion of different groups in an area of empirical literature (Culley et al., 2013). In a relatively recent review of sexual violence research conducted in the past 25 years, McCauley et al. (2019) found that sexual violence research continues to centre around the stories of survivors within socially privileged positions. As Navarro and Ratajczak (2022) bluntly stated, "the conversation on sexual violence has prominently featured one gender (female) and one race (White)" (p. 3766). This has resulted in the continued marginalization and invisibility of women survivors of sexual abuse who identify with minoritized racial and ethnic groups (McCauley et al., 2019). Consequently, our understanding of different consequences of CSA, such as shame (MacGinley et al., 2019), and the outcomes of research conducted to date, such as prevention strategies and interventions (Parry & Simpson, 2016), are most applicable to the needs of White, heterosexual, middle-class, cisgender women, and are less applicable to survivors outside this intersectional category (McCauley et al., 2019). To ameliorate this limitation of CSA research, studies are needed that specifically explore the experiences of CSA survivors from marginalized groups in all aspects of the CSA experience, including how they experience its consequences and interventions.

McCauley and colleagues (2019) encouraged sexual violence research to become informed by intersectionality, to acknowledge the sociohistorical context that shapes the sexual victimization of women with marginalized identities and better understand their experiences. Similarly, Whittier (2016) argued that CSA research needs to be guided by an intersectionality approach "to consider how gender, race, class, and age interact to shape experiences,

interpretations, and responses," (p.99) as these have historically varied among victims based on these social identities. Whittier (2016) stressed a considerable need for more research and theorizing on sexual abuse against working class, poor, and racially minoritized children to better understand these understudied groups of CSA survivors.

The reality is that the necessity to view sexual violence through an intersectionality framework was argued over 35 years ago by Kimberlé Crenshaw (1989), the Black feminist legal scholar who coined the term "intersectionality." In her work, she outlined how sexual violence perpetrated against Black women was simultaneously influenced by racism and sexism. Despite this and the work of other women of color scholars, the voices of CSA survivors from minoritized racial and ethnic groups have largely remained marginalized in CSA research. Social and structural aspects of CSA that create disparate experiences for different groups of survivors have received limited consideration in the empirical literature (Whittier, 2016).

Thesis Objective and Outline

To fill important gaps in the current CSA evidence base, the main objective of my thesis research is to build the current understanding of how women survivors of CSA from minoritized racial and/or ethnic groups experience shame and psychosocial interventions related to CSA. There is a particular focus on how the intersection of racial, ethnic, and gender identities can shape the experiences of women CSA survivors. The goal of this thesis is to highlight how the experiences of women CSA survivors from minoritized racial and/or ethnic groups cannot be fully understood without considering their intersectional experiences and the sociohistorical and cultural context of sexual violence against girls and women from these groups.

The thesis starts off with an introduction and literature review (Chapter 1) that provide important context and background information relevant to the focus of this thesis, as well as

insight into the theoretical framework that largely guides the discussions within this thesis. This thesis is a manuscript-based thesis consisting of three manuscripts. Each manuscript includes an introduction, a clear description of the methods used, results, and discussion sections. The clinical implications and future research directions stemming from the results are discussed in each manuscript. An explanation of how each manuscript is conceptually related to the next is presented between manuscripts 1 and 2, and between manuscripts 2 and 3. This thesis concludes with a discussion chapter that expands on the ideas presented in the manuscripts and elaborates on the implications of the findings. The objectives of three manuscripts are described below.

The first manuscript, presented in Chapter 2, is a scoping review that sought to answer the following research question: What is known from the existing literature about shame among CSA survivors across the life course? The second and third manuscripts, respectively presented in Chapters 3 and 4, are qualitative studies that used an interpretative phenomenological analysis (IPA) design, were informed by intersectionality theory, and were based on analyses of semi-structured interviews with 10 women survivors of CSA who identified with minoritized racial and/or ethnic groups. The second manuscript investigated the following research question: how do the intersecting social identities of women survivors of CSA, and particularly the intersection of race, ethnicity, and gender, impact their experiences of shame? The third manuscript examined the following research question: How do women survivors of CSA from minoritized racial and/or ethnic groups experience psychosocial interventions?

Theoretical Framework: Intersectionality Theory

Overall, this thesis is informed by intersectionality theory (Crenshaw, 1989, 1991). Intersectionality is a theoretical framework that proposes that the multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status, etc.) that make up one's social

location intersect at the micro level of individual experience to reflect multiple, converging, and interwoven systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism, classism, etc.; Crenshaw, 1989, 1991). Intersectionality as an analytical tool has been described as follows:

> Intersectionality is a way of understanding and analyzing the complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways. When it comes to social inequality, people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other. Intersectionality as an analytic tool gives people better access to the complexity of the world and of themselves (Hill Collins & Bilge, 2016, p.2).

The term "intersectionality" gained popularity in 1989 after being coined by Kimberlé Crenshaw. Crenshaw (1989) argued that viewing different systems of oppression, such as sexism and racism, as separate did not adequately capture the difficulties faced by women of color who are simultaneously subordinated by multiple, overlapping systems of oppression. The separability of oppressions is only sufficient to describe the experiences of individuals oppressed by a single system of oppression. This single category analysis, which invalidates the experiences of individuals categorized by intersecting oppressions, is what intersectionality challenges. Crenshaw (1989) clarified that women who face intersecting oppressions (e.g., Black women) may have similar experiences as individuals oppressed by single categories of oppression (i.e., Black men or White women), or they could experience discrimination based on

multiple categories separately (i.e., practices which discriminate on the basis of race and others on the basis of sex), as well as encounter experiences unique to their intersectional identity (i.e., being a Black woman). As Crenshaw (1989) emphasized, the intersectional experience is greater than the sum of different oppressions.

Intersectionality has broadened its scope since its introduction wherein the primary focus was on the experiences of Black women and the race/gender binary. It has been suggested that all individuals have an intersectional identity that influences the way each person experiences the world (Nash, 2008). Intersectionality does not presume that all intersecting identities are equally disadvantaged (Bowleg, 2012). Rather, "intersectionality considers how low (e.g., racial minority, low SES) and high (e.g., upper- or middle-class SES) status social identities intersect to yield disparity and advantage" (Bowleg, 2012, p. 1269).

Throughout this thesis, efforts were made to consider intersectionality within all the different chapters, with a particular focus on the intersection of race, ethnicity, and gender among women CSA survivors. This was done by bringing attention to the realities of minoritized racial and ethnic groups, moving beyond dominant Western narratives as the sole lens for understanding phenomena (Esposito & Evans-Winter, 2021). Moreover, I attempt to underscore how sociohistorical and cultural contexts and systems of oppression shape the experiences of and responses to CSA among marginalized groups and identify research gaps that need to be filled through centering their voices. The application of intersectionality theory will be particularly demonstrated within the two empirical manuscripts included in this thesis, Manuscripts 2 and 3, both of which were informed by intersectionality theory. Both studies center the intersection of race, ethnicity, and gender in their research questions, analyses, and discussions (Esposito & Evans-Winter, 2021).

Moreover, to further acknowledge how systems of oppression, such as racism, contribute to the marginalization of different groups, I have chosen to use the terms "minoritized racial and ethnic groups" and "racially and ethnically minoritized" throughout this thesis, rather than the common term "racial and ethnic minority groups." It has been argued that the term "minoritized" better captures the historical and active process of structural racism in which dominant groups minoritize members of marginalized groups (Black et al., 2023; Wingrove-Haugland & McLeod, 2021). The use of "minoritized" better recognizes that being racially minoritized is about power and equity, rather than because these groups are fewer in quantity or lesser in quality compared to the White "majority" (Black et al., 2023; Wingrove-Haugland & McLeod, 2021). When possible, based on the available evidence, I will aim to present the variations in experiences by different minoritized racial and ethnic groups, as well as the social identities and intersectional identities that shape their experiences related to CSA. This is important for precision, but also, as Black et al. (2023) argued, to recognize the varied exposures to different systems of oppression faced by different groups and to avoid normalizing Whiteness by clustering socially distinct minoritized racial and ethnic groups into one category without acknowledging their unique experiences.

Chapter 1: Literature Review

As CSA is an ongoing and seemingly expanding problem with the rise of online forms of CSA, it is vital to continuously build our understanding of different outcomes of CSA, such as shame, and ways to enhance current supports and interventions for CSA survivors from diverse backgrounds. Shame has been considered the most common consequence of CSA in the clinical literature (Sanderson, 2006) and a core component of the CSA experience in theoretical literature (Finkelhor & Browne, 1985), to the extent that Nathanson (1989) asserted that sexual abuse cannot be studied, understood, or treated without first understanding shame. Empirical research has also repeatedly demonstrated an association between CSA and shame. A thorough review of the many ways in which shame is associated with CSA will be covered in the subsequent chapter, Chapter 2 (Manuscript 1). The present literature review will provide a broad overview of the evolution of the field of CSA and how it has contributed to CSA-related shame and the exclusion of women survivors from minoritized racial and ethnic groups. The focus will be on girls and women who have experienced CSA, as this was the population of interest in my thesis research.

First, I will define the key constructs of interest in this thesis, namely CSA and shame, and present how they are differentially conceptualized across cultures and societies, which will reveal that dominant understandings of CSA and shame may be excluding the realities of many CSA survivors. Next, I will provide an overview of the evolution of CSA theories, as this will provide insight into the probable origins of shame attached to CSA. As these theories largely centered on the experiences of White girls and women, the subsequent section will demonstrate the necessity of an intersectionality framework to understand the CSA experiences of girls and women from minoritized racial and ethnic groups. I will conclude this chapter with a brief

overview of how psychosocial interventions for CSA have progressed yet continue to disregard the needs of CSA survivors from minoritized racial and ethnic backgrounds. These discussions support the goal of this thesis to highlight how the experiences of women CSA survivors from minoritized racial and/or ethnic groups requires consideration of their intersectional experiences and sociohistorical and cultural contexts, and thus warrant research that centers on their unique experiences and needs.

Key Construct: CSA

Defining CSA

Definitions of CSA vary according to the construct of CSA (i.e., upper age limit of whose considered a child and/or the age and relational power position of the perpetrator), the acts that constitute CSA (i.e., contact and noncontact sexual offences), and the nature of consent (Mathews & Collin-Vézina, 2019). The World Health Organization (WHO; 2006) provides a broad definition of CSA and defines a child as a person below the age of 18 years old:

> [child] sexual abuse is defined as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim. (p.10)

In this thesis, with the aim of maximizing inclusivity, I have included studies that align with the WHO's definition of CSA, encompassing both contact and non-contact sexual offences and studies that permitted participants to self-identify as having experienced CSA.

When considering the concept of "childhood," an intersectional approach warrants the recognition that this is a social construct given different meanings across cultures and societies (Norozi & Moen, 2016). As one article stated, "the discourse of childhood has always been employed as a singular, universal phenomenon, hiding differences within and between communities, cultures and societies" (p. 211) and has long assumed that Western models of childhood should be what is considered a typical childhood (Pasura et al., 2013). Yet, conceptualizations of what is considered "childhood," "sexual abuse," and who is considered a valid "childhood sexual abuse victim" are influenced by culture (Pasura et al., 2013; Reavey et al., 2006). For example, an analysis of the social construction of childhood and CSA in six Caribbean countries revealed that childhood is considered to end by the onset of puberty, and only girls who were sexually abused prior to puberty were recognized as valid CSA victims, while adolescent girls and boys at any age were not (Pasura et al., 2013). In a study with South Asian survivors of sexual abuse, including CSA, some survivors preferred to not use the term "rape" or similar words to describe the sexual abuse (Reavey et al., 2006). The authors of this study partly attributed this to the "insufficiency of the Westernised concept of 'rape' which … did not resonate with the contextual dynamics of different South Asian cultures" (Reavey et al., 2006, p.177). In some Latino cultures, as long as a female child was not vaginally penetrated and has an intact hymen, then her honor is preserved, and the family dismisses any further need to acknowledge the experience as sexual abuse (Fontes, 2007). Moreover, in some countries, CSA is rarely discussed and sometimes considered non-existent; for example, there is a lack of CSA data from the Middle East and North Africa, in part due to myths that CSA does not happen in their societies and that it is a Western problem, and an overall cultural resistance to acknowledge CSA as it is a taboo subject (Attrash-Najjar & Katz, 2023; Polonko et al., 2011). Accordingly,

the conceptualization of CSA, constructed primarily through dominant Western discourse and the experiences of White children (Kenny and McEachern, 2000), may not align with the perspectives of CSA survivors from minoritized racial and ethnic groups.

In terms of individuals who have experienced CSA, they are commonly labelled as or describe themselves as CSA "victims" or "survivors," although some individuals identify as both at different times, and some prefer to identify as neither (Hunter, 2010; Warner, 2023). Both terms are used by victims and survivors, in CSA literature, and in different contexts, and so it is important to recognize the necessity and use of both terms (Sexual Assault Kit Initiative (SAKI), n.d.). These two victimization identities have different connotations for individuals who have experienced CSA. CSA survivors have associated the "victim" identity with weakness, passivity, and feeling as though they have not healed from the CSA, while some survivors appreciated the emphasis that the "victim" term places on suffering caused by another person (Warner, 2023). Victim is the term often used in the criminal justice system to acknowledge that a crime has occurred (SAKI, n.d.). CSA survivors have associated the "survivor" identity with strength, empowerment, and having completed a healing process (Phillips & Daniluk, 2004; Warner, 2023), but have also acknowledged the limitations of this label when the "prescriptive stereotype about what a survivor *should* be" makes them feel unable to admit that they may still be suffering from the CSA (Warner, 2023, p. 9). These victimization identities may hold different meanings for women survivors from different racial and ethnic backgrounds (Boyle & Rogers, 2020; Warner, 2023). This will be elaborated further in Manuscript 2, which includes a discussion of how these victimization identities are differentially adopted by CSA survivors and how they can intersect with other social identities to influence feelings of shame. In this thesis, "CSA survivor" is the more commonly used term, because of its emphasis on strength in the face

of adversity and because participants in my thesis research had completed some sort of psychosocial intervention for the CSA, and hence had begun their healing process to some extent. “CSA victim” was also used in this thesis when deemed more appropriate, such as when discussing the treatment of victims in the criminal justice system or when this term was used in the cited literature.

Key Construct: Shame

Defining Shame

Shame is a complex social, self-conscious, and moral emotion that concerns the whole self and is triggered in response to threats to one’s social self and relational bonds (Dickerson et al., 2004; Tangney & Dearing, 2002). Shame has a long history of being neglected and avoided by researchers, and even currently in society, due to its taboo nature (Brown, 2006; Scheff, 2014). Historically, Sigmund Freud (1933/1961) regarded shame as “a feminine characteristic par excellence, which has as its purpose, we believe, concealment of genital deficiency” (p. 132). This and other rare earlier work on shame implied the importance of shame among girls but not boys, and especially that shame should be instilled in girls if they showed curiosity about sexuality (von Raumer, 1861). Consideration of the historical context of shame thus demonstrates its fundamental association with sex and sexuality among girls and women.

Presently, in the English language, without prefacing “shame” with another adjective, it automatically has a negative connotation (Scheff, 2003). Unlike some other languages, English does not have unique words to distinguish every day or adaptive shame from maladaptive shame (Scheff, 2003). Adaptive shame is an ordinary part of social life that usually results from mild social ridicule and allows individuals to learn the boundaries of socially acceptable behavior (Herman, 2011; Scheff, 2003). Maladaptive shame (hereon simply referred to as “shame”) leads

an individual to believe that they are a failure, bad, weak, dirty, insignificant, little, helpless, not intact, and to seek acceptance yet expect rejection from others (Morrison, 2011). One of the early pioneers in shame research, Helen Lewis (1987), defined shame as "one's own vicarious experience of the other's scorn" (p.15) in which one engages in internal dialogue and imagines that in the mind of another person the whole self is being ridiculed or negatively judged. More recently, Brené Brown (2006) conceptualized shame as a psycho-social-cultural construct and "intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (p.45). The general understanding of shame then is that shame arises from viewing oneself negatively and believing that others also perceive the self negatively.

Although shame is generally an emotion to be avoided across many societies (Mayer & Viviers, 2017), it has more ambiguous and sometimes multiple meanings for some cultural groups (Budden, 2009; Sheikh, 2014). For example, some South Asian cultures have multiple forms of shame that can influence the experience of CSA survivors, including "izzat" (honor/respect for self and family), "haya" (modesty and avoidance of premarital sex), and "sharam" that most closely resembles shame described in the English language (Gilligan, & Akhtar, 2006). In some cultures, "having shame" can be a good thing that refers to the preservation of dignity, modesty, moral integrity and maintaining one's standing in the community; conversely, not having any shame can be a negative thing that refers to an individual with no morals, who has lost their prestige and honor, or has brought shame to their family and community (Budden, 2009; Gilligan, & Akhtar, 2006). CSA survivors from cultures and societies with strong taboos against sex and values that dictate whether someone is honorable or shameful based on their exposure to premarital sex can be considered shameful for being a CSA

victim in the first place, and even more shameful if they disclose or report the abuse, as their disclosure shames the whole family (Fontes, 2007; Gill & Harrison, 2019; Maposa et al., 2016).

Development of Shame

The cognitive ability to feel self-conscious emotions such as shame begin to develop around 2 to 3 years of age (Lewis, 2014). Starting around this age, children become aware of the standards and rules of social behavior and are able to evaluate their behavior against such ideals (Lewis, 2014). These ideals are shaped by expectations we form for ourselves, as well as expectations internalized by our family and social and cultural environment (Brown, 2006; Morrison, 2011). Shame is increasingly felt when a child is conscious that they have failed to meet a certain ideal or have behaved in a manner that goes against standards, rules, or goals of the family, culture, or society in which they live (Lewis, 2014).

Extreme levels of shame develop from interpersonal relationships that are abusive, degrading, and characterized by dominance and subordination (Herman, 2011; Saraiya & Lopez-Castro, 2016). There is an empirically recognized association between trauma and shame, discussed as peritraumatic and posttraumatic shame (Lee et al. 2001). Peritraumatic shame refers to shame that arises during and immediately after a traumatic experience (Lee et al. 2001). Posttraumatic shame, the type of shame most referred to in trauma and shame literature (Lee et al. 2001), has been referred to as a secondary emotion that arises after a traumatic event via cognitive attributional processes in which an individual seeks to understand the meaning and cause of the event (Lewis et al., 2014). It has been proposed that "trauma leads to negative cognitive attributions and shame, which in turn leads to poor adjustment" (Lewis et al., 2014, p. 243).

Maladaptive schemas and shame-based beliefs that result from childhood trauma persist if not resolved and contribute to shame proneness in adulthood (Mojallal et al., 2021; Stokes, 2018). Among adults with diverse trauma experiences, high levels of shame have been associated with post-traumatic stress disorder (PTSD; Badour, et al., 2017; Cunningham et al., 2018; Saraiya & Lopez-Castro, 2016). Thus, it has been suggested that shame is central to interpersonal trauma experiences, such as CSA, and should be a central focus of treatment for trauma symptomology (Herman, 2011; Lee et al., 2001; Saraiya & Lopez-Castro, 2016).

Evolution of CSA Theories: Roots of Shame

Girls and women have a long history of being disbelieved, shamed, and blamed for being sexually abused, and this continues to shape their experiences of shame today (Azzopardi et al., 2018). Prior to the 1800s, the customary approach to reports of sexual abuse from women was to not believe these claims, and this extended to disbelief of children – usually girls – who made such claims (Bolen, 2002). In the mid-1800s, several theorists and medical clinicians recognized the existence of CSA, particularly father-daughter incest; however, they all removed blame from the accused offender, and proposed that female children were either responsible or lying due to hysteria, pathology, or their evil intentions against honorable, respectable men (Bolen, 2002).

In 1896, Sigmund Freud proposed the first theory of CSA, named the seduction theory, which proposed that hysteria symptoms, predominantly observed in women by Freud, were a result of CSA by caregivers, mainly fathers (Freud, 1896). This was the first theory that validated the sexual abuse of children and its potential to cause mental health difficulties. Nevertheless, largely due to backlash from his male colleagues and the conservative Victorian society in which Freud lived, he quickly renounced this theory (Rush, 1996). This demonstrates how sociocultural context and, even more so, individuals in socially privileged positions, in this case educated

White men, can shape whose stories, experiences, and needs are prioritized within a society. The recognition of CSA as a reality by Freud and his rather quick renunciation had a detrimental influence on the trajectory of CSA theory development (Bolen, 2002). The theories that followed after the renunciation of the seduction theory by Freud continued to shame victims of CSA and center blame for sexual abuse on victims, particularly girls.

Soon after, Freud introduced a theory of infantile sexuality, later named the Oedipus complex, which in psychoanalytic theory claimed that children have unconscious sexual desires toward their opposite sex parent (Freud, 1899). Thus, when children disclosed that they had been sexual abused, Freud claimed that no sexual abuse had actually occurred, but rather girls had created incestuous fantasies of themselves with their fathers and were disclosing these wishful fantasies. Rush (1996) commented on how Freud's theory effectively encouraged silence among victims:

> Any attempt on the part of the child or her family to expose the violator also exposes her own alleged innate sexual motives and shames her more than the offender; concealment is her only recourse. The dilemma of the sexual abuse of children has provided a system of foolproof emotional blackmail: if the victim incriminates the abuser, she also incriminates herself. (p.275)

Around the same time, Karl Abraham – a close collaborator of Freud – speculated that because only some girls were sexually abused, then there must be something intrinsically wrong with these girls, and the majority of these children unconsciously desired "infantile sexual activity" (Abraham, 1907). These ideas were more readily accepted at the time, instead of admitting that fathers and men may be sexually abusing children and holding them responsible. This highlights

the potent and enduring power of patriarchy as a system of oppression that has long silenced girls and women reporting CSA, in favour of protecting predominantly male perpetrators.

Until the late 1980s, almost a century after Freud renounced the seduction theory, theories and conceptualizations of CSA that shamed victims continued to be formulated. For instance, the idea was brought forward that there were different types of victims – "accidental victims" and "participant victims" (Rogers & Weiss, 1953). Participant victims were often sexually abused more than once and by more than one adult, often a parent, relative or family friend, with this reoccurrence of sexual abuse believed to imply that the victim must be an active participant in the abuse, encouraging and initiating these interactions (Rogers & Weiss, 1953). On the other hand, accidental victims were often sexually abused by a stranger, and were not seen as having encouraged the initiation or continuation of the abuse (Rogers & Weiss, 1953). Psychotherapy articles that followed this conceptualization described children as young as six years old as having a "seductive style" that contributed to the CSA that had occurred (Krieger et al., 1980). Relatedly, for children who did not report the abuse right away, it was claimed that this was because they enjoyed the sexual abuse (Yates, 1982).

A little over 35 years ago, family systems theory proposed that daughters subjected to father-daughter incest gained a "special status," received secondary gain in sexual pleasure, and experienced "a considerable enhancement of her power;" thus, with all these "incentives," the daughter continued the sexual encounters at her own will and was reluctant to end such a "rewarding" relationship (Kadushin & Martin, 1988, p. 298-302), all of which clearly places the responsibility for the continuation of CSA on the victim. These harmful conceptualizations of CSA impacted how victims were perceived in society and treated by professionals to whom they disclosed. Evidently, these early theories were less concerned with the psychological outcomes

for children who were victimized and more focused on formulating explanations centered on relational dynamics leading to CSA, which often incriminated the victim.

Finkelhor and Browne (1985) presented the first conceptual model of the impacts of CSA that they called the Traumagenic Dynamics model. The four traumagenic dynamics, or factors that cause trauma related to CSA, were traumatic sexualization, betrayal, powerlessness, and stigmatization. The dynamic of stigmatization referred to the negative implications "that are communicated to the child around the experiences and that then become incorporated into the child's self-image." (Finkelhor & Browne, 1985, p.532). Shame was described as "logically associated with the dynamic of stigmatization" (Finkelhor & Browne, 1985, p.535). The authors explained that negative messages can be communicated by the offender, those to whom the child disclosed who responded negatively and blamed the child, other people in the child's environment who further stigmatized the child by labelling them with negative characteristics, and through negative social and institutional responses to their CSA disclosures. Beyond direct messages, it was recognized that the child can be stigmatized via shaming attitudes toward CSA within their family and community, as well as by religious and cultural taboos, that the child becomes aware of (Finkelhor & Browne, 1985).

Resultant Stigma of CSA

Contemporary research suggests that the CSA myths and rape myths inherent in early conceptualizations of CSA persist in the present day. As per the Child Sexual Abuse Myth Scale (Collings, 1997), CSA myths revolve around three sets of beliefs: 1) those that shift blame from the perpetrator onto the child (i.e., children who do not report ongoing sexual abuse must want the sexual contact to continue; adolescent girls who wear revealing clothes are asking to be sexually abused); 2) those that minimize the harm of CSA and portray the child as consenting

(i.e., sexual contact with an adult can contribute favorably to a child's subsequent psychosexual development) and; 3) inaccurate beliefs about victim-perpetrator relationships as well as perceptions regarding demographic and social contexts for abuse (i.e., most children are sexually abused by strangers; CSA takes place mainly in poor, disorganized, unstable families). Rape myths have been grouped as dishonesty myths that centre on the idea that women frequently lie about rape; consent myths that determine what counts as consensual sex versus rape; and blame myths that place blame on the victim, for example based on how a woman was dressed, if she consumed substances, behaved flirtatiously, and so forth (Jenkins, 2021).

These myths have led to stigma surrounding CSA and the stigmatization of CSA survivors (Kennedy & Prock, 2018). Describing Goffman's (1963) conceptualization of stigma, Kennedy & Prock (2018) defined stigma as "a dynamic social process that discounts certain groups or individuals based on their perceived inferior moral status and rationalizes animosity toward them," further elaborating that "those who are stigmatized internalize this discounting as self-blame, shame, and the anticipation of negative judgments by others should their secret be revealed." (p. 512). Indeed, research presents that the stigma associated with CSA shapes how CSA survivors view themselves, how they are viewed in society, and the responses they receive from professionals across a variety of systems, all of which have been shown to impact their shame (Kennedy & Prock, 2018). Shame has been described as the main emotional component of stigma (Kennedy & Prock, 2018; Luoma & Platt, 2015), which insinuates that shame will continue to be an issue for CSA survivors as long as larger society continues to adhere to CSA and rape myths. These continue to influence how CSA survivors are treated (Denne et al., 2023; St. George et al., 2022), despite being extensively refuted through scholarly work. Thus, beyond dealing with the trauma of CSA itself, children who are sexually victimized also deal with the

burden of how CSA is viewed in society, as CSA is illegal, socially taboo, and violates social norms about what is appropriate and acceptable in childhood (Kennedy & Prock, 2018; McRobert, 2019).

Notably, some child and adolescent victims who meet all the myths of a "valid victim" (e.g., perpetrator is a stranger, abuse involved penetration, etc.) and have forensic evidence available to support their case may still not be believed by those, especially legal personnel, to whom they disclose on account of their intersecting marginalized identities (Hlavka & Mulla, 2021). Alongside this, greater rape myth acceptance has been associated with other oppressive belief systems, including greater racism, sexism, homophobia, ageism, classism, and religious intolerance (Aosved & Long, 2006; Suarez & Gadalla, 2010). This highlights the need to consider and apply theories that address systems of oppression to understand the vulnerability of girls and women, particularly those from marginalized groups, such as minoritized racial and ethnic groups, to sexual abuse.

Moving Forward: Intersectionality as a Theoretical Framework for CSA

During what became called the anti-rape movement in the 1970s, feminists challenged prevailing narratives about sexual abuse that placed blame and shame on victims who were predominantly girls and women, and instead advocated for blame to be assigned to perpetrators, who were usually men (Bolen, 2002; Gornick & Meyer, 1998). Feminist theories drew attention to patriarchy as an explanatory factor for sexual violence as it gave men power, which they abused through the sexual abuse of women and children (Rush, 1974; Whittier, 2009). Early feminist analyses of the role of patriarchal power in CSA viewed incest, particularly father-daughter incest, and CSA as part a broader web of sexual abuse against women (Brownmiller, 1975) and an early manifestation of male power and female oppression that is promoted by a

patriarchal society (Rush, 1974). Rush (1974) and other feminists argued that incest and CSA were not rare, but rather appeared rare due to the stigma, shame, and anticipated repercussions that prevented victims from sharing their experiences (Whittier, 2009). Though some analyses drew comparisons between CSA and the rape of adult women, it was recognized that the vulnerability of girls was compounded by their disempowered social position as minors (Brownmiller, 1975; Whittier, 2009).

Programs, policies, media coverage, and governmental funding meant to combat CSA and sexual abuse, act against perpetrators, and support survivors resulted from feminist activism. However, like other victories attributed to feminist movements, the increased services, laws, and rights put in place to protect girls and women primarily benefited White middle-class women (Moreton-Robinson, 2021). The attention to institutional and political priorities ended up overriding the original focus of feminist analyses on patriarchy, gender, and power, and feminist work progressively ignored the sexual abuse of children (Gornick & Meyer, 1998; Whittier, 2009). Mainstream culture continued to perceive CSA a medical and criminal problem, despite attempts to shift this paradigm to conceptualize CSA akin to rape as an issue of power and gender (Rush, 1974). As such, the attention to the significance of social forces and systems of oppression in the occurrence of CSA was gradually minimized.

An explicit focus on systems of oppression, namely sexism and racism, and their influence on sexual abuse was brought forward by Black women and women of color feminists. "Intersectionality" was the term eventually used to describe discussions of multiple, intersecting systems of oppression impacting the experiences, including sexual abuse, of racially and ethnically diverse women (Crenshaw, 1989), though these discussions were occurring beforehand. These feminist activists, scholars, and writers emphasized that "woman" should be

conceptualized as a diverse and heterogeneous, rather than homogenous, category (Moreton-Robinson, 2021). They critiqued the representations promoted within mainstream (or White) feminism of the White, middle-class, woman as the "universal woman," as this did not consider how the dissimilar histories and social contexts of different groups of women impacted their experiences in society (Moreton-Robinson, 2021). This idea dates back to 1851 when Sojourner Truth, an American abolitionist and activist for African American civil rights and women's rights, delivered her speech "Ain't I a Woman?" in which she addressed racial and gender disparities, including how she lacked the same rights and consideration in society as White women (though there are currently two versions of her speech; see The Sojourner Truth Project, n.d.).

Antiracist feminist critiques, and specifically Black feminist critiques, arose throughout the different waves of feminism, but especially during the 1970s and 1980s, that stressed the inadequacy of mainstream feminism to capture the history of and ongoing sexual violence against Black women. These works asserted that mainstream feminist discourse was exclusionary and made the experiences of Black women and non-White women invisible (Crenshaw, 1989; Hooks, 1981; Hull et al., 1982). White feminists justified their opposition to include discussions of race within feminist discourse because they claimed it took the attention away from gender (Hooks, 1981). This ignored the reality that racism and sexual violence cannot be separated for some groups, such as Black women (Hooks, 1981). Through this disregard for the varied sexual vulnerability of girls and women from different racial backgrounds, the goal of mainstream feminists was realistically to "empower white women to resist rape by expanding their political or their sexual rights" (Freedman, 2013, p.53). In effect, mainstream feminist scholarship dismissed the oppressive forces that interact with patriarchy to produce "rapeable"

(i.e., White women) and "unrapeable" (i.e., Black women) individuals in the eyes of society (Patrick & Rajiva, 2022). An analysis of sexual abuse, including CSA, that does not consider its relationship with racism is limited. This was one of the prominent messages of Black and women of color feminists who initiated social and political movements and discourse separate from mainstream (or White) feminism.

I will demonstrate the utility of intersectionality to understand CSA among minoritized racial and ethnic girls by examining the sociohistorical context of one of several groups of women who participated in my thesis research, Black women, and how these relate to their current oppression in the context of CSA. Using a historical analysis has been suggested as a useful approach to understand the current experiences of marginalized groups that are shaped by racism (Prather et al., 2018). Concerns have been raised that discussions of intersectionality sometimes fail to credit its origins in Black feminism (Carastathis, 2014). Though this is not the case in this thesis, I have chosen to elaborate on Black girls and women who experience sexual abuse in this section, as intersectionality certainly has its roots in Black feminism. It should be mentioned that, like many early feminist texts (Whittier, 2009), the sexual abuse of children and women were usually grouped together in these early works, and so are presented together in many instances in the following discussion; however, age is a central intersectional dimension of power and inequality that should be included within an intersectionality framework to understand CSA (Whittier, 2016). Moreover, intersectional discussions on shame among women CSA survivors who identify with minoritized racial and ethnic groups, including Black women, will be covered in Manuscript 2 (Chapter 3), and so those discussions will not be repeated here.

Exemplifying the Utility of Intersectionality: Sexual Abuse of Black Girls and Women

The historical and enduring legacy of racism and sociohistorical context of the sexual victimization of Black girls and women influences their present-day experiences as Black women CSA survivors, and the way they experience oppression at institutional and interpersonal levels through pervasive stereotypes that marginalize them (Prather et al., 2018). During slavery, the rape of Black enslaved women by White men was legal and common (Freedman, 2013; Friedman, 1979). Refusal was not an option for these Black women. Aside from the formal and legal power that "masters" had over Black enslaved women, their rape was justified by widespread cultural hearsay that "female slaves lacked sexual morality and would always consent" (Freedman, 2013, p.75).

The viewing of Black women as sexual objects did not desist with the abolition of slavery in America in 1865. After abolition, propaganda and rape laws were used as a form of racial terror to preserve the dominance of White people over Black people (Lerner, 1972; Wriggins, 1983). In many documented cases, when Black women fought against sexual advances by White men, they and others who tried to defend them were met with retaliatory violence (Freedman, 2013). Black women were portrayed as sexually uninhibited and welcoming of all sexual advances (Lerner, 1972). This portrayal of Black women put their claims of sexual abuse into question. Considering the stereotypes created of Black women as hypersexual beings according to this historical racial prejudice, the same respect was not allotted to Black women as White women, and rape against a Black woman who was apparently eager for all sexual advances was not seen as possible nor reprehensible (Lerner, 1972). Fighting to include Black women as eligible victims of rape in the law was met with resistance (Freedman, 2013). Even when rape laws were meant to be race-neutral, the reality was that rape laws primarily acknowledged the

rape of White women. Thus, just as it was the case during slavery, the rape of a Black woman was not seen as a crime after the abolition of slavery. It was made clear within courts that Black women were not believed to experience rape to the extent that White women do, that it will not be taken as seriously if a Black woman is raped compared to a White woman, and that a White man's word will be believed over that of a Black woman (Bohmer, 1974; Giddings, 1984).

The legacy of sexual prejudice toward Black girls and women persists today, as demonstrated through sustained views of Black girls as less chaste than White peers of the same age (Epstein et al., 2017). Due to historical and enduring sexual stereotypes, Black girls and women who are sexually victimized may experience heightened shame, as "they learn that their believability as a victim will be inherently compromised, that they will be blamed for their own victimization, and that they will receive very little support from society" (Slatton & Richard, 2020, p.5). Awareness of systemic racism and fears of secondary victimization by mental health professionals and legal personnel can silence Black women from disclosing CSA and discourage them from seeking support (Tillman et al., 2010).

Research confirms that the ongoing intersecting sexism and racism against Black girls and women exacerbate shaming and dismissive responses to their CSA disclosures, as well as negatively biased treatment across multiple systems. For instance, many studies have demonstrated a continued negative legal bias present toward Black girls and women who are sexually abused (Bottoms et al., 2004; Irving, 2008; Powell et al., 2017). Despite progression in legal statutes, actual court practices continue to reproduce racial inequalities and injustice when Black girls and children from other minoritized racial and ethnic groups report CSA (Hlavka & Mulla, 2021). Moreover, child welfare research has presented that Black children are significantly less likely than White children to have their cases of CSA substantiated, and overall

were the least likely racial group to have their CSA cases substantiated (Atkinson et al., 2022). Though this can be attributed to several factors, one of the possibilities is the lesser likelihood to perceive Black children as legitimate and believable victims of CSA due to stigma against these children. On a broader societal scale, an examination of contemporary media provides clear examples of the continued hyper-sexualization of Black females (Dagbovie-Mullins, 2013; Stephens & Phillips, 2003) and erasure of their history of sexual trauma at the hands of White men (Rajiva, 2022). Evidently, the intersection of sexism and racism continues to perpetuate significant disparities in the recognition, support, and treatment of Black girls and women who are survivors of CSA, exemplifying how their experiences cannot be comprehensively understood without consideration of their intersectional experiences and the sociohistorical context that shapes these.

Psychosocial Interventions for CSA Survivors: Progress and Current Challenges

Throughout the 1900s, literature on treatment for sexually abused children fluctuated between acknowledging that mental health disturbances may be a consequence of CSA and suggesting they were preexisting among children who were abused, as well as acknowledging that perpetrators had committed an abusive act and that some children may have been responsible for the abuse (Bender & Blau, 1937; Gruber, 1981; Krieger et al., 1980; Rasmussen, 1934). Significant progress has been made in the development and effectiveness of psychosocial interventions for CSA survivors to date. Several interventions have been developed that showed effectiveness in improving a broad range of symptoms among child and adolescent survivors of CSA, such as CSA-specific cognitive behavioural therapy (CBT), trauma-focused CBT, and group therapy (Tichelaar et al., 2020). Likewise, different psychological interventions, such as

CBT and different types of group therapies, among several others, have demonstrated therapeutic benefits for adult survivors of CSA (Fávero et al., 2022).

There is also some evidence that certain interventions may be specifically effective for certain groups of CSA survivors. For example, group therapy appears to be particularly effective among female children and adolescents who have been sexually abused (Tichelaar et al., 2020). Moreover, different group therapy models seem to be more effective in reducing specific symptoms among adolescent girls (Avinger & Jones, 2007). This points to the importance of selecting psychosocial interventions for different groups of CSA survivors that have shown to be effective for survivors with their specific social identities and needs.

Capacity to tailor psychosocial interventions for CSA survivors from minoritized racial and ethnic groups may be limited due to the scarcity of cultural diversity across studies of therapy experiences of adult CSA survivors, as noted in a literature review (Parry & Simpson, 2016). Moreover, a recent review of culturally competent interventions for CSA resulted in only nine studies that met inclusion criteria (Tuaau, 2023). Some of these were literature reviews, studies that reported on pre-existing interventions that were simply translated into different languages, and educational prevention programs. As these reviews present, there is a need to increase knowledge on the psychosocial intervention experiences and needs of CSA survivors who identify with minoritized racial and ethnic groups. Presently, as mentioned, due to the longstanding focus on the experiences of White girls and women in CSA research, interventions are likely most applicable to White, heterosexual, middle-class, cisgender women (McCauley et al., 2019).

Challenge: The Influence of Shame on Psychosocial Interventions

Beyond the selection of a formal intervention or treatment modality, other critical factors influence the efficacy of psychosocial interventions. Relevant to this thesis, one of these factors is shame. This will be discussed within the context of interventions with adult CSA survivors.

Once CSA history becomes known to a therapist[2] working with an adult CSA survivor, the shame of both the survivor and the therapist can influence therapeutic progress (Tangney & Dearing, 2011). This could present in therapy as CSA survivors resisting to talk about the CSA and related shame feelings and thoughts, or as therapists avoiding discussions of CSA, shame, or certain difficulties related to CSA that invokes their own shame (Tangney & Dearing, 2011; Taylor, 2015). Adult CSA survivors have reported testing out therapist comfort as they elaborated on their CSA history and could sense when therapists were uncomfortable with a topic (McGregor et al., 2006). When a therapist displayed unease or avoidance in addressing CSA after a survivor had attempted to discuss the abuse, adult CSA survivors reported that this "would often reinforce old feelings of being disrespected, unimportant, powerless, humiliated, and angry" (McGregor et al., 2006, p.52). Counselors who attempt to encourage the cultivation of positive cognitions and compassion toward oneself with CSA survivors without first acknowledging, naming, and addressing their shame may be limitedly facilitating recovery among CSA survivors (McLean, 2021). Therefore, counselors who are not knowledgeable or comfortable with shame in the context of CSA, or who do not have an awareness of their own shame triggers, risk acting out countertransference reactions that, in turn, re-shame CSA survivors (McGregor et al., 2006; Sanderson, 2006).

[2] Counseling, counselor, therapy, therapist, and related terms are used in this thesis in accordance with the terminology used in the literature being cited. Otherwise, for conciseness and to be consistent with Manuscript 3, "counselor" and "counseling" will be primarily used throughout the thesis.

Therapists working with CSA survivors have expressed feeling uncomfortable to discuss certain outcomes that have been associated with shame following CSA, particularly sexual difficulties and inappropriate sexual thoughts related to the abuse (Hovey et al., 2014; Wohl & Kirschen, 2018). Some therapists working with adult CSA survivors assume that survivors themselves will bring up shameful thoughts or feelings as they occur in therapy, and so do not ask about shame (Hovey at al., 2014). In reality, adult CSA survivors often do not feel comfortable sharing their most shameful experiences and thoughts related to the abuse (Alaggia & Mishna, 2014; Pettersen, 2013). Thus, if a therapist does not initiate discussions on shame, this may mean that shameful issues related to CSA will not be addressed. Rather, adult CSA survivors have voiced that they find it helpful when therapists take initiative in educating survivors on common effects of CSA as this helps normalize CSA experiences that they previously kept hidden due to shame and secrecy (McGregor et al., 2006). Specifically, adult CSA survivors have expressed that "for them to feel able to talk about the CSA they needed to know that therapists understood the dynamics and effects of CSA, were able to normalize their experiences, were able to cope with hearing about details of CSA" (McGregor et al., 2006, p.52). When engaging with a therapist who is able to support them to work through CSA-related difficulties, adult CSA survivors have reported diminished shame (Chouliara et al., 2011; Saha et al., 2011). These findings altogether indicate that mental health professionals should deepen their understanding of shame in CSA survivors to effectively recognize it, be able to facilitate discussions on shame-related issues and provide the education that many CSA survivors find beneficial to their healing.

Considering the different ways that shame can negatively influence psychosocial interventions, it is essential for professionals to possess a robust understanding of shame,

including how CSA survivors with diverse intersectional identities may uniquely experience shame related to CSA. It is also crucial to consider how CSA survivors' social identities influence their counseling preferences to foster a positive therapeutic environment, which will ultimately be conducive to discussing shame and reducing these feelings among survivors from diverse social backgrounds. Nevertheless, CSA research on both shame and psychosocial intervention experiences among survivors from minoritized racial and ethnic groups is limited. These knowledge gaps were addressed by Manuscript 2 (Chapter 3) that explored shame among women CSA survivors who identified with minoritized racial and ethnic groups, and Manuscript 3 (Chapter 4) that examined the psychosocial intervention experiences of this group, which revealed their counseling preferences.

Chapter 2: Manuscript 1

A scoping review of shame among child sexual abuse survivors across the lifespan: Findings and trends over three decades (1994-2024) and clinical implications

Rusan Lateef[a], Delphine Collin-Vézina[a], Ramona Alaggia[b], Heather MacIntosh[a]

[a] McGill University

[b] University of Toronto

Abstract

Child sexual abuse (CSA) is a longstanding international problem that affects children from all sociodemographic backgrounds. One of the common consequences of CSA is shame, a complex emotion that often develops from relationships that are abusive and leads individuals to believe that they are flawed and unworthy of belonging and acceptance from others. To better understand how shame impacts the lives of CSA survivors across the lifespan, this scoping review used the Arksey and O'Malley (2005) five-stage framework to examine peer-reviewed research literature published over the last three decades (1994-2024) on shame among child, youth, and adult CSA survivors. A total of 472 studies were selected for analysis in accordance with the search terms. A total of 101 articles were selected for inclusion in this scoping review. The demographic profiles of participants included in these studies and the methodologies that were used are summarized. The results of the scoping review reveal that shame is a common outcome of CSA, shame increases the risk of other negative outcomes, is a deterrent to disclosures, and is a critical aspect of the recovery process for CSA survivors across the lifespan. The findings also begin to reveal that survivor characteristics may influence how shame is experienced. Associated knowledge gaps in need of further exploration and the clinical implications of these findings are discussed.

Keywords: child sexual abuse; shame; children; adolescents; young adults; adult survivors

Introduction

This scoping review explores the relationship between shame and child sexual abuse (CSA). Shame is a complex social, self-conscious emotion and psycho-social-cultural construct that concerns the whole self and is triggered in response to threats to one's social self and relational bonds (Brown, 2006; Dickerson et al., 2004). Adaptive shame, which is an ordinary part of social life that usually results from mild social ridicule, allows individuals to learn the boundaries of socially acceptable behaviour and can motivate a desire for positive self-change (Herman, 2011; Lickel et al., 2014; Scheff, 2003). Maladaptive shame (hereafter referred to as "shame"), which is the focus of this paper, leads individuals to feel inherently flawed, bad, and unworthy of acceptance and belonging, and can motivate individuals to socially withdraw and isolate themselves (Brown, 2006; Sedighimornani et al., 2021). Shame often develops as a result of relationships that are abusive, degrading, and characterized by dominance and subordination (Herman, 2011; Mintz et al., 2017). Children who are abused, especially by a person in a trusted position, such as a caregiver, may develop shame that verges on self-hatred as a result of being treated negatively and made to feel unimportant in a context where they expect to be loved and given special recognition (Bennett et al., 2010; Fonagy et al., 2003; Mintz et al., 2017; Sedighimornani et al., 2021). One type of childhood trauma that has been consistently and strongly linked with shame is CSA.

CSA is a persistent global issue that affects children from all sociodemographic backgrounds, with global prevalence estimates ranging from 3 to 17% for boys and 8 to 31% for girls, though it is often speculated that these numbers are an underestimation of actual CSA rates (Barth et al., 2013; Pan et al., 2021). It has been suggested that shame associated with CSA is more detrimental than shame stemming from other traumas due to the social taboos, stigma, and

secrecy that surrounds CSA (Engel, 2015). As Rahm et al. (2006) stated, “sexual abuse is taboo and shameful, and so is shame” (p.100). Correspondingly, several empirical studies have reported higher shame among adults with a sexual abuse history compared to survivors of other types of traumas (Amstadter & Vernon, 2008; DePrince et al., 2011; Kaysen et al., 2005; La Bash et al., 2014; Wetterlöv et al., 2020).

Shame-based beliefs that result from childhood trauma persist if not resolved and contribute to shame-proneness in adulthood (Mojallal et al., 2021). High levels of shame in adulthood have been associated with post-traumatic stress disorder (PTSD), particularly among survivors of interpersonal traumas (Badour et al., 2017; Bhuptani & Messman, 2022; Saraiya & Lopez-Castro, 2016). As such, it has been suggested that shame should be a central focus of treatment with survivors of interpersonal trauma experiences, including CSA (Feiring & Taska, 2005; Mirabile et al., 2023; Plante et al., 2022). To inform early intervention efforts to prevent the continuation of high levels of shame into adulthood for CSA survivors, it is important to understand how shame is experienced by child and youth survivors of CSA. Moreover, considering that many CSA survivors delay disclosing and receiving help for the CSA (Alaggia et al., 2019), often until adulthood (Hebert et al., 2009; Jonzon & Lindblad, 2004), and thus may continue to harbour unresolved CSA-related shame, it is equally important to understand how shame impacts adult CSA survivors.

While the topic of shame related to CSA has garnered a considerable amount of attention in the literature, a synthesis of the research literature on shame following CSA among survivors of all ages will contribute to an enhanced understanding of how shame presents itself in and impacts the lives of CSA survivors across the life course. Such a comprehensive review would be a useful resource to researchers and clinicians working with survivors of all ages, while

allowing for the identification of knowledge gaps warranting further research. Therefore, this scoping review aims to summarize what is known from peer-reviewed literature published over the past three decades on shame among CSA survivors across the life course, specifically answering the question: What is known from the existing literature about shame among CSA survivors across the life course? Although one previous scoping review has examined experiences of shame among adult CSA survivors (MacGinley et al., 2019), this review included 28 studies published between 1999 and 2017 that solely focused on shame among adult survivors of CSA. Hence, the present scoping review provides an updated, comprehensive overview of the research on shame among CSA survivors through broader inclusion criteria of research published between 1994 to 2024 on CSA survivors of all ages.

Methodology

This comprehensive scoping review was conducted using Arksey and O'Malley's (2005) five-stage framework to better understand shame among CSA survivors. The five stages of the review included: (1) identifying the research question; (2) identifying relevant studies; (3) selection of studies; (4) charting the data; and (5) collating, summarizing, and reporting results.

Identifying the Research Question

This scoping review examined peer-reviewed research literature published over the last three decades (1994-2024) on shame among CSA survivors across the lifespan, including child and youth and adult survivors of CSA. Our main research question was: What is known from the existing literature about shame among CSA survivors across the life course? To determine how research on CSA and shame has evolved over time, we also examined methodological trends across the past 30 years, with this timeline aligning with the overall increase in scientific

attention to child maltreatment from the 1990s onward (Tran et al., 2018). Specifically, we aimed to assess the demographics of study participants and the methodologies used in these studies.

Identifying Relevant Studies

A search of the literature was conducted using specific search terms to retrieve literature on shame among CSA survivors that has been published within the past three decades (1994-2024). Two electronic databases were selected: ProQuest and PsycINFO. The first author developed and implemented the search strategy. Peer-reviewed articles that contained the following terms in their abstract were included in the search: [“shame”] AND [child* OR adolescen* OR youth OR incest] AND ["sex* abus*" OR "sex* victim*" OR "sex* assault" OR "sex* violence" OR "sex* trauma" OR "incest"]. These two comprehensive searches produced 133 duplications, which assured the research team that these were the most relevant databases from which to extract studies. The literature searches for both databases were conducted on February 14, 2024.

Study Selection

Arksey and O’Malley (2005) recommend using inclusion and exclusion criteria that will produce studies that address the central research questions. This scoping review included studies based on their type (quantitative, qualitative, and mixed methods), focus, participant group, and date of publication (see Table 1). The definitions of both shame and CSA are inconsistent and vary across studies within CSA literature (MacGinley et al., 2019; Mathews & Collin-Vézina, 2019). For example, studies may focus on specific types of shame, such as CSA-related shame, bodily shame, internalized shame, external shame, sexual shame, and shame-proneness, among others. To be as comprehensive as possible, this scoping review included any study that reported findings on any type of shame in relation to CSA or sexual abuse before the age of 18 years.

Two reviewers applied the inclusion and exclusion criteria to the articles retrieved in a two-step process. The first author screened the initial 455 articles that resulted from the initial searches of ProQuest and PsycINFO based on their titles and abstracts to assess eligibility for inclusion in this scoping review. This resulted in 148 articles included for further review based on their titles and abstracts. Reference lists of these articles were searched for relevant literature, which yielded an additional 17 articles, for a total of 165 articles that underwent a second screening process based on their full-text by two reviewers – the first author and a university research assistant. Following their individual evaluations of the full-text of all 165 articles against the inclusion and exclusion criteria, the two reviewers met to deliberate on their decisions to include or exclude each article and agreed to include 101 articles in this scoping review. Figure 1 illustrates the study selection process from identification to inclusion according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher et al., 2009) guidelines.

Charting the data

Descriptive data from each study were entered into an Excel spreadsheet. This included author(s), year of publication, study location(s), study objective(s), sample population and size, study design, shame measures used (if applicable), and key findings related to shame and CSA. It was decided for this scoping review to formulate two separate tables, one for studies that focused on children, adolescents and/or young adults (see Table 2 in Supplementary Material) and one for studies on adult CSA survivors (see Table 3 in Supplementary Material). Table 4 temporally categorized the studies as being published within one of three 10-year periods: 1994-2003; 2004-2013; 2014-2024. Table 4 provides a summary of study characteristics for studies conducted during each of the three decades included in this review, which allowed for the identification of

trends over time. Table 4 also includes a total score for each characteristic based on all of the included articles, helping to identify overarching patterns in studies across the entire period.

Collating, Summarizing, and Reporting the Results

The fifth stage of the Arksey and O'Malley (2005) framework involved summarizing and reporting the findings. Charting data allowed for the identification of important findings on what is known about shame among CSA survivors. The first author initiated a thematic analysis (Braun & Clarke, 2006) of the study findings. Braun and Clarke's thematic analysis provided a systematic framework for identifying themes which involved multiple readings of the selected studies by the first author, who extracted themes. These themes were further refined through discussions with the second author until a consensus was reached. The review outcomes facilitated the identification of gaps in the existing evidence base and recommendations for areas in need of improvement to develop a more comprehensive and inclusive understanding of shame within the context of CSA.

Results

Examination of the studies published across the three 10-year time periods included in this scoping review suggest that research on CSA and shame has gained attention over the past 30 years. Only 14% (n = 14) of the included articles were published between 1994 and 2003, 34% (n = 34) were published between 2004 and 2013, and 52% (n=53) were published between 2014 and 2024. With over half of the articles published in the most recent decade, it seems that attention to shame in the CSA context has increased over time. The results will continue with a description of the overall state of the evidence base and methodological trends over the past three decades, including in areas of sampling (i.e., gender, race and ethnicity, and geographic

location), methodology and study design. This will be followed by descriptions of four themes that emerged from a review of the studies.

Sampling

The final sample included 39 studies focused on children, adolescent and/or young adult CSA survivors (see Table 2) and 62 studies that included adult participants (see Table 3). The findings of studies that included a combination of adolescents and young adults up to the age of 25 years (e.g., Nguyen et al., 2021, Lateef et al., 2023, McElvaney et al., 2022, etc.), many of which explicitly stated a focus on "young CSA survivors," will be presented in the category of "children, adolescent and/or young adult CSA survivors" due to their evident focus on "younger" CSA survivors. Studies included various types of clinical, non-clinical, and community samples.

Genders

Of the 101 studies examined, 44 studies were based solely on women survivors and 43 studies included both men and women CSA survivors. Five studies included genders other than male and female. As seen in Table 4, no studies between 1994-2003 included genders other than male or female, one study did between 2004-2013 (Neufeld et al., 2012), and four studies in the past 10 years, between 2014 to 2024 (Barker et al., 2022; McElvaney et al., 2022; Moran & Salter, 2022; O'Loghlen et al., 2023). In total, 14 studies were based solely on male CSA survivors, with a gradual increase in such studies seen across the three decades, from one study in 1994-2003, to four studies during 2004-2013, and nine studies from 2014 to 2024. Moreover, in the past two decades examined, we see that a higher percentage of mixed gender studies included more than 25% rather than less than 25% male participants in their samples.

Racial and Ethnic Diversity

Among the 101 studies, 29 of them had over 50% White participants, 24 had 50% or less White participants, two studies mentioned they had ethnically diverse samples but no percentages were provided, 10 studies included only White participants, 15 studies focused solely on non-White participants, and 21 studies did not mention any information on the race or ethnicity of participants. Of the 15 studies that included solely non-White participants, five of these were conducted in Western countries, nine in non-Western countries, and one in both the United States (US) and West Africa (Maposa et al., 2016). There is an increase across the three decades of studies focused on solely non-White participants, from one published between 1994 to 2003, two between 2004 and 2013, and 12 studies between 2014 and 2024.

Locations

In terms of location, 91 of the 101 studies were conducted in Western countries, and 10 were conducted in non-Western countries. Almost half of the studies from Western countries were conducted in the US (n=44), with the next highest number of studies conducted in the United Kingdom (n=10), followed by Canada (n=9). Of the 10 studies conducted in non-Western countries, one study was conducted in Hong Kong (Chan, 2010), five studies in India (Daral et al., 2017; Joseph & Bance, 2019a, 2019b, 2020; Sharma, 2022), one study each in Chile (Guerra et al., 2021), Brazil (Moreira et al. (2022), Nigeria and Malwai (Nguyen et al., 2021), and one study included survivors from both the US and West Africa (Maposa et al., 2016). Although O'Loghlen et al. (2023) conducted an international online survey, they detailed that 85.3% of participants resided in a Western country and that the country of residence of the remaining 14.7% of participants were "other/prefer not to say"; therefore, this study was categorized as including participants from Western countries due to the lack of clarity regarding what these

other countries were. When observing studies across the three decades, we see that no study was conducted in non-Western countries in the first decade, followed by one in the next decade, and then nine in the most recent decade.

Methodology and Study Design

Studies included 58 quantitative studies, 37 qualitative studies, and six mixed method studies. Although the highest percentage of included studies were quantitative (57%), we see a reduced percentage of quantitative studies as we progress across the three decades and, concurrently, an increase in the percentage of qualitative studies. The majority of studies were cross-sectional (n = 77). Fifteen studies employed longitudinal designs. There were nine intervention studies, which were categorized as a separate type of study design in Table 4. Further characteristics of the quantitative and qualitative studies will be examined separately.

Quantitative Studies

Data collection methods for the quantitative studies and quantitative component of the mixed method studies included self-report questionnaires (n = 53), interviews (n = 6), facial coding systems (n = 2), an online clinical database (n = 1), psychiatric records (n =1), and one study used both an interview and self-report questionnaires.

Shame Measures. Self-report measures of shame were used in the majority of the quantitative and mixed method studies. Across the 54 studies that used self-report measures, 25 different standardized shame measures were used, whereas other studies used in-study designed shame measures or questions. Different self-report measures required participants to report on various types of shame. The following 25 standardized questionnaires were used: Abuse-Specific Shame Questionnaire (also called Shame Questionnaire in some studies), General Shame Questionnaire, Test of Self-Conscious Affect for Adolescents (TOSCA-A) and Adults (TOSCA),

posture abuse-related shame questionnaire, post-traumatic sex scale, Survey of the Body Areas, Body Image Guilt and Shame Scale, Body Image Shame Scale, Experience of Shame Scale, the shame subscale of the Objectified Body Consciousness Scale, body shame subscale of the Body Consciousness Scale Trauma-Related Shame Inventory, Abuse-Related Beliefs Questionnaire (or just the shame subscale), shame item of the Dysphoric Affect Scale, Personal Feelings Questionnaire, Internalized Shame Scale, Experience of Shame Scale, Kyle Inventory of Sexual Shame, External and Internal Shame Scale, Other as Shamer Scale, Jehu's Belief Inventory, Differential Emotions Scale, Shame and Guilt After Trauma Scale, Clinician Administered PTSD Scale, HIV and Abuse Related Shame Inventory (or just the sexual abuse-related shame subscale). The different types of shame assessed through these different measures included CSA-related shame, trauma-related shame, bodily shame, internalized shame, external shame, behavioural and characterological shame, sexual shame, sex-related shame, trait shame, shame-proneness, and general shame feelings. The same or similar types of shame, such as body shame, were assessed using different measures in different studies.

Qualitative studies

Data collection methods for the 37 qualitative studies and the qualitative component of the six mixed method studies included individual interviews (n = 35), focus groups (n = 3), focus groups and interviews (n = 2), an online questionnaire with an open-ended question (n = 1), a self-completed questionnaire with open-ended questions (n = 1), and one study that allowed participants to decide to participate in either a focus group or individual interview. Data analysis methods used across studies were thematic analysis (n = 17), content analysis (n = 9), interpretative phenomenological analysis (n = 7) grounded theory approaches (n = 6), narrative analysis (n = 1), the Vancouver School of Doing Phenomenology analysis (n = 1), qualitative,

analytic-inductive method (n = 1), and Colaizzi's (1978) seven-step method of phenomenological analysis to identify experiential themes (n = 1; McEvoy & Daniluk, 1995). Two studies did not specify the type of analysis they used in their manuscripts, and so they were categorized according to the description of their analyses; specifically, Gilligan & Akhtar (2006) were categorized as using content analysis and Mize et al. (1996) as using thematic analysis.

Themes

Synthesizing the findings from studies on children, youth, and adult CSA survivors revealed four themes that highlight the impact of CSA on shame at different developmental stages.

Shame is Associated with CSA

Studies with both male and female CSA survivors of different age groups have found shame to be associated with CSA.

Child, Youth, and Young Adult Survivors of CSA. In studies with adolescents in Brazil (Moreira et al., 2022) and Italy (Crisma et al., 2004), CSA survivors reported feeling shame following the sexual abuse, indicating that shame was a direct outcome of CSA. Andrews (1997) found that CSA was associated with higher levels of body shame among female adolescents and young adults. Some studies reported higher levels of shame among survivors of CSA compared to survivors of other types of traumas. For example, Negrao et al. (2005) found that female adolescent and young adult CSA survivors discussed their sexual trauma with more verbal shame than women without a CSA history discussing non-sexual trauma experiences. Likewise, Wetterlöv et al. (2020) found that adolescents with direct experiences of sexual potentially traumatic events reported significantly higher levels of shame-proneness compared to adolescents who had experienced several other types of potentially traumatic events.

Certain abuse characteristics and sociocultural attributes may increase the likelihood of shame following CSA or shape how it is experienced. In terms of abuse characteristics, children between 7 to 12 years old more often expressed shame when perpetrators were familiar (78%) rather than strangers (8%), when the abuse was serious (83%) compared to less serious (28%), and if the abuse was repeated (79%) than when it had occurred only once (25%; Hershkowitz et al., 2007). Among child and adolescent CSA survivors, girls have shown higher levels of shame than boys, and shame significantly reduced over a year for girls, but not boys (Feiring et al., 2002b). Meanwhile, Hlavka (2017) provided a detailed account of how child and adolescent boys uniquely experienced shame related to CSA via cultural discourses of masculinity.

Moreover, ethnicity and abuse severity seem to interact together to influence the shame of some CSA survivors. For instance, European American child and adolescent CSA survivors, but not Hispanic and African American child and adolescent CSA survivors, with high abuse severity (determined by six abuse characteristics in this study) had higher levels of abuse-related shame compared to those with low to average abuse severity (Feiring et al., 2001). Moreover, Hispanic children had higher levels of general shame than the other two ethnic groups (Feiring et al., 2001). A qualitative study with adolescents living in West Africa and African young adult women living in the US provided greater insight into how cultural background can shape shame following CSA (Maposa et al., 2016). Several survivors in this study felt shame for failing to meet cultural expectations for women through their exposure to premarital sex and the victim blaming that followed the sexual abuse. Many survivors in this study remained silent about the CSA or sexual abuse they encountered as young adults to protect their own honor and that of their families and prevent bringing shame onto their family through making their abuse known.

Adult Survivors of CSA. Many studies found as association between shame and CSA among adult men and women CSA survivors, including cross-sectional (Barker et al., 2021; Berlin et al., 2023; Dyer et al., 2015; Kim et al., 2009; Lisak et al., 1994; Milligan & Andrews, 2005; Patterson et al., 2023; Rhodes et al., 2018; Shaked et al., 2021; Talbot et al., 2004; Talmon et al., 2004) and longitudinal studies (Andrews et al., 2000). Several studies have found higher levels of shame associated with certain characteristics of CSA, including more CSA severity (Karan et al., 2014), younger age of CSA onset and being abused by a first-degree family member among women survivors (Ginzburg et al., 2006), and being abused by a female compared to a male perpetrator for male survivors (Lisak et al., 1994). Moreover, Rahm et al., (2006) found that women CSA survivors verbally expressed shame in different ways, categorized into the following indicator groups: (1) alienated; (2) inadequate; (3) hurt; (4) confused; (5) uncomfortable; (6) ridiculous.

Survivor characteristics also seem to be shape how shame is experienced following CSA. For example, women CSA survivors have exhibited higher levels of shame than men CSA survivors (Aakvaag et al., 2016; Lisak, 1994). However, research indicates that men uniquely experience shame after CSA in relation to their masculine identity. Qualitative studies that examined the impact of CSA on male survivors found that shame had a powerful impact on male CSA survivors and shaped their sense of self (Dorahy & Clearwater, 2012; Drewitt-Smith & Marczak, 2023; Isley et al., 2008; Patterson et al., 2023). For many men, their shame was connected to masculinity and being a man who has experienced CSA (Chan, 2010; O'Leary et al., 2017; Tryggvadottir et al., 2019). Moreover, men from different ethnicities have differentially expressed the emotional impact of shame following CSA on their wellbeing (Payne et al., 2014).

Ethnicity overall has been shown to impact the shame of adult CSA survivors. Among a group of ethnically diverse undergraduate women White, Asian/Pacific Islander, and Hispanic/Latina women demonstrated more shame than African American women (Watson et al., 2013). Two qualitative studies described how the CSA-related shame of Latina women (Castaneda, 2021) and Aboriginal women (McEvoy & Daniluk, 1995) were respectively shaped by Latina socialized expectations and stigma toward and stereotypes of Aboriginal women.

Shame is a Risk Factor for Other Negative Outcomes

Shame appears to contribute to other difficulties among CSA survivors across the lifespan.

Child, Youth, and Young Adult Survivors of CSA. The studies included in this review implicate shame as affecting two broad areas in the lives of child, adolescent, and young adult CSA survivors: (1) mental health and emotions and (2) relational and sexual difficulties.

Mental Health and Emotions. Shame was associated with mental health symptoms soon and long after the incidence of CSA. Shame following CSA has been associated with depressive symptoms (Alix et al., 2017; Ellenbogen et al., 2018; Feiring et al., 1998; Feiring et al., 2002a), PTSD symptoms (Alix et al., 2017; Ellenbogen et al.,2018; Feiring et al., 1998, 2002a, 2002b; Feiring & Taska, 2005), dissociative symptoms (Ellenbogen et al., 2018; Feiring et al., 2009a), anxiety (Ellenbogen et al., 2018), and suicidal ideation (Alix et al., 2017). In terms of long-term effects, higher levels of shame following CSA predicted PTSD symptoms and suicidal ideation six months later (Alix et al., 2020), PTSD symptoms one year later (Feiring et al., 2002b), and was significantly associated with more intrusive recollections six years later (Feiring et al., 2005).

Several studies have also found shame to mediate the relationship between CSA or issues related to CSA and various mental health problems. Experiences of being shamed were found to

partially mediate the relationship between CSA and depression among adolescents (Aslund et al., 2007). Shame has also been found to partially mediate the relationship between self-blame and PTSD symptoms, and completely mediate the relationship between self-blame and avoidance coping (Alix et al., 2017). Moreover, shame and depressive symptoms were found to partially mediate the relationship between self-blame and suicidal ideation (Alix et al., 2017). Abuse-related shame at the time of abuse discovery mediated the relationship between the number of abuse events and depressive symptoms among child and adolescent CSA survivors (Feiring et al., 2002b), and abuse-specific internal attributions and PTSD symptoms (Feiring et al., 2002a).

Beyond clinical mental health symptoms, shame has been found to negatively impact the emotional wellbeing of child and youth survivors, which has then been linked to further issues. Higher levels of shame among CSA survivors were associated with lower self-esteem and anger among male and female child and adolescent CSA survivors (Ellenbogen et al., 2018; Feiring et al., 1998, 2009b), including anger six years after abuse discovery (Feiring et al., 2007). Among female adolescent CSA survivors in India, internal and external shame were strongly negatively correlated with self-kindness, common humanity, and mindfulness, and internal shame was strongly positively correlated with isolation (Joseph & Bance, 2019b). Mediational effects of shame on the relationship between CSA characteristics and emotional difficulties have also been observed. Abuse-related shame fully mediated the association between self-blame and avoidance coping among female adolescent CSA survivors (Alix et al., 2017). Feiring et al. (2002b) found abuse-related shame to mediate the relationship between number of abuse events and self-esteem at the time of abuse discovery among male and female child and adolescent CSA survivors.

Relational and Sexual Difficulties. Shame among child and adolescent CSA survivors has short-term and long-term impacts on intimacy problems. CSA-related shame has been

correlated with sexual concerns among male and female adolescent survivors (Ellenbogen et al., 2018). At abuse discovery, shame and a self-blaming attributional style mediated the relationship between number of abuse events and eroticism (Feiring et al., 1998). Abuse-specific stigmatization, including abuse-related shame and abuse-specific self-blame attributions, one year after abuse discovery predicted sexual concerns and dysfunction six years later (Feiring et al., 2009b). In fact, abuse-specific stigmatization predicted which youth were at risk for sexual difficulties later in life more than more than abuse severity (Feiring et al., 2009b). Finally, Feiring et al. (2013) found a statistically significant indirect path from abuse-specific stigmatization one-year following abuse discovery to subsequent dating aggression perpetration and victimization six years after abuse discovery through anger at six years post-abuse discovery.

Adult Survivors of CSA. Pettersen (2013) found that CSA survivors discuss shame in the context of CSA in relation to the following facets of their lives, in order of highest to lowest number of mentions: (1) body; (2) emotions; (3) self-image; (4) sex; (5) family; (6) food; and (7) therapy. The findings from other studies with adult CSA survivors included in this scoping review revealed that shame negatively affects their lives in several domains: (1) mental health; (2) relationships and sexuality; and (3) suicidality.

Mental Health. Among women CSA survivors, shame was positively correlated with psychological distress, PTSD symptoms, anxiety, psychoticism, paranoid ideation, interpersonal sensitivity (Rahm et al., 2013), and emotional distress, and negatively correlated with resilience (Ginzburg et al., 2006). Watson et al. (2013) found that shame partially mediated the relationship between CSA and alexithymia symptoms. Moreover, in a study with both women and men, body shame fully mediated the relationship between CSA and binge eating (O'Loghlen et al., 2023).

Among HIV-positive men and women CSA survivors, sexual abuse-related shame was positively correlated with HIV-related stressors, trauma-related symptoms, mood and anxiety symptoms, behavioural difficulties, psychiatric distress, and negatively correlated with perceived availability of social support (Neufeld et al., 2012) and health-related quality of life (Persons et al., 2010). Willie et al. (2016) found that greater sexual abuse-related shame was associated with more anxiety and depressive symptoms particularly for heterosexual women in this group.

***Relationships and Sexuality*.** Shame has been found to mediate and moderate the relationship between CSA and several aspects of relational and sexual wellbeing. In terms of relational wellbeing, sexual shame has been shown to mediate the effect of CSA on relationship satisfaction (Barker et al., 2021). Shame also significantly mediated the association between CSA and interpersonal conflict in another study (Kim et al., 2009). Interestingly, hardiness has been found to have a significant moderating effect on the negative impact of internalized shame on marital/relationship intimacy among CSA survivors (Feinauer et al., 2003).

Regarding sexual wellbeing, higher levels of shame have been associated with greater sexual dysfunction (Gewirtz-Meydan & Godbout, 2023), whereas sexual shame completely mediated the relationship between a history of CSA and sexual function among community sample of women CSA survivors (Pulverman & Meston, 2020). Shame has also been shown to moderate the association between CSA and compulsive sexual behaviour disorder (Gewirtz-Meydan & Godbout, 2023). Women survivors have voiced their perception that reducing shame and guilt and improving self-esteem are key facilitators in reducing participation in risky sexual behaviour (Senn et al., 2017). Lastly, shame has been found to significantly predict adult sexual revictimization among women survivors in cross-sectional (Kessler & Bieschke, 1999) and longitudinal studies (Tapia, 2014).

Suicidality. In studies with women CSA survivors, shame has been associated with suicidal ideation (Kealy et al., 2017). Shame-proneness was associated with suicidal ideation across time in a longitudinal study that spanned 36 weeks (You et al., 2012). Bodily shame has been shown to partially mediate the effect of CSA on self-harm (Milligan & Andrews, 2005).

Shame is a Deterrent to Disclosure

Child, Youth, and Young Adult Survivors of CSA. In studies conducted with CSA survivors across the world, shame has been identified as a barrier to CSA disclosure (Crisma et al., 2004; Guerra et al., 2021; Hershkowitz et al., 2007; McElvaney et al., 2014; Schönbucher et al., 2012), and even as the most common reason for not disclosing the CSA (Daral et al., 2017; Malloy et al., 2021; Münzer et al., 2016). In a study that compared female CSA survivors aged 13 to 24 years in Nigeria and Malawi, embarrassment for self or family was the most common reason for non-disclosure among survivors in Malawi, but not Nigeria, although it was still a reported barrier for some survivors in Nigeria (Nguyen et al., 2021). This suggests that sociocultural context may influence the impact of shame on CSA disclosure experiences. In line with this, females and victims of multiple perpetrators compared to, respectively, males and victims of single perpetrators, were more likely to delay disclosure due to shame (Kellogg & Hoffman, 1997).

McElvaney and colleagues (2022) provided a detailed description of how shame manifests in the disclosure experiences of young people in both Canada and Ireland, signifying how shame plays a key role in the CSA disclosure process. The types of CSA disclosure experiences that individuals have can also impact their shame. For instance, female adolescent and young women CSA survivors whose initial CSA disclosure was accidental expressed greater shame than survivors who initially disclosed the abuse themselves (Bonanno et al., 2002).

Children who experience CSA may be able to accurately predict their parents' reactions to a CSA disclosure (Hershkowitz et al., 2007). A study found that 50% of boys and girls between 7- to 12-year-olds who were victims of CSA reported feeling afraid or ashamed of their parents' responses, and this impacted their disclosure decisions (Hershkowitz et al., 2007). Specifically, 88% of the children who delayed disclosure, 79% of those who disclosed to friends or siblings, and 77% of those who did not disclose spontaneously expressed fear or shame of their parents. The majority of parents (87%) of children who reported fear and shame of their parents indeed had unsupportive reactions to the CSA disclosures. Following disclosure of the CSA, shame continues to manifest in and impact the lives of CSA survivors in different ways, including struggles with identifying as a CSA survivor, an ongoing sense of responsibility for the abuse and exhibiting maladaptive behaviours associated with shame, receiving ongoing shaming responses to disclosures, as well as making efforts to overcome shame (Lateef et al., 2023).

Adult Survivors of CSA. Though shame can be both a motivator and inhibitor of disclosure (Macintosh et al., 2016), most studies have identified shame as a key barrier to CSA disclosure among adult CSA survivors (Marmor, 2023; Taylor & Norma, 2013), including male CSA survivors (Easton et al., 2014; Patterson et al., 2023; Sharma, 2022; Sorsoli et al., 2008). Shame tied to survivors' ethnicities and culture can also act as a barrier to disclosure and help-seeking (Castaneda, 2021; Gill & Harrison, 2019; Gilligan & Akhtar, 2006). The act of not disclosing can further exacerbate shame (Troya et al., 2021). Shame can be triggered both during and after disclosure (Mize et al., 1996; Villarreal, 2014), with the responses of disclosure recipients having the potential to increase or decrease feelings of shame depending on their level of supportiveness (Macintosh et al., 2016; Moran & Salter, 2022). With consideration of more recent avenues of disclosure, CSA survivors who have publicly disclosed about their CSA have

voiced a reduction in shame after doing so, in part due to being heard and feeling like they contributed to social change (Moran & Salter, 2022).

Shame is Central in the Recovery Process and Reduced through Treatment

Shame is experienced in different steps involved in seeking support following CSA. Over a quarter of Indigenous child and adolescent CSA survivors expressed shame, most commonly implicit shame responses, within the investigative interviews with police officers (Hamilton et al., 2016). More prompts had to be used by interviewers to elicit a CSA disclosure from children who verbally expressed shame during interviews compared to children who did not verbally express shame (Hamilton et al., 2016). Female adolescent survivors have expressed shame during forensic medical examinations in different ways, including feeling shame during the examination and as a result of questions asked, as well as fears of how they are being viewed by staff (O'Keeffe & McElvaney, 2022).

Shame is also an important factor to consider in formal treatment for CSA, as decreases in shame over time have been associated with a decrease in depressive and PTSD symptoms, as well as improvement in self-esteem among child and youth CSA survivors (Feiring et al., 2002b). Within the included studies, two interventions were found to reduce shame among child and adolescent CSA survivors: trauma-focused cognitive-behavioral therapy (TF-CBT) and compassion-focused visual art therapy (CVAT). TF-CBT led to more improvement in shame among children compared to child-centered therapy (Cohen et al., 2004), and these lower levels of shame among children treated with TF-CBT persisted 12-months post-treatment (Deblinger et al., 2006). CVAT was shown to significantly reduce trauma-related shame and increase self-compassion among female adolescent CSA survivors in India (Joseph & Bance, 2019a, 2020). Lastly, young CSA survivors voiced several strategies that helped them reduce their shame

following their CSA disclosures, mainly realizing that they are not alone in being abused through educational materials, media outlets, and speaking to other CSA survivors (Lateef et al., 2023).

Adult Survivors of CSA. Shame can both hinder and facilitate recovery among adult CSA survivors in different ways and is a prominent feature of their recovery journey (Chouliara et al., 2014). On the one hand, shame has been identified as a barrier to seeking help to deal with the CSA by both men (Tryggvadottir et al., 2019) and women (Villarreal, 2014). After engaging with professional support, shame can prevent CSA survivors from discussing their CSA history with counsellors (Janikowski & Glover, 1994).

On the other hand, feeling shame is the reason why some women CSA survivors decided to attend a self-help group (Rahm et al., 2013). CSA survivors have identified that shame processing was pivotal to their recovery (Chouliara et al., 2014), while male CSA survivors have described a de-shaming process across the life course that is often enabled by therapy and self-seeking support (Drewitt-Smith & Marczak, 2023). Therapeutic engagement can facilitate post-traumatic growth among CSA survivors, which women characterized as no longer feeling shame (Hartley et al., 2016). Women CSA survivors found that group therapy helped them transform from a "traumatized self," characterized by shame and negative self-perceptions, to a "positive self" characterized by self-acceptance and confidence (Saha et al., 2011). Women CSA survivors have identified several factors that helped reduce their feelings of shame in their healing process, including volunteering, helping others, education on biological responses to sexual assault, shifting blame to the abuser rather than inward, and spirituality (Arias & Johnson, 2013).

Several interventions were found to be effective in reducing feelings of shame among adult CSA survivors. First, shame was significantly reduced among women CSA survivors who participated in a trauma-focused and present-focused group (Ginzburg et al., 2009), and received

DBT-PTSD (Görg et al., 2017) and interpersonal psychotherapy (Talbot et al., 2011). In the study by Ginzburg et al. (2009), changes in shame mediated the treatment effect on PTSD symptoms. In a compassion focused therapy (CFT) group intervention for adult female survivors of CSA (CFT-SA), shame not only decreased from pre- to post-intervention, with the decrease maintained at a 3-month follow up, but the greatest number of participants endorsed the "Shame and Compassion" module as the most helpful of the 12 modules (McLean et al., 2022). Finally, among HIV-positive CSA survivors, CSA-related shame and dissociative symptoms predicted poor or positive outcomes for a support group condition; specifically, survivors with higher CSA-related shame but lower dissociative symptoms showed improvement (Hansen et al., 2017).

Discussion

This scoping review included 101 studies that provided a useful summary of the participants included and methodologies used in studies that have produced significant findings on shame and CSA, as well as what is known about shame among child, youth, and adult CSA survivors. Overall, this review highlighted that shame is strongly associated with CSA, shame increases the risk of other negative outcomes and is a deterrent to CSA disclosures, and shame is central in the recovery process of CSA survivors and can be reduced through different interventions.

The largest proportion of studies were quantitative (n = 58), followed by qualitative (n = 37), and mixed methods studies (n = 6). Of the quantitative and mixed methods studies, the vast majority used self-report questionnaires, including in-study designed shame measures or questions. There are several limitations associated with the use of self-report questionnaires in shame research. First, the use of instruments designed in-study that have not been validated limit the ability to make assertive conclusions from such research (Saraiya & Lopez-Castro, 2016). Second, self-report measures constrain the type of shame that CSA survivors could report, as

they usually focus on particular types of shame. Moreover, the use of self-report measures is potentially limiting as they largely measure explicit shame that participants are conscious of and willing to disclose (Saraiya & Lopez-Castro, 2016; Scheff, 2003). Overall, the use of many different shame measures with their associated variable definitions of shame challenges the comparability of results across studies, a crucial limitation of quantitative research on shame (Blum, 2008). Nevertheless, this scoping review demonstrated that quantitative studies provided statistical confirmation of significant associations between CSA and shame, as well as shame and other outcomes, whereas qualitative interviews with CSA survivors provided further details on the psychological mechanisms underlying these associations. Qualitative studies allow survivors to express their shame in their own words, rather than constricting their experiences to fit within quantitative measures with limited to no flexibility in their options; therefore, more qualitative studies that specifically examine shame among CSA survivors at different life stages can provide a more nuanced understanding of how shame is experienced across the life course.

Research gaps were also identified as part of this review process. First, there was a lack of inclusion of gender identities other than male and female in the studies included in this scoping review, indicating a clear research gap on this topic. Second, only 14 of the 101 studies in the final sample were based solely on male CSA survivors. All but one (Hlavka, 2017) of these studies were adult samples. The qualitative studies that specifically elaborated on shame among male CSA survivors (Dorahy & Clearwater, 2012; Drewitt-Smith & Marczak, 2023; Hlavka, 2017) demonstrated the pervasiveness of shame in the self-concept and lives of male survivors, to the extent that one participant said, “shame is actually what you are” (Dorahy & Clearwater, 2012, p. 162) and another emphasized “oh god the power of shame, the toxic power of shame” (Drewitt-Smith & Marczak, 2023, p.682). Therefore, there is a need for further

research on the shame experiences of male CSA survivors, especially child and adolescent boys. Moreover, men from different racial and ethnic backgrounds have expressed shame related to CSA in distinct ways (Payne et al., 2014) and male survivors from non-Western countries have voiced how societal taboos surrounding sex and sexuality added to shame in hindering their CSA disclosures (Sharma, 2022); therefore, there also seems to be a need to apply an intersectional lens to research in this area to better understand how different social identities and contexts interact with being a male CSA survivor to shape their experiences of shame.

In line with this, shame experiences of CSA survivors from minoritized racial and ethnic groups are marginalized in the literature. Only 10 of the 101 studies were conducted with CSA survivors from non-Western countries, suggesting the need for more research with CSA survivors from non-Western countries. Moreover, just 15 studies included exclusively non-White participants, with merely five of these studies conducted in Western countries. Findings of the limited studies that centered on minoritized racial and ethnic CSA survivors revealed that their shame was impacted by their racial and/or ethnic identities through relevant cultural expectations within their groups, cultural values of shame, or societal stigma and stereotypes attached to their identities (i.e., Castaneda, 2021; Gilligan & Akhtar, 2006; McEvoy & Daniluk, 1995). These results are anticipated since shame arises when individuals perceive that they have failed to meet specific ideals or have behaved contrary to familial, cultural, or societal values or norms (Brown, 2006; Lewis, 2014). Therefore, further research is needed to understand how shame manifests in CSA survivors that considers their diverse familial, cultural, and social backgrounds.

It is established in the literature that shame is associated with CSA. Despite this, only four qualitative studies have directly explored the shame experiences of adult CSA survivors (Dorahy & Clearwater, 2012; Drewitt-Smith & Marczak, 2023; Pettersen, 2013; Rahm et al.,

2006) and two qualitative studies have specifically examined manifestations of shame in the disclosure process (McElvaney et al., 2022) and post-disclosure experiences of young CSA survivors (Lateef et al., 2023). As such, there is arguably a greater need for qualitative research on shame with both child and youth and adult CSA survivors. Notably, the four qualitative studies that specifically focused on the lived experiences of shame among adult CSA survivors were all comprised of solely White and European participants. Therefore, findings from these studies are limitedly applicable to CSA survivors who are not White or European. This is a clear research gap that needs to be addressed through qualitative studies that explicitly explore the lived experiences of shame among CSA survivors from minoritized racial and ethnic groups. The application of intersectionality theory would be helpful in building this knowledge. As Levine (2021) notes, an intersectional approach in research to studying the effects of sexual violence is "particularly well poised to consider variation in individual, interpersonal, institutional, and cultural dimensions of sexual violence" (p.147) and avoids unnecessary replication of studies with similar populations.

Clinical and Research Implications

Several clinical implications can be derived from the findings of the studies in this scoping review. First, although both studies with children and youth (Feiring et al., 2002b) and adults (Aakvaag et al., 2016) have found higher levels of shame among female compared to male CSA survivors, it may be more clinically useful to recognize that male and female survivors may internalize and experience shame differently following CSA, and that this can affect their recovery processes. Male CSA survivors have described their shame associated with CSA in connection with their male identity starting from childhood and adolescence (Hlavka, 2017), and this shame connected to being a male victim of CSA continues into adulthood (Chan, 2010;

Dorahy & Clearwater, 2012; Drewitt-Smith & Marczak, 2023; O'Leary et al., 2017; Tryggvadottir et al., 2019). These limited findings indicate that gender socialization can shape how shame is experienced by CSA survivors and suggest a need for therapeutic interventions that are sensitive to these gender-specific experiences. Accordingly, scholars have argued a need for therapists to utilize male-centric communication that is sensitive to the unique needs and experiences of male CSA survivors (Teram et al., 2006; Tryggvadottir et al., 2019).

Second, studies with both children and youth and adult CSA survivors in this scoping review demonstrated that cultural context, race, and ethnicity can shape the levels and quality of shame experienced by CSA survivors from diverse racial and ethnic backgrounds. This is a limited area of research, and further research that specifically examines shame among CSA survivors from minoritized racial and ethnic groups is needed. Meanwhile, therapists should adopt an approach informed by an intersectional framework that acknowledges the unique struggles of CSA survivors from minoritized racial and ethnic communities (Sawrikar & Katz, 2018) as taking the same therapeutic approach with White and minoritized racial and ethnic survivors may be unsuitable and even exacerbate the trauma experienced by racially and ethnically minoritized survivors (Sawrikar & Katz, 2017).

Third, high levels of shame reported by CSA survivors of all ages confirm its persistence as a harmful consequence if unresolved, which is further supported by longitudinal studies in this review. Children may not disclose CSA for several reasons, such as feeling shame, and the majority of children who felt shame or fear to disclose to their parents experienced unsupportive responses from them (Hershkowitz et al., 2007). Studies with adult CSA survivors showed that shame could increase or decrease following CSA disclosures depending on whether the responses were negative or positive, respectively. To mitigate the shame that is experienced in

childhood following CSA, parents, teachers, school counsellors, and other adults in trusted positions to whom children may disclose CSA should be educated on how to respond to disclosures positively to avoid retraumatizing, or triggering shame and promoting silence among, children and youth who disclose CSA. By providing this crucial education, a more supportive environment may be created within homes and schools that encourages children to come forward and receive the help they need. This can mitigate long-term mental health outcomes associated with CSA-related shame and potentially reduce or prevent the continuation of shame into adulthood. To better support CSA survivors who disclose in childhood, more research is needed on strategies and interventions that reduce shame among child and youth CSA survivors. Overall, further research on recovery across the life course from CSA-related shame is needed.

Fourth, high levels of shame were shown to be associated with various mental health, emotional, relational, and sexual difficulties in CSA survivors in different developmental periods, in addition to suicidality among adult CSA survivors. Shame also mediated the relationships between CSA and several negative symptoms. This suggests that resolving shame could decrease other negative symptoms. Indeed, both studies with youth (i.e., Feiring et al., 2002b) and adults (Ginzburg et al., 2009) found this to be the case. In fact, it has been suggested that "shame is at the core of nearly every symptom victims experience" (p.33), and that healing from shame provides survivors of childhood trauma with the courage and motivation to resolve other issues related to their trauma (Engel, 2015). However, shame beliefs and feelings can deter individuals from sharing shameful experiences with therapists or other professionals (Baumann & Hill, 2016; Macdonald & Morley, 2001). Studies in this scoping review corroborate these findings (Hamilton et al., 2016; Janikowski & Glover, 1994). Thus, professionals working with CSA survivors across the lifespan should become aware of how shame impacts the lives of CSA

survivors and how it manifests, to be able to recognize it, and make the reduction of shame a key target in treatment. The paper by Rahm et al. (2006) could be used as a useful tool for professionals to identify the ways shame may be verbally expressed by CSA survivors, while the studies in this review that reported on interventions and strategies that alleviate shame could be incorporated into services.

Limitations

The results of this scoping review should be interpreted in view of the following limitations related to the search strategy used and resultant studies that were included in this review. First, only studies published in English were included in the scoping review, which may have contributed to the lack of studies from non-Western countries in the final sample of studies and led to the exclusion of important research published in other languages. Second, though the scoping review included studies from various countries, a large majority of studies were conducted in Western countries, and thus the findings may not be applicable to CSA survivors living in countries that were not represented in this review. Relatedly, although many studies in this review included racially and ethnically diverse samples, most did not discuss or explore possible differences among CSA survivors from different racial or ethnic backgrounds, and so similarities and differences among CSA survivors were not adequately captured in these studies. Finally, given the extent of published and unpublished studies across the world, the search was restricted to specific search engines, peer-reviewed journals, and search terms; therefore, the scope of identifying other potentially valuable studies or resources on this topic area was limited.

Conclusions

The studies included in this scoping review revealed that shame is a common outcome of CSA, shame increases the risk of other negative outcomes, is a deterrent to disclosures, and is a critical

aspect of the CSA recovery process for survivors across the lifespan. It also became apparent that several areas remain underexplored. Broadly, male CSA survivors, particularly child and adolescent boys, CSA survivors who identify with genders other than male and female, as well as CSA survivors from minoritized racial and ethnic groups remain understudied. Considering that CSA is a global phenomenon that impacts individuals of all sociodemographic backgrounds, CSA research must be more inclusive of the voices of diverse CSA survivors in order to better understand their unique needs and experiences of a central detrimental emotion that defines the experience of CSA – shame. Clinical work can be informed in many ways by the comprehensive overview presented in this scoping review of how shame impacts the lives of CSA survivors across the life course.

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Tables

Table 1

Inclusion and Exclusion Criteria

Inclusion Criteria	• Original, empirical, peer-reviewed studies • Primary research studies that used qualitative, quantitative, or mixed methods designs • Published in English language • Published between 1994-2024 • Studies that include a significant (quantitative) or key (qualitative) finding related to shame and CSA • Intervention studies that include a focus on addressing shame among CSA survivors • Includes participants who are CSA survivors of any age
Exclusion Criteria	• Reviews, theoretical papers, commentaries, editorials, dissertations, case studies, conference abstracts • Studies that do not separate findings for CSA from other traumas • Studies that did not report a significant finding on shame among CSA survivors • Non-English publications

1994-2003
2004-2013
2014-2024

Table 2

Characteristics of Studies focused on Children, Youth, and Young Adult Survivors of Child Sexual Abuse

Author(s), Year, Location	Study Objective	Sample Characteristics	Research Design	Shame Measure(s), if applicable
Alix et al. (2017) Canada	To investigate self-blame, shame, and coping strategies amongst sexually abused female adolescents and their impact on PTSD symptoms, depression, and suicidal ideation.	147 female CSA survivors Ages: 14-18 years Race/ethnicity: 71.4% Canadian, 9.5% Caribbean, 8.2% Latin American, 10.9% other	Quantitative. Cross-sectional. Self-report questionaries.	The Abuse Specific Shame Questionnaire (measures shame related to CSA)
Alix et al. (2020) Canada	To investigate if self-blame, shame, and maladaptive coping strategies amongst sexually abused female adolescents predicts PTSD, depressive symptoms, and suicidal ideation 6 months later.	100 female CSA survivors Ages: 14-18 years Race/ethnicity: 76% Canadian, 13% Caribbean, 11% other	Quantitative. Longitudinal (6 months apart). Self-report questionnaires.	The Abuse Specific Shame Questionnaire (measures shame related to CSA)
Andrews (1997) United Kingdom	To investigate the role of shame, particularly bodily shame, between the relationship of bulimia and childhood abuse amongst teenage and young adult women	69 teenage and young adult women (11 had experienced CSA) Ages: 15-25 years Race/ethnicity: N/A	Quantitative. Cross-sectional. Semi-structured interview.	In-study designed questions asked in interview about bodily shame
Åslund et al. (2007) Sweden	To investigate the relationship between psychosocial risk factors (parental separation, parental unemployment, and experiences of sexual abuse) and depression in adolescents, and whether shame can account for this association	5048 adolescents (CSA sexual touching reported by 11.9% of boys and 29% of girls; CSA involving intercourse reported by 6.8% of boys and 12.5% of girls) Ages: 15-17 years Genders: 9th grade cohort: 1450 (50%) boys, 1422 girls (50%); 2nd year cohort: 1097 (50%) boys, 1079 (50%) girls Race/ethnicity: N/A	Quantitative. Cross-sectional. Self-report questionnaires.	Shaming Index (being shamed by others) developed by authors

Bonanno et al. (2002) United States	To examine facial expressions of emotion as possible nonverbal markers of past CSA experience and of CSA survivors' willingness to voluntarily disclose such experience when provided the opportunity to do so	137 female adolescents and young women (67 CSA survivors, 70 non-abused comparison group) Race/ethnicity: 53% White and 47% minority (Black or Hispanic)	Quantitative. Part of a longitudinal study. Facial tracking system and coding of narrative interview transcripts.	Participants' facial behavior during the open-ended narrative interview were coded using the Emotion Facial Action Coding System (EMFACS). EMFACS criteria were used to translate the coded facial muscle movements into facial expressions, including shame
Cohen et al. (2004) United States	To examine the differential efficacy of trauma-focused cognitive-behavioral therapy (TF-CBT) and child-centered therapy for treating PTSD and related emotional and behavioral problems in children who have suffered sexual abuse	203 child survivors of CSA Ages: 8 to 14 years and their primary caretakers Genders: 79% girls, 21% boys Race/ethnicity: 60% White, 28% African American, 4% Hispanic American, 7% Biracial, 1% other	Quantitative. Longitudinal (before and after treatment, 12 weeks apart). Self-report questionnaires. Reports on an intervention.	Shame Questionnaire (measures CSA-related shame)
Crisma et al. (2004) Italy	To explore the main barriers to disclosure, the answers received during disclosure, and their main needs throughout this process	36 CSA survivors Ages: 31 participants less than 18 years, 4 participants between 18-22 years, 1 participant older than 22 years Genders: 35 females, 1 male Race/ethnicity: 100% Italian	Qualitative. Cross-sectional. Phone interview. Content analysis.	
Daral et al. (2017) India	To examine the barriers to the disclosure process of child maltreatment amongst adolescent females and the familial characteristics that put female children at risk for physical, sexual, and emotional abuse	1060 female adolescents in school (26.6% experienced CSA) Ages: 10-19 years Race/ethnicity: 100% Indian	Quantitative. Cross-sectional. Self-report, semi-structured questionnaire.	

Deblinger et al. (2006) United States	To determine whether differential responses to trauma-focused CBT and child centered therapy (CCT) for treating CSA survivors with PTSD has lasting effects following treatment and to further examine predictors of treatment outcome	183 CSA survivors and their primary caregivers (92 in TF-CBT treatment, 91 in CCT treatment) Ages: 8-14 years Genders: 79% girls, 21% boys Race/ethnicity: 60% White, 28% African American, 4% Hispanic American, 7% Biracial, 1% other	Quantitative. Longitudinal (T1 at 6 months follow up, T2 at 12 months). Self-report questionnaires. Reports on an intervention.	The Shame Questionnaire (measures CSA-related shame)
Ellenbogen et al. (2018) Canada	To investigate the contrasting experiences of physical abuse related shame and sexual abuse related shame, if these types of shame are associated with the same mental health outcomes, and if these associations exist even after controlling for severity of abuse	151 adolescent CSA survivors Mean age: 15.9 years Genders: 69.5% female, 30.5% male Race/ethnicity: N/A	Quantitative. Cross-sectional. Self-report questionnaires.	Shame Questionnaire (measures CSA-related shame)
Feiring et al. (1998) United States	To examine the role of shame and a self-blaming attribution style as factors to explain the level of psychological distress in child and adolescent victims of sexual abuse	142 child and adolescent CSA survivors Ages and genders: 82 children ages 8 to 11 years (72% girls, 28% boys) and 60 adolescents ages 12 to 15 years (82% girls and 18% boys) Race/ethnicity: 42% African American, 33% White, 18% Hispanic, and 6% other (including Asian and Native Americans)	Quantitative. Cross-sectional. Self-report questionnaires.	In-study developed shame questionnaire (4 questions about feelings of shame related to CSA)
Feiring et al. (2001) United States	To examine ethnic group differences in abuse characteristics, appraisal processes, primary caregiver support, and adjustment to sexual abuse from the time of abuse discovery to 1 year later.	130 child and adolescent CSA survivors Ages: 8 to 15 years Genders: 72% female, 28% male Race/ethnicity: 44% African American, 37% European American, 19% Hispanic	Quantitative. Longitudinal (T1 at abuse discovery, T2 at 1 year later). Children interviewed to answer questionnaires and parents completed self-report questionnaires.	Two measures of shame developed by authors: 1) General Shame Questionnaire to measure general shame and 2) four questions about feelings of shame related to CSA)
Feiring et al. (2002a) United States	To explore the nature and role of specific attributions for sexual abuse and their relation to general attribution style, shame, and symptom development from the time of abuse discovery to 1 year later.	137 child and adolescent CSA survivors Ages and genders: 80 children ages 8 to 11 years (59 girls and 21 boys) and 57 adolescents ages 12 to 15 years (43 girls and 14 boys) Race/ethnicity: 43% African American, 32% White, 17% Hispanic, and 8% other (including Asian and Native Americans)	Quantitative. Longitudinal (T1 at abuse discovery, T2 at 1 year later). Children interviewed to answer measures and parents completed questionnaires.	In-study developed shame questionnaire (4 questions about feelings of shame related to CSA)

Feiring et al. (2002b) United States	To examine adjustment following sexual abuse as a function of shame and attributional style.	147 child and adolescent CSA survivors Ages and genders: 83 children ages 8 to 11 years (61 girls and 22 boys) and 64 adolescents ages 12 to 15 years (47 girls and 17 boys) Race/ethnicity: 40% African American, 34% White. 18% Hispanic, and 8% other (including Asian and Native American)	Quantitative. Longitudinal (T1 at abuse discovery, T2 at 1 year later). Children interviewed to answer self-report questionnaires.	In-study developed shame questionnaire (4 questions about feelings of shame related to CSA)
Feiring & Taska (2005) United States	To investigate persistence in abuse-related shame during a 6-year period.	118 CSA survivors completed all three assessments (T1 to T3 - within 8 weeks of abuse discovery, 1 year later, 6 years later). Ages: 54% of the sample were adolescents ages 13 to 17 years, and 46% were young adults ages 18 to 23 years Genders: 76% female, 24% male Race/ethnicity: 39% African American, 31% White, 21% Hispanic, and 9% other (including Native American and Asian)	Quantitative. Longitudinal (T1 at abuse discovery, T2 at 1 year later, T3 at 6 years later). Self-report questionnaires.	1) In study-developed shame questionnaire at T1 and T2 with 4 questions re: abuse-related shame. At T3, 4 more questions added to original shame measure to ensure reliability at older ages. 2) The Test of Self-Conscious Affect for Adolescents (TOSCA-A) and Adults (TOSCA) to measure general shame proneness. 3) Posture abuse-related shame: Shame posture score
Feiring et al. (2007) United States	To examine a model in which stigmatization for CSA was expected to be related to anger, which in turn was expected to be related to affiliation with deviant peers	T1 (abuse discovery): 160 youth CSA survivors. Ages: 55% children (ages 8 to 11 years) and 45% adolescents (ages 12 to 15 years) Genders: 73% female, 27% male Race/ethnicity: 41% African American, 31% White, 20% Hispanic, and 8% other (including Native American and Asian) T2: 147 of participants from T1 were seen 1 year later T3: 121 of participants from T1 seen 6 years later	Quantitative. Longitudinal. (T1 at abuse discovery, T2 at 1 year later, T3 at 6 years later). Self-report questionnaires.	1) CSA-specific shame (4 self-developed questions). 2) Attribution about Abuse Inventory developed by authors (abuse-specific self-blame attributions) 3) Summary stigmatization score (combined two questionnaires)

Feiring et al. (2009b) United States	To examine potential pathways from CSA to subsequent romantic intimacy problems	At T1 (abuse discovery): 160 CSA survivors Ages: 55% of the sample were children ages 8 to 11 years and 45% were adolescents ages 12 to 15 years Genders: 73% female, 27% male Race/ethnicity: 41% African American, 31% White, 20% Hispanic, and 8% other (including Native American and Asian) At T2: 147 of the original participants from T1 were seen 1 year later. At T3: 121 of the original participants from T1 seen 6 years later	Quantitative. Longitudinal. (T1 at abuse discovery, T2 at 1 year later, T3 at 6 years later). Self-report questionnaires.	1) CSA-specific shame (4 self-developed questions). 2) Attribution about Abuse Inventory developed by authors (abuse-specific self-blame attributions) 3) Summary stigmatization score (combined two questionnaires)
Feiring et al. (2009a) United States	To examine potential pathways from CSA to negative self-schemas to subsequent dissociative symptoms and low global self-esteem	At T1 (abuse discovery): 160 CSA survivors Ages: 55% of the sample were children ages 8 to 11 years (M=9.6 years), and 45% were adolescents ages 12 to 15 years (M=13.5 years). Genders: 73% female, 27% male Race/ethnicity: 41% African American, 31% White, 20% Hispanic, and 8% other (including Native American and Asian). At T2: 147 of the participants from T1 were seen 1 year later At T3: 121 of the participants from T1 were seen 6 years later	Quantitative. Longitudinal. (T1 at abuse discovery, T2 at 1 year later, T3 at 6 years later). Self-report questionnaires.	1) CSA-specific shame (4 self-developed questions). 2) Attribution about Abuse Inventory developed by authors (abuse-specific self-blame attributions) 3) Summary stigmatization score (combined two questionnaires)
Feiring et al. (2013) United States	To examine prospective pathways from externalizing behavior problems and stigmatization (abuse-specific shame and self-blame attributions) to anger and dating aggression.	At T1: 160 youth CSA survivors Ages: 55% children ages 8 to 11 years and 45% adolescents ages 12 to 15 years Genders: 73% female, 27% male Race/ethnicity: 41% African American, 31% White, 20% Hispanic, and 8% other (including Native American and Asian). At T2: 147 of participants from T1 were seen 1 year later. At T3: 121 of the participants from T seen 6 years later	Quantitative. Longitudinal. (T1 at abuse discovery, T2 at 1 year later, T3 at 6 years later). Self-report questionnaires.	1) CSA-specific shame (4 self-developed questions). 2) Attribution about Abuse Inventory developed by authors (abuse-specific self-blame attributions) 3) Summary stigmatization score (combined two questionnaires)

Guerra et al. (2021) Chile	To strengthen understanding of CSA disclosure amongst Chilean populations, particularly with a gendered perspective.	Quantitative Phase: 210 CSA survivors residing in Chile Ages: 10 to 18 years Genders: 80% female, 20% male. Qualitative Phase 10 CSA survivors residing in Chile Ages: 18 to 20 years Genders: 70% female, 30% male	Mixed methods. Cross-sectional. **Quantitative phase:** Information inputted on an online database by professionals treating victims. **Qualitative phase.** Semi-structured interviews. Thematic analysis.	
Hamilton et al. (2016) Australia	`To explore how shame is expressed and discussed during investigative interviews with Aboriginal children, and how interviewers reacted to these responses.	70 CSA survivors Ages: 5-16 years Genders: 60 female, 10 male Race/ethnicity: 100% Australian Aboriginal	Quantitative. Cross-sectional. Semi-structured interviews (conducted by police officers).	
Hershkowitz et al. (2007) Israel	To examine how children disclosed sexual abuse by alleged perpetrators who were not family members.	30 alleged victims of sexual abuse Ages: 7 to 12 years and their parents (20 mothers and 10 fathers) Genders: 18 boys and 12 girls Race/ethnicity: 100% Israeli Jewish Hebrew-speaking	Quantitative. Cross-sectional. Interviews with children and parents.	
Hlavka (2017) United States	To explore how young men understand their sexual victimization experiences.	31 male CSA survivors Ages: 5 to 17 years Race/ethnicity: 18 White, 7 Black, 4 Latino, and 2 Native American	Qualitative. Cross-sectional. Semi-structured forensic interview. Qualitative, analytic-inductive method with analytic bracketing.	
Joseph & Bance (2019a) India	To assess the effectiveness of the intervention of compassion-focused visual art therapy at improving self-compassion and reducing trauma related shame amongst sexually abused children	10 female CSA survivors. Ages: 12 to 17 years Race/ethnicity: 100% Indian	Mixed methods. Longitudinal (pre-test and post-test score after three-week intervention). Reports on an intervention. Quantitative: Self-report questionnaires. Qualitative: Follow up focus groups, and interviews with victims and their significant others. Thematic analysis.	Trauma-Related Shame Inventory (trauma-related shame)

Joseph & Bance (2019b) India	To investigate the association between self-compassion and traumatic shameful memories amongst sexually abused children to inform effective interventions at reducing trauma-related shame.	158 female CSA survivors Ages: 79.1% between 15-17 years Race/ethnicity: 100% Indian	Quantitative. Cross-sectional. Self-report questionnaires.	Trauma-Related Shame Inventory (trauma-related shame). The Experience of Shame Scale (measures categorical shame, behavioural shame, and bodily shame).
Joseph & Bance (2020) India	To evaluate the effectiveness of the child-centered therapeutic program Compassion focused Visual Art Therapy (CVAT) on treating female CSA survivors.	36 female CSA survivors Ages: 86.1% between 15 to 17 years, 13.9% between 12 to 14 years Race/ethnicity: 100% Indian	Quantitative. Longitudinal (pre-test and post-test after seven-week intervention). Reports on an intervention. **Phase 1:** Self-reported questionnaires. Followed by focus group discussions and interviews with sexually abused children and their significant others. **Phase 2:** Experimental and control group engaged in the CVAT. Post-testing repeat of the self-report questionnaires from Phase 1.	Trauma-Related Shame Inventory (trauma-related shame)
Kellog & Hoffman (1997) United States	To describe feelings, disclosure characteristics, family dysfunction, and health risky behaviors in those adolescents having unwanted sexual experiences (USE) with multiple perpetrators compared with those adolescents having USE(s) with single perpetrators.	538 adolescents and young adults (54% of the females and 15% of the males had USEs. Overall, 48% had USEs) Genders: 86% female, 14% male Race/ethnicity: 76% Hispanic, 16% non-Hispanic White, 7% African American, and 1% other	Quantitative. Cross-sectional. Self-report questionnaires.	Shame option in self-developed questionnaire about reasons for delay in disclosure/non-disclosure: shame (fear, embarrassment, not wanting to get self or anyone in trouble, no one would believe me)
Lateef et al. (2023) Canada	To qualitatively explore the manifestation of shame in the post-disclosure experience of young CSA survivors.	11 CSA survivors Ages: 15 to 24 years Genders: 10 female, 1 male Race/ethnicity: Cultural identities reported included Hispanic backgrounds, Indigenous, Italian, Croatian, Canadian, Caucasian, and Tajikistan	Qualitative. Cross-sectional. Semi-structured interviews. Thematic analysis.	

Malloy et al. (2021) United States	To assess the CSA and CSA disclosure experiences of incarcerated female CSA survivors	94 serious female offenders in a juvenile facility (44 had experienced CSA) Ages: 15 to 24 years Race/ethnicity: 38% Latina, 21% African American, 18% Caucasian, and 22% other	Quantitative. Cross-sectional. Interview with a checklist of questions developed for this study.	Participants read a list of possible reasons for disclosure or non-disclosure, including feelings of shame or embarrassment
Maposa et al. (2016) United States and West Africa	To (1) examine the experiences of living with sexual abuse and HIV risk of African women and girls living in the United States and West Africa; (2) compare experiences of young adult African women living in U.S. to a much younger sample of African girls living in a West African metropolitan area; and (3) examine factors that support or encumber ways in which African girls and women navigate sexual relationships, (sexual) abuse, HIV risk, and associated vulnerability	5 African women in the United States (22 to 25 years of age) and 5 girls from West Africa (12–18 years of age)	Qualitative. Cross-sectional. Semi-structured interviews. Thematic analysis using an interpretive team approach.	
McElvaney et al. (2014) Ireland	To understand the factors influencing informal disclosure of CSA experiences, taking account of dynamics operating prior to, during, and following disclosure.	22 CSA survivors and 14 parents of these youth Ages of youth: 7 to 18 years Genders: 73% girls and 27% boys Race/ethnicity: N/A	Qualitative. Cross-sectional. Semi-structured interviews. Grounded theory methodology.	
McElvaney et al. (2022) Ireland & Canada	To identify possible manifestations of implicit shame in the disclosure experiences of young people who had been sexually abused in childhood or adolescence.	47 CSA survivors Ages: 15 to 25 years Genders: 42 female, 4 male, 1 non-binary Race/ethnicity: racial and cultural identities included Hispanic backgrounds, Indigenous, Croatian, Québécoise, Haitian, Jamaican, Somalian, Dutch, Caucasian, and Black	Qualitative. Cross-sectional. Semi-structured interviews. Thematic analysis.	
Moreira et al. (2022) Brazil	To analyze cases of sexual violence among teenagers at school.	38 adolescents who had experienced sexual violence Ages: 13 to 17 years Genders: 81.6% female, 18.4% male Race/ethnicity: Skin color reported was 42.1% Brown; 18.4% White; 21.1% Black; 13.2% Yellow; 5.3% Indigenous	Quantitative. Cross-sectional. Self-report questionnaires.	Type of questionnaire not specified; potentially self-developed questions.

Münzer et al. (2016) Germany	To examine barriers to disclosing sexual victimization and perceived social support after disclosure from the perspective of children and adolescents	42 children and adolescents CSA survivors Ages: 6 to 17 years Genders: 25 girls, 17 boys Race/ethnicity: N/A	Quantitative. Cross-sectional. Questionnaires administered through interview.	Barriers to disclosure explored using open-ended question.
Negrao et al. (2005) United States	To investigate the contributions of shame, humiliation, and anger by examining the relationship between emotional coherence, disclosure of CSA, and trauma	163 females (67 had experienced CSA) Ages: Mean age of participants in the CSA disclosure group was 18.9 years, nondisclosure group was 18.3 years, and the nonabused group was 17.8 years. Race/ethnicity: 53% White and 47% minority (Black or Hispanic)	Quantitative. Part of a longitudinal study. Facial tracking system and coding of open-ended narrative interview transcripts.	Emotion Facial Action Coding System (EMFACS). EMFACS criteria were used to translate the coded facial muscle movements into facial expressions of anger, shame, and embarrassment
Nguyen et al. (2021) Nigeria & Malawi	To better understand disclosure of sexual violence in Nigeria and Malawi.	Females CSA survivors between the ages of 13 to 24 years old in Nigeria (n = 456) and Malawi (n = 256)	Quantitative. Cross-sectional. Face-to-face structured questionnaire administered by trained interviewers in the local language.	Those who did not disclose were asked the reasons for not telling anyone, and those who did not seek help were asked their reasons for not seeking help.
O'Keeffe & McElvaney (2022) Ireland	To gather the perspectives of young people on forensic medical examinations	6 female CSA survivors Ages: 13 to 18 years Race/ethnicity: N/A	Qualitative. Cross-sectional. Semi-structured interviews. Thematic analysis.	
Schönbucher et al. (2012) Switzerland	To study the process of disclosure among adolescents from the general population who had experienced CSA	26 adolescent CSA survivors Ages: 15 to 18 years Genders: 23 girls, 3 boys Race/ethnicity: 22 were Swiss, 4 were of foreign nationality	Qualitative. Half-standardized interviews. Qualitative inductive content analysis.	Questions on feelings of guilt and shame: participants were asked whether they had ever felt guilty for or ashamed of each event of experienced CSA (yes/no).
Wetterlöv et al. (2020) Sweden	To examine whether shame proneness and guilt proneness were associated with direct and indirect experience of potentially traumatic events (PTEs). We investigated the relationship between gender, PTEs, shame, and guilt among adolescents	314 adolescents in upper secondary schools Ages: 15 to 20 years Genders: 64.8% female. 35.2% male Race/ethnicity: N/A	Quantitative. Cross-sectional. Self-report questionnaires.	Test of Self-Conscious Affect for Adolescents (TOSCA-A; measures shame proneness)

Table 3

Characteristics of Studies focused on Adult Survivors of Child Sexual Abuse

Author(s), Year, Location	Study Objective(s)	Sample Characteristics	Research Design	Shame Measure(s), if applicable
Aakvaag et al. (2016) Norway	To explore shame and guilt in men and women following various types of severe violence and their relation to mental health	2437 (54%) women and 2092 (46%) men (306 had CSA history; 128 reported rape before 18) Ages: 18 to 75 years Race/ethnicity: 96% of Norwegian origin	Quantitative. Cross-sectional. Computer-assisted telephone interviews. Self-report questionnaires.	Authors of this study developed a brief instrument, Shame and Guilt After Trauma Scale (measures trauma-related guilt and shame)
Andrews et al. (2000) United Kingdom	To examine the role of cognitive-affective appraisals and childhood abuse as predictors of crime-related PTSD symptoms	118 men and 39 women who were victims of a violent crime (5% CSA only, and 7% both CSA and physical abuse in childhood) 138 participants followed up 6 months later Ages: 18 to 76 years Race/ethnicity: N/A	Quantitative. Longitudinal (T1 within 1-month post-crime, T2 at 6 months later). Semi-structured interviews in which authors rated responses to self-report questionnaires on a Likert scale.	In-study developed questions about shame
Arias & Johnson (2013) United States	To examine the perspectives of adult female CSA survivors on their healing process in recovery.	10 female CSA survivors Ages: 44 to 56 years Race/ethnicity: 80% White, 20% African-American	Qualitative. Cross-sectional. Semi-structured interviews. Constructivist grounded theory design.	

Barker et al. (2021) (online, based in United States)	To examine the impact of CSA on relationship satisfaction in a sample of adults through measuring sexual shame and romantic partner attachment.	732 adults in a committed relationship (105 adults identified as CSA victims—19% of women and 7% of men) Ages: 18-76 years Genders: 422 women, 305 men, 5 did not identify with a gender Race/ethnicity: 78% White, 6.8% African American, 6.1% Asian, 5.9% Hispanic or Latino, 0.5% American Indian, 2.3% other	Quantitative. Cross sectional. Online self-report questionnaires.	Kyle Inventory of Sexual Shame (measures sexual shame/ feelings about current and past sexual choices and behaviors)
Berlin et al. (2023) Canada	To examine the links between lifespan trauma and methamphetamine use among gay men	33 men (25% CSA survivors) Ages: 25 to 62 years Race/ethnicity: 64% White, 21% Indigenous, 15% other	Qualitative. Cross-sectional. Semi-structured interviews. Thematic analysis.	
Castaneda (2021) United States	To explore the disclosure process among Latina women who were sexually abused as children, and specifically the privacy rule criteria used to manage their disclosure and privacy	7 female CSA survivors Ages: 20 to 60 years Race/ethnicity: 100% Latina (3 Chicanas, 3 Mexican, and 1 Cuban-Colombian-American)	Qualitative. Cross-sectional. Semi-structured interviews of open-ended questions with the "testimonios" methodology. Thematic analysis.	
Chan (2010) Hong Kong	To (1) understand the traumas and struggles of male sexual abuse survivors, and (2) determine and understand the needs of male sexual abuse survivors.	12 male survivors of childhood trauma in Hong Kong (11 were CSA survivors, 1 had experienced sexual abuse in adulthood) Ages: 26 to 52 years	Qualitative. Cross-sectional. Focus groups, followed by, in-depth individual interviews. Thematic analysis of focus group and interview data.	

Chouliara et al. (2014) United Kingdom	To explore experiences of recovery from CSA in male and female survivors who have/have not utilized mental health services	22 male and female adult CAS survivors over 18 years old Race/ethnicity: N/A	Qualitative. Cross-sectional. Semi-structured individual interviews following the critical incident technique. Interpretative phenomenological analysis.	
Dorahy & Clearwater (2012) New Zealand	To understand further the "lived experience" of male adults who have a CSA history; and examine the experiences of shame and guilt in adult males sexually abused as children	7 male CSA survivors Ages: 37 to 64 years Race/ethnicity: 100% New Zealand European	Qualitative. Semi-structured focus group interview. Interpretative phenomenological analysis.	
Drewitt-Smith & Marczak (2023) United Kingdom	To investigate self-conscious emotions such as guilt, shame, embarrassment, anger, and fear in male CSA survivors	9 male CSA survivors Ages: 38 to 72 years Race/ethnicity: 100% White (7 White British, 1 White Scottish, 1 any other White background)	Qualitative. Cross-sectional. Semi-structured interviews. Interpretative phenomenological analysis.	
Dyer et al. (2015) Germany	To investigate the association between CSA survivors' body and traumatic experience and to determine the emotions associated with the body parts related to the traumatic experience	97 women (45 had CSA history, 52 had no CSA history) Ages: mean age of 32.9 years Race/ethnicity: N/A	Quantitative. Cross-sectional. Self-report questionnaires.	Survey of the Body Areas (feelings of shame associated with highlighted body parts). Body Image Guilt and Shame Scale (BIGSS; measures shame related to body image)
Easton et al. (2014) United States	To investigate the barriers of disclosure amongst a large group of male CSA survivors	460 male CSA survivors Ages: 19 to 84 years Race/ethnicity: 90.7% White, 9.3% ethnic minorities	Qualitative. Cross-sectional. Participants recruited from three national organizations which help CSA survivors. Study based on one open ended item from the disclosure portion of a survey. Content analysis.	
Feinauer et al. (2003) United States	To determine if hardiness was effective in moderating the negative effects of the perceived trauma and severity of the sexual abuse and internalized shame on relationship intimacy	195 adult female CSA survivors Ages: mean age of 36 years Race/ethnicity: "The majority of subjects were […] Caucasian."	Quantitative. Cross-sectional. Self-report questionnaires.	Internalized Shame Scale (measures internalized shame)

Gewirtz-Meydan & Godbout (2023) Israel	To investigate the moderating role of traumatic sexuality in the association between CSA and sexual difficulties amongst CSA survivors	393 CSA survivors Ages: 24 to 41 years Genders: 78% female, 22% male Race/ethnicity: 31% Arabs	Quantitative. Cross-sectional. Self-report questionnaires	PT-SEX self-report scale (5 items pertaining to shame and guilt)
Gill & Harrison (2019) United Kingdom	To identify and explore key socio-cultural patterns that hold true across sample of British Asian women survivors of sexual violence. Examine (1) how abusers gain access to their victims, (2) family and community responses and (3) the role of cultural factors in concealing CSA/SV	13 British South Asian (Indian or Pakistani descent) women survivors of sexual violence (8 were CSA survivors and 5 were survivors of sexual abuse as adults) Ages: 25 to 50 years	Qualitative. Cross-sectional. Semi-structured interviews. Grounded theory approach.	
Gilligan & Akhtar (2006) United Kingdom	To understand cultural barriers to the disclosure of child sexual abuse in Asian communities	130 "Asian" women Ages: 20 to 60 years Race/ethnicity: 90% from Urdu/ Punjabi-speaking communities, 10% from Bangla-, Pushto- and Gujarati-speaking communities	Qualitative. Cross-sectional. Case study model. Focus groups.	
Ginzburg et al. (2006) United States	To investigate the validity, reliability, and structure of the Abuse-Related Beliefs Questionnaire (ARBQ) among adult survivors of CSA.	**Study 1:** 170 female CSA survivors. Ages: 34.7% were 20 to 29 years; 41.2% were 30 to 44 years; 24.1% were 45 to 60 years. Race/ethnicity: 62.1% White, 13.6% Latino/Mexican American, 7.7% African American, 5.9% Asian American, 2.4% Native American, 8.3% other **Study 2:** 70 female CSA survivors. Ages: 25.7% were 20 to 29 years; 58.5% were 30 to 49 years; 15.8% were 50 to 69 years. Race/ethnicity: 50.8% White, 14.5% Latino/Mexican American, 13% African American, 8.7% Native American, 5.8% Asian American, 7.2% other	Study 1. Quantitative. Cross-sectional. Self-report questionnaires. Study 2. Quantitative. Cross-sectional. Self-report questionnaires.	Abuse-Related Beliefs Questionnaire

Ginzburg et al. (2009) United States	To evaluate the effectiveness of group psychotherapy in reducing levels of shame and guilt in adult survivors of childhood sexual abuse at risk for HIV, and whether such reductions would mediate the effects of treatment on PTSD symptoms. To examine mediators of treatment response, specifically the relationships between shame, guilt, and PTS symptoms	166 female CSA survivors assigned to one of two treatment groups or a waitlist group. Ages: mean age of 36.78 years in trauma-focused group therapy; mean age of 37.01 years in present-focused group therapy Race/ethnicity: In trauma-focused group (66.7% White/European American; 11.1% Black; 9.3% Other Hispanic/Latino; 7.4% Other; 5.6% Asian American). In present-focused group (58.9% White/European American; 8.9% Asian American; 8.9% Other Hispanic/Latino; 7.1% Other5.4% Black; 5.4% Mexican American; 5.4% Native American)	Quantitative. Longitudinal (pre-treatment, immediately posttreatment, and 6 months posttreatment). Reports on an intervention. Self-report questionnaires.	Shame subscale of the Abuse-Related Beliefs Questionnaire (subscale is composed of 6 statements pertaining to an aspect of shame related to the abuse)
Görg et al. (2017) Germany	To compare individual ratings of trauma-related emotions and radical acceptance between the start and end of DBT for PTSD (DBT-PTSD) related to CSA	23 female CSA survivors Ages: 17 to 65 years Race/ethnicity: N/A	Quantitative. Secondary analysis of longitudinal data. Reports on an intervention. Self-report questionnaires.	Clinician Administered PTSD-Scale (includes measures of persistent negative emotional states including shame)
Hansen et al. (2007) United States	To (1) illustrate the use of classification and regression trees as a clinically useful outcome prediction tool; (2) identify subgroups of patients living with HIV who are predicted to have poor outcome in group treatments for CSA	177 HIV-positive adults with CSA history Ages: mean age 42.8 years Genders: 97 women and 80 men. Race/ethnicity: 10.9% Caucasian, 67.8% African American, 16.7% Hispanic/Latino, 4.6% other	Quantitative. Secondary data analysis of cross-sectional data. Reports on an intervention. Self-report questionnaires.	HIV and Trauma-Related Shame (developed in-study). Includes two shame subscales: 1) Shame Concerning HIV Infection 2) Shame Concerning Childhood Sexual Abuse
Hartley et al. (2016) United Kingdom	To investigate posttraumatic growth (PTG) amongst female CSA survivors including what factors are involved, how growth impacts their lives, and what facilitated or hindered PTG	6 female CSA survivors Age: 30 to 52 years Race/ethnicity: 50% British, 50% Indian	Qualitative. Cross-sectional. Semi-structured interviews. Interpretative phenomenological analysis.	

Isley et al. (2008) United States	To examine the long-term impact of Catholic clergy child sexual abuse perpetrated on boys	9 male CSA survivors Ages: 31 to 67 years Race/ethnicity: N/A	Qualitative. Cross-sectional. Interviews. Thematic analysis.	
Janikowski & Glover (1994) United States	One purpose was to examine opinions regarding incest-related counseling, including barriers, in the context of substance abuse treatment.	36 clients undergoing treatment for substance abuse with history of incest Ages: 21 to 55 years Genders: 53% women, 47% men Race/ethnicity: N/A	Quantitative. Cross-sectional. Self-report questionnaires.	In-study developed questionnaire
Karan et al. (2014) United States	To (1) examine the course of shame over 16 years of prospective follow-up among borderline patients and axis II comparison subjects and (2) determine risk factors associated with feelings of shame among borderline patients	290 adults with borderline personality disorder Ages: mean age 27 years Genders: 77.1% women Race/ethnicity: 87.2% White, 12.8% non-White	Quantitative. Longitudinal (16 years). Self-report questionnaires.	One item ("full of shame") from the Dysphoric Affect Scale
Kealy et al. (2017) Canada	To investigate the relationship between suicidal ideation and experiences of guilt and shame among women seeking psychotherapy, and to examine the role of CSA in this relationship	68 women (41% reported CSA) Ages: 18 to 61 years Race/ethnicity: 63% Caucasian, 10% First Nations, 9% South Asian, 8% Asian, and 10% other ethnicity	Quantitative. Cross-sectional. Self-report questionnaires.	Personal Feelings Questionnaire-2 (measures frequency of shame- and guilt-related affects)
Kessler & Bieschke (1999) United States	To investigate whether shame and dissociation would mediate the relationship between experiences of CSA and adult victimization	548 women (154 reported CSA, 394 reported no CSA). Ages: 18 to 51 years Race/ethnicity: 92.47% White, 2.40% were Asian, 1.54% were biracial, 2.51% were Black, 0.77% were Hispanic, and 5.47% did not identify with a racial or ethnic category	Quantitative. Cross-sectional. Self-report questionnaires.	The Internalized Shame Scale (ISS; measures the extent to which participants have internalized painful levels of shame emotions)

Kim et al. (2009) United States	To examine whether shame-proneness mediates the relationship between women's histories of childhood sexual abuse and their current partner and family conflict and child maltreatment	129 mothers of children enrolled in a summer camp program for at-risk children from financially disadvantaged families (among 64 maltreated participants, 4% had experienced CSA) Ages: mean age of 34.25 years Race/ethnicity: 50% African American, 34% European American, 12% Latina, and 4% other ethnic background	Quantitative. Cross-sectional. Self-report questionnaires.	Differential Emotions Scale (measures frequency of 12 basic emotions in participants' daily lives and includes a shame subscale)
Lisak (1994) United States	To derive psychological themes that describe the psychological impact of CSA on male survivors	26 male CSA survivors Ages: 21 to 53 years Race/ethnicity: 1 African American, 2 Native American, and 23 European American.	Mixed methods. Cross-sectional. Qualitative: Semi-structured interview. Thematic analysis. Quantitative: Self-report questionnaires.	
MacIntosh et al. (2016) Canada	To explore the reported experiences of CSA survivors in disclosing their CSA history to romantic partners	27 CSA survivors (19 of these survivors were included in analysis) Genders: 20 women, 7 men Ages: 31 to 29 years Race/ethnicity: N/A	Qualitative. Cross-sectional. Telephone interviews. Thematic analysis.	
Marmor (2023) Israel	To deepen the understanding of the disclosure process for sibling sexual abuse in the Israeli Orthodox Jewish society, as perceived by siblings themselves.	24 adults from Israeli Orthodox Jewish communities. Ages: 19 to 68 years Genders: 14 women, 10 men	Qualitative. Semi-structured interviews. Constructivist-grounded theory methodology.	
McEvoy & Daniluk (1995) Canada	To examine, in-depth, the lived experiences of CSA for adult Native women.	Six Aboriginal women CSA survivors Ages: 29 to 53 years	Qualitative. Cross-sectional. Unstructured, in-depth, interviews using Adlerian technique of early recollection. Some women also drew pictures to stimulate self-reflection. Colaizzi's (1978) seven-step method of phenomenological analysis (existential phenomenology)	

McLean et al. (2022) Australia	To explore both the acceptability and preliminary efficacy of a compassion focused therapy group intervention for adult female survivors of CSA (CFT-SA). To determine if there were any changes in outcome measure scores after participating in the 12-week intervention and at 3-month post-intervention follow-up	30 women CSA survivors completed program; 25 attended the follow-up session 3-months after completion Age of participants who completed the program: 18 to 65 years Race/ethnicity: "Majority of participants across groups were Caucasian, with 3 participants identifying as Indigenous, Filipino, and Salvadorian respectively"	Quantitative. Longitudinal (T1 at pre-intervention within 2 week-period before intervention; T2 post 12-week intervention; T3 at 3-month post-intervention follow up). Reports on an intervention. Self-report questionnaires.	External and Internal Shame Scale (measures internal and external shame and generates global shame score). Other as Shamer Scale (measure of external shame consisting of items measuring how people think others evaluate them).
Milligan & Andrews (2005) United Kingdom	To (1) consider the contributions of childhood physical and sexual abuse and different aspects of shame and anger to self-harming behaviours in 89 women prisoners and (2) examine mediating roles of shame and anger in any link between childhood abuse and self-harm	89 female inmates (14% CSA only, and 26% reported both CSA and childhood physical abuse). Ages: 70% were between 21 and 39 years Race/ethnicity: 76% Caucasian	Quantitative. Cross-sectional. Self-report questionnaires.	Experience of Shame Scale (measures characterological, behavioural, and bodily shame).
Mize et al. (1996) United States	To qualitatively explore stories from a social constructionist paradigm emphasizing the process, experience, and results of disclosure of childhood incest to the family of origins by adult women.	21 CSA survivors Ages: 17 to 48 years Genders: 20 female, 1 male Race/ethnicity: "Ethnic background was primarily White although four of the women were of color."	Qualitative. Cross-sectional. Semi-structured five-page questionnaire.	
Moran & Salter (2022) Australia	To explore the role of institutionalised dignity as a medium for the social and political participation of CSA survivors who testified to the Australian Royal Commission into Institutional Responses to CSA. to explore how dignity is a feature of the experience, practice, and the structure of a therapeutic politics	26 CSA survivors Ages: between their early 20s and mid-80s, with more than half aged 50 years or older Genders: 10 men, 15 women, 1 non-binary gender participant. Race/ethnicity: N/A	Qualitative. Cross-sectional. Semi-structured interviews. Case study methodology. Secondary reflexive thematic analysis.	

Neufeld et al. (2012) United States	To describe the development of a measure of shame regarding sexual abuse and HIV infection, including evaluating the factor structure and establishing the reliability and validity of HIV and Abuse Related Shame Inventory.	271 HIV-positive CSA survivors aged 18 years or older Genders: 137 male, 130 female, 4 transgendered. The 4 transgendered participants were categorized according to their self-identification (3 female, 1 male). Race/ethnicity: 68% African American, 17% Hispanic/Latino, 10% Caucasian, and 5% other	Quantitative. Cross-sectional. Self-report questionnaires.	HIV and Abuse Related Shame Inventory (HARSI)
O'Leary et al. (2017) Australia	To explore gender-specific outcomes and describe the development of a scale to measure the effects of CSA on men	Qualitative: 20 men CSA survivors Ages: 19 to 46 years Race/ethnicity: 70% Anglo-Australian, 15% non-English speaking background, 10% born overseas, 5% Aboriginal Quantitative: 147 men CSA survivors Ages: 18 to 64 years m Race/ethnicity: N/A	Mixed methods. Cross-sectional. Qualitative: Interviews. Conventional content analysis. Quantitative: Self-report questionnaires.	Male Sexual Abuse Effects Scale (developed in-study)
O'Loghlen et al. (2023) Online (international: 85.28% Western countries, 14.72% other/ prefer not to say)	To understand the childhood maltreatment-binge eating relationship more fully by examining three types of shame (internal, external, body) and psychological distress as mediators in this relationship	530 adults with self-reported binge eating symptoms (174 experienced CSA) Genders: 76.7% female, 13.21% male, 9.06% non-binary, 0.75% prefer not to say. Race/ethnicity: 76.04% White, 8.49% Asian, 6.42% multiple ethnicities, 1.89% Black, 1.7% Hispanic, 5.47% other/prefer not to say/do not know	Quantitative. Cross-sectional. Online self-report questionnaire.	Internalised shame scale–shame subscale (measures internal shame). Other as Shamer scale-2 (measures external shame). Body Image Shame Scale (measures body shame).
Patterson et al. (2023) New Zealand	To explore themes of the impact of male CSA over the course of the lives of male CSA survivors.	9 male CSA survivors Ages: 42 and 67 years Race/ethnicity: 7 were New Zealand European, 2 were other European.	Qualitative. Cross-sectional. Semi-structured interviews. Interpretative phenomenological analysis.	

Payne et al. (2014) United States	To examine the reported CSA-related psychological and behavioural challenges of 150 US men, with equal numbers of Blacks, Latinos, and non-Latino Whites.	150 men CSA survivors Ages: mean age of those affected by CSA was 34.9 years; mean age of those non-affected was 37.5 years Race/ethnicity: 50 participants each Black, Latino, White.	Qualitative. Cross-sectional. Semi-structured open-ended interview. Content analysis.	
Persons et al. (2010) United States	To examine the impact of shame regarding both sexual abuse and HIV infection on health-related quality of life among HIV-positive adults with a history of CSA.	247 HIV-infected adults with a history of CSA. Ages: mean age of 42 years Genders: 51% female Race/ethnicity: 69% African American/Black, 17% Hispanic, 10% White, 5% other race/ethnicity.	Quantitative. Cross-sectional. Self-report questionnaires.	31-item measure with 3 subscales was used to assess sexual abuse-related shame (shame related to CSA), HIV-related shame, and the impact of HIV-related shame on behavior.
Petterson (2013) Norway	To answer the research question: How can shame from sexual abuse be described within the context of a Norwegian incest center?	19 adults who had experience with sexual abuse (16 had experienced CSA, 1 was not certain, 2 had not experienced CSA but had experienced sexual abuse in their families) Genders: 16 women, 3 men Race/ethnicity: 100% Norwegian	Qualitative. Cross-sectional. Focus groups. Constructivist grounded theory. Analysis based on four steps from Kvale (1996).	
Pulverman & Meston (2020) United States	To explore potential mechanisms of action to account for the relationship between CSA and sexual function.	120 adult women (63 with CSA history) Ages: mean age of CSA survivors was 26.42 years Race/ethnicity of CSA survivors: 44 Caucasian, 7 African American/Black, 6 Biracial/multiracial, 5 Asian, 1 Native American/ Alaska Native	Quantitative. Cross-sectional. Self-report questionnaires.	Kyle Inventory of Sexual Shame (measures sexual shame/ feelings about current and past sexual choices and behaviors)
Rahm et al. (2006) Sweden	To explore whether and how women exposed to CSA verbally express unacknowledged overt and covert shame, when interviewed about their physical and mental health, relations and circumstances relating to the sexual abuse. If shame was present, to describe the quality of the shame expressed by the women.	10 women CSA survivors Ages: 22 to 57 years Race/ethnicity: Swedish-born and Swedish-speaking subjects	Qualitative. Cross-sectional. Interviews. Content analysis.	

Rahm et al. (2013) Sweden	To (1) investigate how participants rated their mental health and to what extent they were at risk of developing PTSD; (2) investigate the relationship between mental health, PTSD, women's interpersonal relationships, reasons for participating in a self-help group (SHG) and CSA characteristics; (3) examine whether shame and guilt correlate with psychological distress and PTS symptoms.	87 women CSA survivors Ages: 19 to 67 years Race/ethnicity: N/A	Quantitative. Cross-sectional. Self-report questionnaires.	Questionnaire developed for this study assessing reasons for attending a self-help group (10 options including "feeling shame")
Rhodes et al. (2018) United Kingdom	To investigate the first-person perspective of psychosis sufferers who survived CSA	7 women with a CSA history who suffer from psychosis Ages: 32 to 48 years Race/ethnicity: 2 White/English, 1 White/European, 2 Black British, 1 Asian/British, 1 Mixed Race/English	Qualitative. Cross-sectional. Interviews. Interpretative phenomenological analysis.	
Saha et al. (2011) United Kingdom	To explore how the sense of self evolves through the recovery process after intensive therapy that focuses on issues pertaining to CSA. Describe the changes in their sense of self through group therapy	4 women CSA survivors Ages: 34 to 61 years Race/ethnicity: 100% White British	Qualitative. Cross-sectional. Narrative life story approach involving three interviews: (1) Life-story interview (2) Recovery-story interview (3) a semi-structured interview. Narrative analysis.	
Senn et al. (2017) United States	To describe the four-stage process followed to develop and refine a targeted sexual risk reduction intervention for CSA survivors with sexual risk behaviour	10 women CSA survivors Ages: 22 to 49 years Race/ethnicity: 9 African American, 1 mixed race	Qualitative. Interviews. Conventional content analysis.	
Shaked et al. (2021) Israel	To examine the internal discourses of incest survivors in Israel, reflected in self-reported internal dialogs which emerged during interviews.	13 female adult incest survivors residing in central Israel Ages: 23 to 51 years	Mixed methods. Cross-sectional. Qualitative: Semi-structured interviews. Qualitative content analysis. Quantitative: used interview data.	

Sharma (2022) India	To learn about the experiences of disclosing abuse among male CSA survivors in India	11 adult men survivors of CSA in India Ages: 20s to 50s (mean age 39 years)	Qualitative. Cross-sectional. Two face-to-face semi-structured interviews with each participant. Interpretative phenomenological analysis	
Sorsoli et al. (2008) United States	To understand the experiences of CSA disclosure among male CSA survivors	16 male CSA survivors Ages: 24 to 61 years Race/ethnicity: 11 Caucasian, 2 African American, 1 Puerto Rican, 1 part Native American, and 1 African Cuban	Qualitative. Cross-sectional. Two in-depth, semi-structured interviews with each participant. Grounded theory approach.	
Talbot et al. (2004) United States	To explore relationships among CSA history, shame-proneness, and dissociation in female psychiatric patients	99 women with and without reported histories of CSA hospitalized in a psychiatric unit. Ages: 37 years Race/ethnicity: 88% White, 11% Black or African American or other minority-group members	Quantitative. Cross-sectional. Self-report questionnaires.	Nine items from 3 subscales (Shame, Shyness, and Inner-Directed Hostility) of the Differential Emotions Scale (measures frequency of 12 basic emotions in daily life) used to examine global negative emotions about the self
Talbot et al. (2011) United States	To compare interpersonal psychotherapy with usual care psychotherapy among women in community mental health centers	70 women CSA survivors Ages: mean age 36 years Race/ethnicity: 41 White, 29 Black	Quantitative. Longitudinal (assessed at study entry and at 10, 24, and 36 weeks). Reports on an intervention. Self-report questionnaires.	Shame subscale of the Differential Emotions Scale (measures frequency of experiences of shame in participants' daily lives)
Talmon & Ginzburg (2018) Israel	To examine a model in which the relation between CSA and an individual's discomfort when in close proximity to others is mediated by disrupted body boundaries, and the relation between CSA and body shame is mediated by body self-objectification	843 college/university students in Israel Ages: 18 to 56 years Genders: 63.6% females, 36.4% males Race/ethnicity: N/A	Quantitative. Cross-sectional. Self-report questionnaires.	Body Shame was assessed with: 1) The bodily shame subscale of the Experience of Shame Scale 2) The shame subscale of the Objectified Body Consciousness Scale
Tapia (2014) United States	To examine the factors that lead to an increased risk of adult sexual re-victimization among CSA survivors	114 women CSA survivors Race/ethnicity: 86.8% African American	Quantitative. Secondary analysis of a longitudinal study.	Jehu's (1988) Belief Inventory (assesses problematic sexual behavior and beliefs)

Taylor & Norma (2013) Australia	To examine how women from non-culturally and linguistically diverse backgrounds are impeded by family members when attempting to disclose or report CSA	64 female CSA survivors Race/ethnicity: 100% Caucasian	Qualitative. Cross-sectional. Participants had option of a semi-structured, in-depth individual interview or focus group interview. Thematic analysis.	
Troya et al. (2021) Ireland	To examine the association between self-harm repetition, mental health conditions, suicidal intent, and CSA experiences among people who frequently self-harm.	Quantitative: 188 adults with self-harm history (79 reported a CSA history). Ages: mean age of 37.38 years Genders: 60.1% women Qualitative: 36 adults (72.2% had CSA history) Genders: 66.6% women Race/ethnicity: N/A	Mixed methods. Cross-sectional. Quantitative: Psychiatric records. Qualitative: Semi-structured interview. Thematic analysis.	
Tryggvadottir et al. (2019) Iceland	To explore the experience of male survivors of suicidal thoughts following sexual violence within the framework of men and masculinity	7 male survivors of sexual abuse (6 had experienced CSA; 1 had experienced adult sexual assault) Ages: in their 40s to 60s Race/ethnicity: N/A	Qualitative. Cross-sectional. Vancouver School of Doing Phenomenology. 17 interviews were conducted with seven male survivors: two interviews with four survivors, and three interviews with three survivors	
Villarreal (2014) United States	To describe Latina's experience of sexual assault disclosure and answer the research question: What feelings and consequences do Latinas remember experiencing during their initial disclosure?	13 Latina women CSA survivors Ages: 18 to 40 years	Qualitative. Cross-sectional. Semi-structured in-depth interviews. Thematic analysis.	
Watson et al. (2013) United States	To examine the role that CSA may play in body surveillance and sexual risk behaviors among undergraduate women	556 undergraduate women Ages: 18 to 56 years Race/ethnicity: 239 African American; 171 White; 52 Asian/Pacific Islander; 39 Multiracial; 37 Hispanic/ Latina; 9 Middle Eastern; 5 East Indian; 2 Native American; 1 Other West Indian; 1 did not respond	Quantitative. Cross-sectional. Anonymous online completion of self-report questionnaires.	The body shame subscale of the Objectified Body Consciousness scale (assess the extent to which a woman feels that she is inadequate if her body does not conform to societal expectations)

Willie et al. (2016) United States	To examine the associations between HIV-related shame, sexual abuse-related shame, posttraumatic growth, and anxiety and depressive symptoms	225 heterosexual women and men who have sex with men (MSM) living with HIV who have CSA history Ages: Women mean age of 43.49 years, men mean age of 41.2 years Genders: 101 women, 124 men Race/ethnicity: Women (78% Black, 8% White) MSM (77% Black, 25% White, 16% Multiracial)	Quantitative. Secondary analysis of cross-sectional data. Self-report questionnaires.	Sexual abuse-related shame subscale (measures CSA-related shame) of the HIV and Abuse Related Shame Inventory (HARSI)
You et al. (2012) United States	To examine the association of SI and emotions derived from the Differential Emotions Theory among treatment-seeking women with major depression and CSA histories	106 women CSA survivors Ages: mean age of 35 years Race/ethnicity: 50 White, 44 African American, and 12 of Hispanic origin	Quantitative. Longitudinal (assessed at baseline, 10, 24, and 36 weeks). Self-report questionnaires.	The Differential Emotions Scale-IV (assesses frequency of 12 emotions, including shame). A measure of shame-proneness (a sum of shame, shyness, and inner-directed hostility scales) derived from a previous study

Table 4

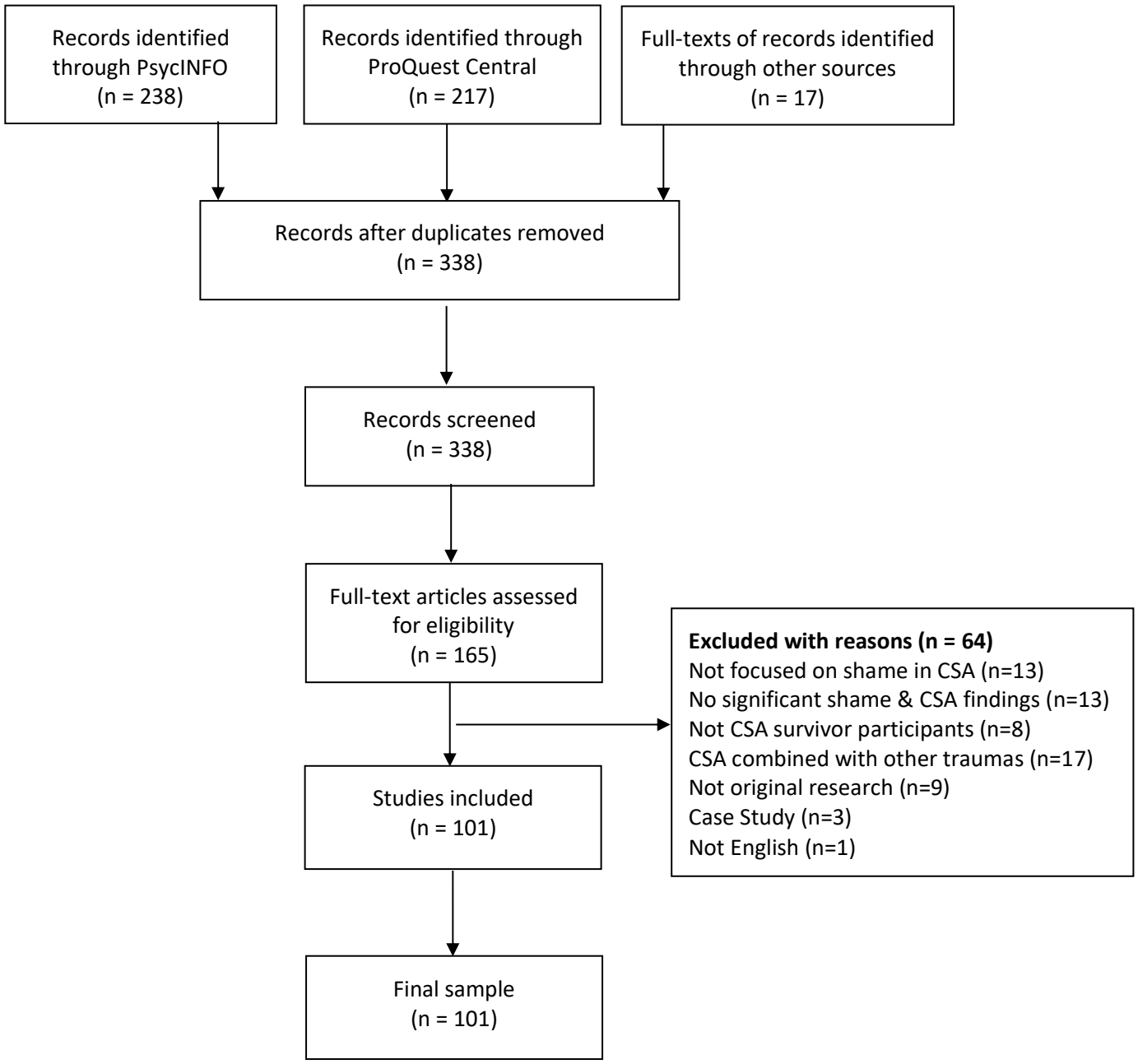
Final Sample Study Characteristics

	1994-2003 (n=14)	2004-2013 (n=34)	2014-2024 (n=53)	Total (n=101)
	n (%)	n (%)	n (%)	n (%)
Location				
Western country	14 (100%)	33 (97%)	44 (83%)	91 (90%)
Non-Western	0 (0%)	1 (3%)	9 (17%)	10 (10%)
Methodology				
Quantitative	11 (79%)	22 (65%)	25 (47%)	58 (57%)
Qualitative	2 (14%)	12 (35%)	23 (43%)	37 (37%)
Mixed Methods	1 (7%)	0 (0%)	5 (10%)	6 (6%)
Design				
Cross-sectional	9 (64%)	22(65%)	46 (87%)	77 (76%)
Longitudinal	5 (36%)	7 (21%)	3 (6%)	15 (15%)
Intervention	0 (0%)	5 (14%)	4 (7%)	9 (9%)
Participant Demographics				
Gender				
All female	5 (36%)	15 (44%)	24 (46%)	44 (44%)
All male	1 (7%)	4 (12%)	9 (15%)	14 (13%)
Mixed (25% or L male)	4 (28.5%)	6 (18%)	6 (12%)	16 (16%)
Mixed (> 25% male)	4 (28.5%)	9 (26%)	13 (25%)	26 (26%)
Mixed (% unknown)	0 (0%)	0 (0%)	1 (2%)	1 (1%)
Race/Ethnicities				
All White	0 (0%)	7 (21%)	3 (6%)	10 (10%)
All non-White	1 (7%)	2 (6%)	12 (22%)	15 (15%)
More than 50% White	5 (36%)	11 (32%)	13 (25%)	29 (29%)
50% or less White	5 (36%)	11 (32%)	8 (15%)	24 (24%)
Racially diverse (no%)	0 (0%)	0 (0%)	2 (4%)	2 (2%)
No data available	3 (21%)	3 (9%)	15 (28%)	21 (20%)
Age Group				
Children and youth	7 (50%)	12 (35%)	20 (35%)	39 (38%)
Adults	7 (50%)	22 (65%)	33 (65%)	62 (62%)

Figure

Figure 1

Article Selection Process



Bridging Manuscripts 1 and 2

This thesis seeks to present how women CSA survivors who identify with minoritized racial and/or ethnic groups experience shame and psychosocial interventions related to CSA, with a specific focus on how their intersectional racial, ethnic, and gender identities influence these experiences. The initial step in this line of inquiry was to assess what the existing literature currently indicates about how shame impacts the lives of CSA survivors, as well as what groups of CSA survivors are understudied (with a specific focus on groups at the intersection of race, ethnicity, and gender). Manuscript 1 was a scoping review that synthesized empirical literature on shame among CSA survivors of all ages. Findings from this scoping review indicated that shame is associated with CSA, shame increases the risk of other negative outcomes and is a deterrent to CSA disclosure, and that shame is central to the recovery process of CSA survivors and can be reduced through interventions. Several research gaps also became apparent. A glaring research gap was the need for qualitative studies that explicitly explore the lived experiences of shame among CSA survivors from minoritized racial and ethnic groups, as the four existing qualitative studies that specifically explored the shame experiences of adult CSA survivors were comprised entirely of White and European participants.

Manuscript 2 addressed this major gap in the understanding of shame among CSA survivors that was specified in Manuscript 1. Manuscript 2 used an IPA design and applied an intersectional perspective to explore how the intersecting social identities of 10 women survivors of CSA, particularly the intersection of race, ethnicity, and gender, impacted their experiences of shame. Manuscript 2 is the first known qualitative study to specifically explore the shame experiences of women CSA survivors who identify with minoritized racial and/or ethnic groups, and the first to explore shame among adult CSA survivors through an intersectional lens.

Chapter 3: Manuscript 2

An Intersectional Perspective on Shame among Women Survivors of Child Sexual Abuse from Minoritized Racial and Ethnic Groups

Rusan Lateef[a], Delphine Collin-Vézina[a], Ramona Alaggia[b], Heather MacIntosh[a]

[a] McGill University

[b] University of Toronto

Abstract

Shame has been identified in the clinical, theoretical, and empirical literature as a core component of the child sexual abuse (CSA) experience. Despite this, there are a limited number of studies that have directly explored the qualitative experiences of shame among adult CSA survivors. Moreover, the longstanding trend in sexual violence research of centring on the experiences of White women has effectively marginalized the voices of women CSA survivors from minoritized racial and ethnic groups. Using an interpretative phenomenological analysis design, this study fills a longstanding gap in the literature by exploring the following research question: how do the intersecting social identities of women survivors of CSA, and particularly the intersection of race, ethnicity, and gender, impact their experiences of shame? Interpretative phenomenological analysis of interview transcripts with 10 women CSA survivors who identified with a minoritized racial and/or ethnic group produced three Group Experiential Themes: 1) internalized shame tied to intersectional identity; 2) intra-familial reinforcement of shame and silence; and 3) maintenance of shame through systemic racism. Study findings are discussed using an intersectional perspective to highlight how shame following CSA can be molded through social location and consolidated via interpersonal dynamics and interwoven systems of privilege and oppression.

Keywords: psychosocial outcomes; moral emotions; shame; child sexual abuse; gender-based violence; trauma; intersectionality; race; ethnicity

Introduction

Child sexual abuse (CSA) is a global phenomenon that impacts children of all sociodemographic backgrounds (Barth et al., 2013) and can lead to numerous negative consequences for survivors (Hailes et al., 2019), including feelings of shame. Shame is a self-conscious emotion that leads individuals to believe that they are failures, bad, weak, dirty, insignificant, and to yearn for acceptance while expecting rejection from others (Morrison, 2011). Shame has multiple meanings and purposes in different cultural groups and can be seen as an emotion to be avoided, a positive force for behavioral change, or both (Budden, 2009; Mayer & Viviers, 2017; Sheikh, 2014). Shame associated with CSA can also be shaped by cultural norms and values. For example, South Asian women have discussed how different types of shame based in their culture are connected to sex, which they regard as a taboo subject, and family honor, which significantly impacted CSA disclosure and help-seeking decisions (Gill & Harrison, 2019; Gilligan, & Akhtar, 2006). Moreover, Payne et al. (2014) found that Black and Latino male CSA survivors discussed shame issues more often than White male survivors. Watson et al. (2013) found that White, Asian/Pacific Islander, and Hispanic/Latina women CSA survivors endorsed more body shame than African American women CSA survivors. These limited findings suggest that sociocultural context can impact how shame manifests in CSA survivors; however, they do not provide a detailed analysis of the processes shaping disparate experiences of shame among survivors from minoritized racial and ethnic groups.

To further appreciate the centrality of shame in CSA and the need to consider social and cultural context, we need to consider how shame develops. Shame is increasingly felt when a person feels they have failed to meet a certain ideal or have behaved in a manner that goes against expectations set by their family, culture, or society (Brown, 2006; Morrison, 2011). CSA

violates social norms about what is acceptable in childhood (McRobert, 2019); thus, all CSA survivors may innately feel shame and internalize the social stigma associated with CSA as shame, self-blame, and anticipatory stigma in which one fears negative judgements by others (Kennedy & Prock, 2018). Individuals who experience CSA are also more likely to feel shame due to the sexual nature of the abuse and societal victim-blaming (Kennedy & Prock, 2018).

This internalized shame for having experienced CSA may be compounded by messages received within different social and cultural groups, as well as sexual stigma targeted at social groups that are stigmatized and oppressed in and of themselves, and even more so within the context of sexual violence. For instance, ethnicity can influence groups' views of CSA, taboos surrounding sex, sexual scripts, the value of shame, and gendered sexual socialization, which can conceivably affect feelings of shame following CSA (Fontes & Plummer, 2010; Gill & Harrison, 2019; Moulding, 2015). In terms of race, the historical and enduring legacy of racism and the sociohistorical context of sexual violence against women of color influence their present-day experiences as survivors and how they experience oppression at institutional and interpersonal levels through pervasive stereotypes that discredit them as victims (Dylan et al., 2008; Leath et al., 2021) – even as children (Powell et al., 2017). An intersectional analysis of CSA trials in the U.S. revealed that age, gender, racial, and class stereotypes were exploited by defense attorneys to diminish the credibility of sexual abuse claims by children from marginalized groups (Powell et al., 2017). Despite consent statutes, myths about how children should behave after experiencing sexual abuse persisted to discredit victims of color who did not conform to the archetypal image of a child survivor of CSA (Powell et al., 2017), demonstrating the problematic result of generalizing expectations formulated from a subset of CSA survivors onto all children.

Shame has been identified as the most common emotional aftereffect of CSA in the clinical literature (Sanderson, 2006, p. 325), a core component of the CSA experience in theoretical literature (Finkelhor & Browne, 1985), and a common outcome of CSA in empirical research (MacGinley et al., 2019). In spite of this, only four published studies have directly explored the qualitative or lived experiences of shame among adult CSA survivors (Dorahy & Clearwater, 2012; Drewitt-Smith & Marczak, 2023; Pettersen, 2013; Rahm et al., 2006). Notably, all four studies included only White and European participants. This reflects a longstanding trend in sexual violence research of overrepresenting and overgeneralizing findings obtained from a narrow subset of survivors, specifically White women, often those in socially privileged positions (McCauley et al., 2019). Arguably, the lack of research studies directly examining shame among CSA survivors from minoritized racial and ethnic groups has led to an understanding of shame and its impact that is incomplete and biased towards the experiences of more represented groups, specifically White and European survivors of CSA.

More recently, McElvaney and colleagues (2022) found that shame played a key role in the CSA disclosure process, while Lateef and colleagues (2023) found that shame manifests and impacts the lives of CSA survivors in various ways post-disclosure of CSA. While both of these studies included racially and ethnically diverse samples and added to the limited literature that used qualitative methodologies to directly describe survivors' experiences of shame, the relevance of social identities in shaping these experiences was not a focal point. A scoping review on adult CSA survivors' shame experiences concluded that there was a gap in the evidence base on shame among survivors from marginalized groups, and a need for future studies to apply an intersectional approach to explore shame among diverse survivors (MacGinley et al., 2019).

The experiences of shame among CSA survivors from minoritized racial and ethnic groups are not adequately represented in the CSA literature. Addressing the demographic limitations within the existing evidence base is essential for developing a more comprehensive and culturally sensitive understanding of shame among CSA survivors. This study addresses a longstanding gap in the literature by exploring the experiences of shame among women CSA survivors who identify with minoritized racial and/or ethnic groups using a qualitative methodology. The following research question guided the researchers in this study: How do the intersecting social identities of women survivors of CSA, specifically the intersection of race, ethnicity, and gender, impact their lived experiences of shame?

This study was informed by intersectionality theory (Crenshaw, 1989) to reveal the different forms of privilege and oppression at play in the experience of shame following CSA based on intersecting social identities, particularly race, ethnicity, and gender. Intersectionality is a theoretical framework that proposes that the multiple social categories (e.g., race, ethnicity, gender) that make up one's social location intersect at the micro level of individual experience to reflect multiple, converging, and interwoven systems of privilege and oppression (e.g., racism, sexism) at the macro, social-structural level (Crenshaw, 1989, 1991). For the past 30 years, intersectionality has been proposed as an essential theoretical framework to understand sexual violence against racially minoritized girls and women, to acknowledge sexual violence as a mechanism through which gender and race inequalities are perpetuated (Armstrong et al., 2018; Crenshaw, 1991). Nevertheless, this is the first known study to apply intersectionality to qualitatively examine shame from the perspectives of adult CSA survivors from minoritized racial and ethnic groups. This focus aligns with a best practice guide to intersectional approaches

in psychological research that encourages studies to challenge assumptions that a social category (e.g., "women") validly represents all subgroups in that category (Warner, 2008).

Throughout the paper, we have attempted to be mindful of the implicit biases that can be embedded in language used to describe marginalized groups and their experiences. For example, participants in this study are mainly described as belonging to "minoritized racial and ethnic groups" rather than "racial and ethnic minority groups." This represents a conscious shift in language that recognizes that being a "minority" is not an inherent characteristic, but rather being minoritized is a result of social, historical, and institutional processes that place groups in subordinate positions based on their social identities (Wingrove-Haugland & McLeod, 2021). Moreover, "race" and "ethnicity" are viewed as separate socially constructed concepts. Race is defined as a categorization of humans based on superficial physical characteristics such as skin color, hair, and facial features. Ethnicity is used to describe a group who share culture, language, ancestry, and/or nationality. Individuals can identify with a variety of racial and ethnic identities.

Methods

This study used an interpretative phenomenological analysis (IPA) design (Smith et al., 2022). IPA is a qualitative research methodology with an idiographic focus that seeks to understand how life experiences are understood from the perspective of each participant in a study, while correspondingly focusing on patterning of meaning across participants (Smith et al., 2022). Qualitative methods have been suggested as an ideal option to examine intersectionality as they allow for the complexities and multiplicity of experiences to be more comprehensively captured than quantitative methods (Warner, 2008). Intersectionality principles were incorporated throughout the research design, as will be detailed in the sections that follow. This project was approved by the research ethics committee of (name of the institution anonymized).

Sampling

Purposeful sampling was used to recruit 10 participants from three non-profit organizations that serve survivors of sexual violence in two large Canadian provinces. The most recent IPA guidelines suggest that a sample size of 10 is optimal for IPA research projects at the doctoral level or higher (Smith et al., 2022), and so this was the target number of participants for this study. The recruitment flyer distributed by these organizations outlined the inclusion criteria, that participants had to be 1) 18 years of age or older; 2) identify as a woman; 3) speak fluent English; 4) identify with a racial and/or ethnic minority group; and 5) currently receiving, or in the past year received, some sort of psychosocial intervention for experiences of CSA, such as counseling or therapy. The last criterion ensured that participants were not disclosing for the first time during the study and were currently receiving or had received support for the CSA, to mitigate the risk of emotional distress that could arise from revisiting traumatic experiences for the first time in the research interview. In line with group-centered intersectional research, the inclusion criteria aimed to recruit marginalized groups whose experiences have been underrepresented in an area of scholarship (Choo & Ferree, 2010; Warner, 2008), in this case women from minoritized racial and ethnic groups in CSA and shame research. Despite being open to both cisgender and transgender women, only cisgender women responded to the flyer.

Potential participants were required to complete an online screening questionnaire. Included in this questionnaire was the following question: *Did you experience sexual abuse before the age of 18 years old*? We allowed participants to self-identify as having experienced CSA based on this broad criterion. Participants who met all the inclusion criteria were contacted via email to confirm their eligibility and arrange a pre-interview phone call. During this phone call, the principal investigator explained the purpose of the study, outlined what participation

would entail, including the topics of focus, and received verbal confirmation from potential participants of their emotional readiness to discuss these topics. This phone call aimed to reduce the likelihood of unexpected distress during the interview and allowed individuals to make a more informed decision to participate. For those who wanted to participate, an interview was scheduled, and they were sent a detailed consent form. All participants provided signed informed consent prior to the start of the interview.

Data Collection

Participants completed an in-depth, semi-structured interview through phone call or Zoom videoconferencing software, depending on their preference. The length of interviews ranged from 57 minutes to 2 hours and 46 minutes, with an average interview length of about 1.5 hours. At the end of each interview, participants were offered a resource list for their province of residence, which included relevant community organizations and telephone and virtual support services, to access psychosocial support if needed.

Demographics Questionnaire

Participants were asked demographic questions in an open-ended fashion that allowed them to define their race and ethnicity and other social identities as they chose, rather than constraining them to identity with pre-determined categories that may not align with how they identify (Windsong, 2018). Participants were also asked about certain aspects of the CSA (i.e., age of onset, duration, perpetrator relation, disclosure recipients, etc.), but not about the acts of abuse.

Interview Guide

The interview guide was developed using intersectional principles, with a focus on using broader language to allow individuals to describe their experiences as they chose. Open-ended, exploratory questions that directly reference intersections and allow participants to discuss social

identities together have been repeatedly recommended as a method to gather responses through qualitative interviews (Warner, 2008; Windsong, 2018), and this was incorporated in the guide.

Data Analysis

The principal investigator (first author) analyzed the transcripts according to the steps of IPA outlined by Smith and colleagues (2022). IPA analysis requires each participant's case to be analyzed in-depth as a single case through the following five steps, before moving onto the next case. First, the transcript was read multiples times to allow the researcher to become immersed with the data. The second step involved an exploratory examination of the language use and semantic content of the transcript, using the margins to make exploratory notes on any preliminary interpretations of how the participant described their experiences. Third, the extensive exploratory notes were turned into experiential statements that aimed to capture the most important aspects of participant experiences, based on the participant's original words and exploratory notes that reflected the researcher's interpretation. The next step was to search for connections across experiential statements and to cluster together statements that were closely aligned. Finally, each cluster of experiential statements was given a title that captured its characteristics, and these became the participant's Personal Experiential Themes. A table was created that included each Personal Experiential Theme and all the instances in the transcript in which this theme was apparent along with the respective page and line numbers.

Following the independent analysis for each participant, similarities and differences in Personal Experiential Themes across participants were assessed. Based on the convergences observed across cases, Group Experiential Themes were identified that highlighted the shared and unique features of the experience across the majority of participants. In general, with a larger

sample (i.e., 10 or more participants), a Group Experiential Theme should be endorsed by at least half of the participants in the study to be considered valid (Smith et al., 2022).

Trustworthiness and Authenticity Strategies

Dependability of the data was ensured through digital recordings and verbatim transcription of the interviews (Drisko, 1997). Trustworthiness in this study was established through providing a detailed description of participants and findings that emerged. Firstly, a rich, thick description of participants in the study "allows readers to make decisions regarding transferability" (Creswell & Poth, 2018, p.263). Table 1 provides details of the social identities of participants based on information they provided through the demographics questionnaire. Confirmability of themes was established through direct quotes from participant interviews (Drisko, 1997). Each participant's experience is presented as an individual idiographic case, allowing readers to better assess the potential transferability of findings based on individual participant characteristics. Trustworthiness was further established through the presentation of negative case analysis and disconfirming evidence in the results, wherein findings that did not fit the pattern of a theme were included in to give a realistic assessment of the phenomenon under study rather than attempt to alter participant narratives to fit the theme (Creswell & Poth, 2018).

IPA recognizes the active role of the researcher in the analysis process, requiring their close interpretative engagement while listening to or reading participants' accounts (Smith et al., 2022). The principal investigator conducted the interviews and the analysis and was responsible for making sense of participants' experiences. While verbatim extracts from participant interviews were used to stay close to participants' perspectives, the interpretations may have been influenced by the researcher's own, experientially-informed lens. To mitigate potential biases in interpretation, the principal investigator engaged in peer debriefing with a group of

three CSA researchers (three co-authors) to provide opportunities for her interpretations to be discussed and challenged. These three researchers reviewed and confirmed the study findings.

Positionality Statement

There were four authors that contributed to this study. The principal investigator identifies as a woman and academic from a minoritized ethnic group. She has a decade of experience in CSA research, with publications on shame among CSA survivors. The principal investigator's visible minoritized ethnic background made many participants feel more comfortable sharing their lived experiences, as verbally expressed by several participants. She acknowledges that her positionality might have influenced the study to an extent, such as interpretations of the data, as discussed above. The three co-authors of this paper identify as White women with established expertise in CSA research. Although the co-authors do not identify as racially minoritized, their membership in other marginalized groups, such as LGBTQ+ and minoritized linguistic groups, which intersect with their identity as women, contributed to a nuanced understanding of intersectionality within the research team. Shared experiences of navigating various forms of marginalization allowed the team to appreciate the complex dynamics of power, privilege, and oppression that can also affect CSA survivors with intersecting marginalized identities.

Sample Description

Ten women survivors who identified as being members of a minoritized racial and/or ethnic group participated in this study (see Table 1 for demographic information). All names used to refer to participants are pseudonyms. In terms of abuse characteristics, the age of onset of the earliest experience of CSA was between four to 15 years of age, with an average age of onset of 9.3 years. Duration of CSA ranged from a one-time occurrence to 11 years. Two participants had

experienced two separate CSA experiences (i.e., CSA by two different perpetrators at different times), two had three separate CSA experiences, and one had four separate experiences.

Results

The analysis yielded three Group Experiential Themes that highlighted how shame is defined and experienced by women CSA survivors who identify as members of minoritized racial and ethnic groups: 1) internalized shame tied to intersectional identity; 2) intra-familial reinforcement of shame and silence; and 3) maintenance of shame through systemic racism. Themes were developed through an intersectional lens to illustrate how the shame of CSA survivors were shaped by their social identities and consolidated via interpersonal interactions and broader macro-level forces. For each theme, the stories of each participant are presented as idiographic cases to comprehensively illustrate their unique intersectional vulnerabilities and experiences.

Theme #1: Internalized Shame tied to Intersectional Identity

Overall, this group of racially and ethnically diverse women reported that they felt shame following CSA to varying degrees in connection with their intersectional identities, particularly at the intersection of race, ethnicity, and gender. In some cases, other social identities, such as religion, intersected with gender to uniquely and interconnectedly generate shame. As survivors shared their perspectives on shame related to the CSA, they recognized that there were beliefs within and attached to their social identities that had contributed to their CSA-related shame.

Amanda (37, Black Caribbean) described shame as "thinking of yourself negatively" and, in relation to the CSA, "you always feel like people are looking at you, you know, and thinking, ew, like, like they can see your shame. They can see what happened to you." Amanda both thought of herself negatively and perceived others to be constantly negatively judging her in

relation to the CSA, even people who weren't aware of the abuse. She expressed that her feelings of shame caused her to cautiously monitor how she presented herself in society and concealed her "real self" – a behavioral manifestation of shame: "[sigh] I, I have like 2 selves, you know […] You have like your stage self, and then you have your, your real self." She also expressed a desire for Black people to monitor how they presented themselves, expressing that when she sees Black people "dressed any kind of way, or you know acting any kind of way, I, I'm, that's shameful to me big time, *especially* if they're Black, because I don't want that as a representation of who I am." Amanda seemed to be cautious of the racial stigma that becomes associated with her when Black people in her vicinity act in a way that perpetuates negative racial stereotypes.

Amanda recognized that certain interconnected social identities – "Christianity aspect," "race, to a degree," and "being a woman" – had the strongest impact on her feelings of shame:

> I think they're definitely interrelated. […] from the moment in time when I was molested, it determined the rest of my life. It determined how I thought of myself as a Christian, as a Black woman, or as a Black person, as a woman. Right. Um so yeah, I think that is all tied in. And yeah, the whole thing is covered in shame.

Evidently, following CSA, shame became attached to her different social identities individually and interconnectedly. Her shame was further exacerbated as she internalized messages linked to her religious identity. For example, she described her CSA-related shame as such: "You feel dirty your entire life." As she elaborated, it became clear that her feelings of being "dirty" were tied to expectations in her religion, which she felt she had failed to adhere to:

> with the molestation, you had all, I had all these thoughts going through my head growing up that I was dirty, right? And so, coming from like a Christian background, that

> was amplified, you know, cause I thought, "oh, I have these thoughts and I wanted it and it felt good, but that's bad," you know. That's satanic or something, right?

Amanda's use of the word "satanic" emphasized the extent of her negative self-judgement. She also stated that the fact that her "virginity was taken" as a result of the CSA made her think "I'm not special anymore" due to the importance of chastity in Christianity, especially for girls.

Brandy (33, Black, Caribbean, Euro) described her shame as "holding onto something that you feel responsible for…um that's negative," which for her led to self-hatred and feeling "dark, lonely [sigh]" and "not being enough." She identified that her intersectional identity of "being a Black woman" most strongly influenced how she experienced shame. For example, she alluded to the "strong Black woman" stereotype and how her self-perceived failure to protect her body and what it represented as a Black woman led to feelings of disappointment and self-blame:

> I think just the identity component of who your body is as a Black woman. What it represents. That kind of integrity and that strong, strong attitude that allows things to happen to you. So, it's kind of that component of self-defence. I feel, I feel like I let myself down by not protecting my body in other ways.

Moreover, the "angry Black woman" stereotype caused her to downplay and conceal feelings of anger related to both CSA and sexual victimization she experienced as an adult in her workplace, as she felt this would further discredit her first as a woman, and even more so as a Black woman:

> as women, it's like we're not expressed, we're not allowed to express anger the way men do, right. But I think understanding the stereotypical Black woman and anger. Like if I had expressed even *a notion* of anger in my workplace like, I would have been dismissed as like "angry Black woman", right […] we're taught to talk low and be soft in society.

Asma (26, Black, African) internalized messages received directly and indirectly related to her social identities, which fueled her feelings of shame related to her multiple experiences of CSA. She emphasized how her negative self-judgements and anticipated negative judgements from others, which are characteristic of shame, led her to be "very silent" when she felt shame:

> shame means I think for me, um turning things inward. So not being able to see how the exterior reason why something's happened, and feeling like whatever negative, whatever consequence you have, it's all your fault, and it's all… you're the main reason why something negative is happening in your life, and you are afraid to say something about it because it's your fault, so you can't involve more people in it.

During the interview, Asma identified her cultural background as Burundian and that certain beliefs common in her cultural community played a pivotal role in the internalized shame she harbored. For instance, any complaint she made related to male perpetrators was dismissed as "just men behavior." She observed that girls were advised to alter their behavior around men who exhibited inappropriate behavior rather than hold these men accountable, which implied that girls were responsible for avoiding abuse:

> I think it's just made me reluctant to combat the feeling of shame […] I come from a, a, a, not a country, but a group of people who don't like to blame men for anything. Feeling like if I can't blame the men, then someone has to be blamed, so it has to be me.

Shame stemming from these cultural messages were augmented by the historical adultification and hyper-sexualization of Black girls. Asma eventually internalized these stereotypes and believed that they contributed to victim-blaming she faced for CSA she suffered at 14 years old:

> And there's a lot of accusation in terms of looking grown very quickly. You are a kid, but everything you wear somehow is a problem […] you feel like anything a Black woman

> wears is sexualized automatically. If you're wearing anything tight, then you are enticing […] I played into it. Like I'd wear something very simple and feel like I was asking for something from a guy, or I was being, I was being, what's the word – jezebellish.

Asma internalized beliefs that she was promiscuous and believed that she experienced repeated incidents of CSA because, "there might have been something in me that enticed people or that enticed um perpetrators, whatever we call them, to look for me or just target me specifically."

When asked what shame meant to her, **Brianna** (25, Black, Caribbean) responded, "I think it's a feeling of guilt? Yeah, about something you're not so proud of." In relation to the CSA, she stated "I was really ashamed […] it wasn't something I was proud of, especially with the fact that it happened while I was quite younger." She expressed that she "thought people could sense that you've been sexually abused, just being around them" and that this persuaded her to largely withdraw from social interactions. Despite feeling as though counseling had helped reduce her feelings of shame, she voiced in tandem "I don't think it's ever going to go away like permanently." Brianna elaborated less than the other Black women survivors in this study on how her social identities shaped her shame following CSA, though she identified that her young age at the time of the CSA contributed to her shame, as well as her racial, ethnic, and religious identities as they are all "against sexual abuse."

Winnie (26, Indigenous) stated, "shame for me, it's, it's more than just me, it's more than just what I'm feeling […] and how I feel silenced, or I feel, like, somehow dirty" and that, for her, shame "goes generations deep." For Winne, shame was strongly tied to her identity as an Indigenous survivor of CSA. She described CSA as both taboo and normalized in her community as a result of colonialism and generations of violence against Indigenous people: "shame is being an individual of a… [pause] of a peoples that are, as much as we're known, we're silenced." She

added, “when you, you add on the generations of those experiences? By the time you get to my generation, it's so impacted that as a child, you really do feel like… [long pause] dirt’s got more value than you.” As a child, Winnie internalized messages that stemmed from the dismissal of Indigenous survivors, including herself, who disclosed CSA: “This is what builds that shame, that hopelessness, that ‘what's the point, nobody gives a shit.’” This disregard led to feelings of worthlessness throughout her childhood: “I felt that I didn't matter, that I didn't mean anything, that I had no value, and I had no worth. And that I basically was here to serve White men.”

In **Marie**’s (46, Chinese Mauritian) case, her shame manifested as a poor sense of self-worth and attempts to isolate and shrink her presence in social settings, suggesting efforts to conceal her perceived shameful self. Marie described the consequence of “the cultural aspect of […] shaming your kids to, to be compliant, having expectations of what path you would take in life, the secrecy of sexual abuse and shoving it under the rug,” as follows: “I've always thought there was something wrong with me, that I was different um... And I always tried to stay small and if people didn't notice me, then I wouldn't get like unwanted attention.” Additionally, Marie felt that she was shamed for disclosing the CSA and experiencing mental health difficulties as a result of the CSA, as there is stigma in her culture surrounding mental health issues: “the piece of like the sexual abuse, that that's um that’s a secret to be kept […] *that* piece of it, there’s shame involved […] any mental health related stuff is um, there's a huge stigma.”

Aashvi (40, Punjabi, Indo-Canadian, South Asian) felt that her longstanding engagement in a variety of therapeutic interventions, her perception of herself as a “survivor/thriver” and that she’s “winning this,” and making life changes that she was proud of (i.e., shifting from alcohol use as a coping mechanism, which was shameful, to instead supporting other CSA survivors, which she was proud of) had greatly reduced her shame:

> the shame to the child sexual abuse now is very faint, *very* faint. When it will come up, it'll come up in, in a very like, when I'm *very* triggered. […] that's where that shame will come in because I can't shake it off. Like it's too, it's it's it's in a layer where it's, I can't shake it off

Aashvi struggled to define shame as a result of how shame is conceptualized in her ethnic community: "it's still a little vague, because I think shame is very intertwined with guilt, and it's like one word, one feeling within our community." Moreover, sexual socialization in her ethnic community included messages that were shaming toward girls exposed to sex: "my mom said, in Punjabi it's like you know 'a boy can wash himself and he's totally okay. But a girl you can't wash yourself and you're not.' Like this is how I grew up thinking." She informed that she was not made aware of the words for genitalia in her language, which inadvertently sent the message growing up that anything sex-related was not to be discussed. As such, Aashvi identified that her intersectional identity as a South Asian Punjabi woman survivor of CSA shaped her shame.

The remaining three participants all reported that they outwardly present as White women and that their Indigenous background was not a pivotal component of their upbringing or life experiences. They did not associate their CSA-related shame to their racial or ethnic identities. **Brisa** (22, Indigenous) described her shame as "probably one of the worst feelings I would ever feel." She defined shame as when "you don't feel comfortable and like proud of who you are." She reported that she felt shame for a long time; however, at the time of the interview, she stated she has "no real shame" thanks to "*many* years of counseling" and for the following reasons: "I moved out, like I'm doing my master's. So, like being pretty independent and self-sufficient right now is – like I'm, I'm proud of myself." The only social identity that Brisa felt contributed to her shame was "the queer aspect a little bit, because some, cause when I was assaulted by my

female co-worker, it was around the time I was questioning myself." She thought "it wouldn't have happened if I, I don't know, if I wasn't questioning" her sexual orientation at the time.

Angela (28, Caucasian, Aboriginal[3]) described her CSA-related shame as "something that you feel negatively about, as, like it's… something you've done, and you are the reason that you feel this way." She described battling with thoughts of "I kinda may have been asking for it or um… you know, almost like I deserved it." Angela most strongly tied her shame to "being a woman survivor," as she said "women are predominantly the abused um gender. Um and so, I [sigh], I don't, I don't want to hold onto that um… the pain, and the shame, and all the negative feelings" placed on women who are victimized. She added, "I'd like to think of myself as more of a survivor," because "it happened, but I don't want it to dictate how my life is and goes." So, the intersection of gender and survivorhood shaped Angela's shame, with her "woman" identity reinforcing her shame beliefs, and her "survivor" identity challenging her feelings of shame.

Cindy (42, Caucasian, Native[4]) described shame as "you feel damaged, you feel broken." Cindy voiced that the main social identity that contributed to her shame was "just being female in general." She felt silenced as a woman and received early sexual socialization messages that normalized sexual abuse against girls: "I was taught by my mother, lay on your back, open your legs and be a good girl. […] So, that's what I did, for a very long time." Moreover, though Cindy did not explicitly tie her victimization identity to her shame, when she contemplated whether she identified as a "victim" or "survivor," this led to negative self-reflections about her potential permanent state of being broken as a result of the CSA: "I've always viewed myself as being a very strong person and, but, I've had to come to recognize that something broke inside me,

[3] In Canada, "Indigenous" is generally the preferred umbrella term that collectively refers to First Nations, Métis, and Inuit groups. The terms "Aboriginal" and "Native" were used only when participants described their identities with these terms.
[4] See footnote 3.

and… [pause] I don't know if it's gonna heal 100%." She elaborated, "I find it very difficult to say that I'm a survivor if I'm not living my best life," reasoning that "I survived it but I'm not surviving because it is impacting my life so horribly." For these reasons, she concluded that "unfortunately, I still view myself as a victim." Her use of the word "unfortunately" inferred that identifying as a "victim" instead of a "survivor" added to her negative self-perception.

Theme #2: Intra-familial Reinforcement of Shame and Silence

Nine CSA survivors in this study had disclosed a CSA incident to at least one family member, and the majority of them (n = 7) received messages and critical disclosure responses from family members that perpetuated silence and shame related to the CSA. These negative experiences and how they impacted survivors will be examined in this theme. Five survivors tied the negative familial reactions to their racial and/or ethnic background, and Cindy to her cultural background.

Amanda (37, Black, Caribbean) did not feel comforted when she first disclosed the CSA to her mother as "there was no hugging, no consoling," As a result, it took her a long time afterwards – almost 20 years – to disclose the CSA to other family members. When she did, she was met with denial and invalidation: "When I told my family members […] they said, 'there's no way, no you weren't molested.' So, they denied it. I was *so* shocked, like how could you say that to someone?" This response caused her to retreat back to coping with the abuse in silence: "that was the end of it. I was in shock. And you're not supposed to talk back to your elders, so, I just left it." Amanda described the silencing of CSA victims as an intergenerational issue in her family and a within-group issue for the Black community, using "we" to indicate her experiences of being invalidated and silenced as a collective experience among Black women, in her opinion:

> we, as Black women, don't treat ourselves fairly enough, you know. It's like all this horrible stuff happens to us, and we just stay silent. And if someone else that's Black,

> your family member, says something, they just tell you to shut up […] my whole family's been raped and molested, and no one ever talks about it. And you can't heal like that. And you can't help others, right. So, I think it's more so an internal cultural thing.

Amanda emphasized the need to discontinue the silence surrounding sexual victimization of Black women, so that these women stop internalizing messages that hinder their healing.

Asma (26, Black, African) observed in her childhood that **"**people don't really talk about traumatic things" in her family and, specifically, "women don't really talk about anything" traumatic. She extensively discussed the very integral impact of not being supported and, even more so, being ridiculed by her family in fueling her shame following her CSA disclosures. Her immediate disclosure of CSA after it occurred at a community event led to a plethora of shaming reactions, beginning with community members making comments like "who knows that this really happened and look at how she's dressed." The unsupportive response from her parents included the silent treatment, victim-blaming, and even inviting the perpetrator to a family function afterwards, which shattered her previous beliefs that her parents would protect her:

> it was pretty difficult. I had this big fantasy that like if anything happens to me, my parents are going to be with me and they're gonna support me, and they're not gonna let anything bad happen to me, and that event I was like they don't care. Like they, they are not doing anything. This guy came back, my mom kept having an evening, and my dad is not talking to me, and everyone's joking, and it's not funny because I'm scared now.

The lack of familial protection post-disclosure led Asma to develop self-critical core beliefs that there was something inherently wrong with her and that she was destined to be re-victimized:

> I had this very gloomy vision of life where I can't protect myself, and I can't be protected from these things […] if things can happen to you when you're young and you're

> supposed to be super-protected, what do you think is going to protect you now at 17 in the middle of the night? Nothing. It's just gonna happen.

These familial responses led Asma to internalize beliefs of self-blame for negative things that occurred in her life. This led her to exercise extreme caution when disclosing subsequent sexual abuse, as she feared that sharing details of the incidents would reveal that she caused the abuse. Asma admitted that even in therapy she concealed details of the context that led to the CSA for this reason: "I've always shied away from specific details, specific conversation points […] I feel like it'll incriminate me […] I've shied away from details, and from blame-putting."

Asma emphasized the shame of being a CSA survivor as the first-born daughter of an immigrant family from her ethnic group, as her abuse and shame are enmeshed with her family: "your sexual assault stories are not yours. They also belong to [your parents] […] I'm ashamed. They're ashamed too, like this is very embarrassing to them." Due to the shame it cast upon her family, she perceived, "it's almost worse to talk about something than to actually have lived it."

Marie (46, Chinese Mauritian) identified that her shame and related self-blame largely stemmed from the response she received from her mother after she cautiously disclosed the CSA: "I told my mom just like a really small snippet, just to see um what she would say." Marie was advised to avoid the perpetrator – a guest who was living in their house at the time. It was made clear to Marie through no further follow up from her mother that "it wasn't something that we were going to talk about. It's not something that she was going to talk about […] and pretend it didn't happen." This promoted silence and self-blame as she tried to understand this response:

> I guess having this understanding that um… that, let's say, talking about the abuse um is not okay. That this is supposed to be a secret, that… and underlying that…I guess

> feelings of blame or – yeah, like thinking that it's my fault. If we're, if it's not an open conversation, then is it because that I did something wrong?

Placing responsibility on Marie to avoid the perpetrator within her own childhood home contributed to fears of negative judgement from others throughout Marie's life: "it would bring up a lot of anxiety of like, would I be judged? Would I be um… would people think that I was responsible, that I did something to encourage it? Or should I have known better?" Once she overcame anticipatory stigma when talking about the CSA through therapy, she was shamed by her family for attending therapy: "my mom's mentioned several times since I've been in therapy like 'can't you just get over it?'" This feedback suggested to Marie that there was something wrong with her for not being able to overcome the CSA. She attributed these attitudes to cultural stigma attached to therapy and the expectations of silence of CSA: "there's the piece of like the sexual abuse, that that's um that's a secret to be kept. But also, because we're not admitting it, then we're also not seeking out help. That the child will just forget about it." As she broke her silence, Marie said that several family members disclosed to her that they had also experienced CSA and only felt "okay to talk about" it because Marie did, breaking the pattern of silence in her family.

In contrast, **Aashvi**'s (40, Punjabi, Indo-Canadian, South Asian) narrative demonstrated that attitudes toward CSA may be so ingrained in select families of certain cultural origins that they persist despite extensive efforts to break the silence and shame. Aashvi was silenced via different mechanisms when she disclosed CSA to her family members and received extensive backlash when she reported the CSA. When she first disclosed, multiple family members, including her parents, met with the intrafamilial perpetrator to organize a plan to silence Aashvi: "how should we do this so that way it doesn't come out and our family's not tainted. […] So, it

was very much like, let's get [Aashvi] quiet. What can we do to get her quiet?" It was clear to her that the family priority was to silence her and conceal the abuse: "It was very much of a let's cover it up." She reasoned that her family prioritized this over her needs since "the parents end up feeling shame" so much so "that they forget about the child" who is seen as shaming the family by disclosing.

At the same time, Aashvi received messages from family members that implied there was something wrong with her due to the CSA and concurrently placed shame and guilt on her. For instance, she was told that no one would want to marry her because "you're used, you're abused, you're tainted" (shaming her for being a CSA victim) and that no one would want to marry any girls in her family if they found out about the CSA (guilting her for potential negative impact of disclosing). Aashvi experienced a mix of shame and guilt when one of her cousins did not get married: "I held that shame, like the fact that she didn't get married, was it because of me?" When Aashvi reported the abuse, she was considered to have "went against the family" and led to "fighting with the family and them not agreeing to things that you're doing because I come from a South Asian background." She was left feeling like "not one person had my back."

Winnie (26, Indigenous) was silenced by family members who she perceived harbored internalized shame that stemmed from intergenerational CSA and a history of discrimination and poor treatment of Indigenous survivors who decided to disclose and report CSA:

> my biological family, where it was almost normalized, you know where it's just like, "Yeah, this happens to us, we don't talk about it, just keep your mouth shut, because otherwise we're gonna have problems with the cops, or Children's Aid, or this, or that!"

Winnie's perspective was that family members internalized the racism against them, leading to hopelessness and expectations of being disregarded as CSA survivors: "you're taught, you know,

‘okay, hush, hush. Keep it quiet. Let's not talk about it […] they're not gonna listen to us anyways.’” These within-group attitudes, circulated by family members, predictably fuelled Winnie’s beliefs of being less important and undeserving of support, and maintained her silence.

Cindy (42, Caucasian, Native) had experienced multiple instances of intra-familial CSA. When she disclosed the CSA by an intrafamilial perpetrator who she found out had been sexually abusing girls in her family for generations, her family normalized and dismissed her experience: “nobody really did anything about it […] everyone treated it like it was nothing. Like it was, just another day.” Later in childhood, when she had disclosed to her mother that her stepfather was sexually abusing her, her mother “didn’t really do anything about it” and proceeded to marry the man. These dismissive reactions fueled her feelings of shame: “you tell her, and she does nothing, and then the family makes you feel like crap, you feel completely worthless.” She was encouraged to stay silent about the CSA: “nobody spoke up, nobody cared, nobody like, it was just all, ‘shh, don’t talk about it,’ you know. Sweep it under the rug.” Cindy attributed her familial responses to intergenerational CSA in her family and “the culture back then, like that generation […] you keep your business to yourself.” Moreover, the cultural community in which she grew up encouraged silence about family issues:

> family background and cultural background of being from Newfoundland, and in these small communities, there is a lot of judgment and a lot of shame […] you don’t follow those rules, you are an outcast […] you get labeled in so many different ways.

As an adult, Cindy continued to receive CSA disclosure responses that exacerbated her CSA-related shame. For instance, her husband’s frustration with her for continuing to suffer from the CSA exacerbated her shame for continuing to be a *victim* of CSA, and not a *survivor* whose recovered: “he doesn’t understand why I’m not better yet, or I’m not fixed, per se.” These types

of conversations maintained her shame: “you have guilt and shame and, just a bunch of things that won’t ever go away, cause they just keep reminding you.”

Brisa (22, Indigenous) voiced that the “hardest” part of her CSA experience was not being supported or protected by her mother after disclosing that her mother’s partner was abusing her: “I think cause [starts tearing up] … ugh, sorry. Just like realizing your own mother is like not there for you…is like the hardest [tearing up] sorry.” Like Cindy, after disclosing, Brisa’s mother continued her relationship with the perpetrator. She also attacked Brisa’s integrity by accusing her of lying and shamed Brisa for allegedly having negative intentions for “falsely” accusing the perpetrator. Brisa emphasized the betrayal she felt viewing her mother publicly side with the perpetrator when she testified in court, which shattered her beliefs of being protected by her: “to be betrayed by her like time after time after time. Like she chose the other side each time […] we took the stand. And to see her like literally on the other side – *such* a betrayal.”

Theme #3: Maintenance of Shame through Systemic Racism

Shame among CSA survivors (n = 7) was triggered and maintained through interpersonal and systemic racism, such as racialized interactions in different public institutions that undermined the significance of CSA against them. Several survivors compared their lived experience to that of White survivors, conveying how Whiteness exists in White-dominant Western societies as the standard by which other groups are compared and compare themselves and their treatment.

Amanda (37, Black, Caribbean) expressed her frustration over the perceived positioning of Black people in a subordinated status in society that trivialized their experiences of CSA and other traumas: “I can’t speak for other Black people, but you know, when you are a person of color, nothing about your experiences seems as important as a White person, either male or female.” In her view, the significance attributed to a person is determined by race, irrespective of

gender. Two factors that contributed to Amanda's meta-perception of Black trauma survivors were her personal experiences with mental health professionals and the media. She perceived encounters with multiple male mental health professionals who were not Black, especially those who were White, as negative and void of overt empathy toward her experience of CSA. Their demeanor toward her made her self-conscious and made her question if her CSA was being regarded as less valid due to racial biases toward Black women that these professionals held:

> The first [therapist] made me feel shameful because he was so, you know, like you're trash, you know. I think, yeah, that's where I felt shame […] he just treated me like, I don't know, like not a human [little laugh]. So, after spilling my guts, I felt ashamed.

Beyond shaming interpersonal interactions, Amanda expressed that she had observed racial biases in the media that empathized with White victims of violence and extensively broadcasted their experiences, while marginalizing stories of violence against Black children. She cited an instance where the murder of one White girl was highly publicized and annually commemorated, contrasting this to the minimal media coverage for the recent murders of a group of children of color. She concluded, "so, yeah, we, I definitely feel that, that I'm not as important." At one point in the interview, Amanda reflected that the intergenerational silencing of Black girls and women who have been sexually abused stems from the historical legacy of slavery.

Brandy (33, Black, Caribbean) identified that her race was "mixed" and said she had a White family and Black family. She noted the impact of her media exposure in childhood: "at my White family's house, the media and the things that were um like more prevalently around was more like sexually suggestive of young women." Growing up as a visibly Black girl, she felt early on that those depictions did not represent her: "my body and who I was felt very differently – there was that context." Up into present adulthood, Brandy regularly altered her physical

appearance, communication style, and behavior to be "perceived more on the White spectrum of acceptance." Brandy made these alterations to reduce her chances of discrimination and being stereotyped in ways she had previously experienced: "I kind of talk or prove to them like I'm not stereotypical, like, type of something, like you just can't treat me that way." Her extensive efforts to prove she is "not stereotypical" revealed her negative meta-perception of Black women in society. Her adult disclosure of sexual abuse made her acutely aware that, despite her efforts to shield herself from societal prejudice, she would face stigma as a Black woman survivor:

> I had almost convinced myself that I *was* White. That I *had* those privileges. And it was like very damning when I realized something had happened to me and I sat in a room of White people, and nothing was done about it. And then I left and then it was all like, kind of within the week daunting that that it was like "oh shit! I'm a Black woman! Ohhh *that's* why." And realizing, you know, also that's why the men know that they can, and I realized I have put myself in a very dangerous situation because I forgot that I was Black [laughs]. And once I really realized, I was able to see things as they were.

Brandy expressed, "getting somebody to pay attention or listen or take it seriously is very difficult when you're not a White person." She reflected that she "would've felt less shamed I think if I have gotten that kind of background and ethical support sooner." Brandy re-established her connection with her identity as a Black woman to comprehend how she was treated as a survivor:

> remembering those ethnic components and those, you know, those parts of me that I had actually lost. Um I'm more whole in that, in understanding you know we can't pretend they don't doesn't exist, we can't pretend racism doesn't exist.

Brandy reduced her shame through a lot of reflection on the gendered and racial societal dynamics that made her vulnerable to CSA: "understanding the perpetrators and what I was to them… […] I had to realize a lot of it *has* to do with culture and race and um belief systems."

Asma (26, Black, African) experienced microaggressions and manifestations of racism in different public institutions that made her feel that she was afforded less importance as a Black female survivor of CSA compared to White survivors. For instance, Asma received no encouragement from police officers to report the CSA when they picked her up after she ran away to escape the excessive harassment by others following her CSA disclosure at 14 years old. She contrasted this with the police response toward her non-Black friends who disclosed CSA:

> so much was being poured into them in terms of resources, and like "I can't believe this happened to you." Where, in my head, I felt like I could hear the whole like "I believe this could happen to you" when they would talk to me, and, and I didn't know how to, and I didn't want to accuse them

Her research as an adult on the treatment of Black CSA survivors confirmed her suspicions of differential treatment based on race: "you realize it *is* a thing. It is a thing that they, they, they don't see it as that bad because it's you." The constant dismissal from different professionals to whom she disclosed made her think "*no one* cares." She settled, "I'm not gonna get the support. There's no point in being vulnerable. So, you harden your shell, and you just keep going."

After she was sexually assaulted as an adult, Asma was motivated to validate her experiences in a way she had not been able to do as a child; however, she was left disappointed: "I feel very much like every steps of, any um actionable steps that I wanted to take to get justice or get help, it was kind of like brushed off as it's not that bad." Firstly, the social service staff she consulted with discouraged her from pressing charges, claiming that she did not have a strong

case. Moreover, she felt her interactions with healthcare staff were void of empathy: “There was no like ‘I’m so sorry this happened to you.’” Healthcare staff made incorrect assumptions about her ethnic identity in front of her and assumed the perpetrator was from the same (incorrect) ethnic background as her. These microaggressions, along with the greater focus on her ethnicity than on the physical pain she was experiencing due to the sexual assault, made Asma feel as though she was being treated as a Black woman claiming she was sexually assaulted, rather than as a legitimate sexual assault victim. She contrasted this with her White friend who was sexually assaulted and received empathy and resources from the police, social services, and healthcare staff. Asma remarked, “we had the same kind of, the same experience, but two different social experiences.” The institutional responses she received as an adult reinforced the shame she had developed in her youth from being invalidated as a survivor. This caused her to retreat inward and resume her silence, which resulted in a further lack of support. Asma described this as “a vicious cycle”: “you show emotions, you don't get the support you need. You don't show emotions, no one feels you need the support that you actually do need.”

Brianna (25, Black, Caribbean) perceived that, as a racially minoritized CSA survivor, she encountered stigma for both her race and being a CSA survivor. She did not provide any specific examples nor elaborate, but she referred to interactions with professionals and the general public:

> there’s a certain expression of judgment and stigmatization from people that are not of the same race as I am in the general public. Not just from the counseling and the rest, but from the general public. So, you have people out there who just have this judgmental feeling or expression toward you, considering the fact you’re of a different ethnic background from them, and also you’re a survivor of an abuse.

Aashvi (40, Punjabi, Indo-Canadian, South Asian) believed that the visibility of her racial identity contributed to the dismissal of her reports in the criminal justice system, and that personnel in this system had preconceived notions of CSA in different racial and ethnic groups:

> if you want to ask me how race and ethnicity plays in the police system, that's a whole different ball game, because they don't, they think, like they they have no sense of what happens […] They just think like they have their clear white box, like this is what happened. So, I've had a lot of difficulties with judicial and policing, um because –and I, I believe it has a lot to do with my race, how I, who I am, how I look.

Aashvi commented that her Canadian identity and being able to speak in the official languages of the country have likely made "a difference when it comes to filing charges and being heard."

Winnie (26, Indigenous) understood her CSA experiences within the context of historical and ongoing oppression of Indigenous communities. Winnie ascribed the discrimination and high rates of sexual abuse against Indigenous women to the ongoing impacts of colonization. Throughout her interview, she contrasted the dismissal of Indigenous CSA survivors with the validation of non-Indigenous CSA survivors, and how this fueled her shame:

> I honestly felt like, it was all, it was like, there was them, and there was me. It's like, you know, these kids, they could say that they were abused, whatever, they get the support. For me, it's kinda like… I found that growing up as a child, I had a really hard time having that voice […] it's okay, apparently, for us? And so that shame made me feel worthless, it made me feel devalued, it made me feel like I had no voice. And that's only, that's only grown, and that's only been perpetuated further as I've gotten older.

Winnie, like Asma, described a reciprocal influence of silence and lack of support from public institutions meant to support survivors. She observed that Indigenous CSA survivors remained

silent about CSA due to negative histories with different systems, resulting in a lack of support. Conversely, when they sought support, they were silenced through negative interactions in these institutions. She gave the example of Indigenous survivors reporting CSA to the police and how abuse against them is trivialized, reflecting a broader view of Indigenous people as unimportant:

> the fact that depending on the demographics of your people, cops also know that you're less likely to be heard and that you guys are just problems. You know, another crazy Indian claiming that the White man did something to them. […] society doesn't give a shit about us.

She experienced "when you disclose especially being Indigenous, you know, every single one stereotype that you can imagine comes up" and negatively influenced her treatment throughout her life. Winnie felt that societal ignorance of the struggles of Indigenous people is maintained due to the "lack of actual access of our information to the general public." She gave the example: "you get about this much of a media segment on our issues, and then it's been media-blocked."

Lastly, **Marie** (46, Chinese Mauritian) did not discuss interactions in public institutions nor societal stigma toward her social identities as influencing her shame. Rather, her perception of the greater societal stigma toward CSA compared to other types of abuse impacted her shame:

> shame is such a big piece of it um…because it's not acceptable to talk about it, as opposed to like physical abuse, right? Like I feel like people talk about like physical abuse like "yeah, did you get hit when you were a kid?" Like it's, it's so like – at least amongst my peers.

Discussion

This research examined how shame is related to CSA experiences among women survivors who identified as being a member of a minoritized racial and/or ethnic group. This

novel study challenges the historical and persistent exclusion and suppression of the voices of women of color in sexual violence scholarship (McCauley et al., 2019). Analysis of survivor interviews resulted in three Group Experiential Themes related to shame: 1) internalized shame tied to intersectional identity; 2) intra-familial reinforcement of shame and silence; and 3) maintenance of shame through systemic racism. The findings underscore the need to prioritize inclusion and diversity in CSA research, disrupting the practice of conceptualizing phenomena largely based on the voices of White survivors (McCauley et al., 2019). Findings are discussed through an intersectional lens to illustrate how shame following CSA can be shaped by the intersectional identities of survivors and the interactions between diverse systems of oppression.

All CSA survivors in this study described experiencing shame related to the CSA in various ways and were able to elaborate on their feelings of shame beyond mere definitional explanations. This points to a crucial aspect of identity that warrants consideration in the case of CSA survivors – being a CSA survivor. The few studies that have explored the "victim" and "survivor" identities (the two primary victimization identities available to individuals who have experienced sexual violence) have found that these too follow sociocultural scripts that dictate what it means to be a "victim" or a "survivor," which has implications for the self-perceptions of survivors (Warner, 2023). Warner (2023) found that women survivors associated the "victim" identity with weakness and the "survivor" identity with strength and being someone whose successfully recovered, persevering post-abuse, and ready to advocate for others. In our study, this was exemplified by Aashvi and Brisa who reported feeling minimal to no shame related to the CSA as a result of feeling like they are thriving in their current lives and have made life changes they were proud of, and Aashvi for being in a position now to help other CSA survivors. Women survivors of CSA have indicated a desire to adopt the survivor identity as this provides

them with a source of strength (Phillips & Daniluk, 2004); however, some survivors have reported feeling unable to identify as a "survivor" as they don't fit its social script (Warner, 2023). Social expectations around what it means to be a survivor, and seemingly the assumption that one will meet these expectations by adulthood, was exemplified by Marie whose mother questioned how Marie had not "moved on" from the CSA and Cindy whose husband questioned why she was not yet "fixed." This perceived failure to achieve the level of strength and recovery associated with the survivor identity can deepen feelings of shame that stem from feeling weak and like a failure; for example, Cindy viewed her identification as a "victim" as "unfortunate" and a reflection of her continued state of being "broken" and continuing to suffer from the CSA.

Alternatively, some CSA survivors have expressed a reluctance to adopt the "victim" and "survivor" labels entirely due to the stereotypes, societal perceptions, and messages associated with being identified as someone whose experienced CSA (Hunter, 2010). Indeed, a recent study found that CSA survivors struggled with identifying themselves as survivors of CSA as they found this shameful, in large part due to their awareness of shaming stereotypes and stigma attached to CSA and CSA survivors in society (Lateef et al., 2023). Marie perceived that there was a heightened societal stigma attached to CSA when compared to other types of childhood abuse. Awareness of this societal stigma contributed to the anticipatory stigma described by Amanda and Brianna, who sought to isolate themselves and conceal their perceived shameful self (Morrison, 2011) due to beliefs that others, including those to whom they had not disclosed, could somehow discern their past CSA by merely looking at them. This prompts consideration of the extent to which the victim or survivor identity takes precedence in the lives of CSA survivors in relation to other social identities, and the extent to which this contributed to attempts to isolate and conceal oneself among survivors like Amanda, Asma, Brianna, and Marie. Notably, three

Black women in this study – Amanda, Brandy, and Asma – also concealed aspects of themselves stereotypically associated with Black women to try to avoid shame and blame for the CSA.

An intersectional perspective warrants the exploration of how social identities may shape victimization identities, considering that intersecting systems of White supremacy and patriarchy have long rendered the histories and experiences of racially minoritized women survivors invisible (Boyle & Rogers, 2020; Crenshaw, 1989). An exploration of how "victim" and "survivor" identities were prioritized in the self-conceptualizations of women of color and White women found women of color to be more socioemotionally committed to the "survivor" identity than White women (Boyle & Rogers, 2020). Moreover, women of color with a stronger "survivor" identity reported higher self-esteem and lower overall distress than White women (Boyle & Rogers, 2020). Related patterns were observed in our study and can be partially explained by considering the race and gender stereotypes attached to different groups of racialized women, and the internalized expectations that those create. For instance, Brandy expressed shame for not being able to protect herself, and specifically her body as a Black woman, alluding to the "strong Black woman" stereotype – a stereotype that Black women are naturally strong and resilient against all stresses they encounter (Hill Collins, 2004). This stereotype places a burden on Black women to deny their humanistic and mental health needs through the obligation to display strength in the face of oppression, discrimination, and apparently sexual violence in the case of several Black women in this study and other studies (Warner, 2023) whose distress following the CSA was disregarded and denied by others.

Black women in this study also talked about the impact of the "angry Black woman" stereotype in maintaining their silence and the "Jezebel" stereotype in fueling their feelings of shame and self-blame. The Jezebel stereotype is a historical stereotype used to perpetuate the

harmful and false idea that Black women are promiscuous and hypersexual and was used to justify sexual violence against Black women, particularly by White men, during (and after) slavery (Hill Collins, 2004). Black women have recognized that this stereotype normalizes sexual violence against them in the present day (Leath et al., 2021) and, alarmingly, Black women who endorse this stereotype and have more frequent experiences of sexual objectification are themselves more likely to justify violence toward women (Cheeseborough et al., 2020). Asma internalized racialized sexual stereotypes and victim blaming messages related to how she was dressed when she was assaulted, to the extent that she believed she was promiscuous and that there was something within her that caused men to sexually abuse her. It can be speculated that awareness of this racialized gender stereotype also influenced the shame Amanda felt when she witnessed Black people "dressed any kind of way." Black girls may be acutely vulnerable to internalizing the Jezebel stereotype as younger Black women have shown higher endorsement of this stereotype than older Black women (Brown et al., 2013). Hence, Black girls who experience CSA may internalize negative stereotypes that place responsibility on Black girls for all sexual encounters, encouraging shame beliefs that they are inherently bad and responsible for the CSA.

Winnie, the sole Indigenous survivor in this study who expressed a strong connection to her Indigenous identity, also discussed how stereotypes and the oppression of Indigenous peoples as a whole contributed to her feelings of worthlessness and hopelessness to receive support following CSA. Winnie discussed how she became aware at an early age, in part due to messages she received by family members, of the lack of support to expect from different public institutions as an Indigenous victim. Relevant to the CSA context, Anderson (2016) provides a history of the sexual stereotypes that were placed on Indigenous women during colonization to subordinate and justify the rape of Indigenous girls and women. Our research highlights that

CSA survivors learn in childhood how they are perceived in society, their validity as victims, and the level of (or lack of) support they can expect from their families, institutions, and society.

This leads to the often overlooked need to include age as a central intersectional dimension of power and inequality through which children who are sexually abused may be oppressed (Whittier, 2016) and invalidated (Powell et al., 2017). All children are in a subordinate social position, possessing limited legal rights and social or economic power, as a result of their age and being minors. Adults have power over children on all these dimensions, and thus children are inherently in a socially disadvantaged position (Whittier, 2016). Our results identify important processes that occur in childhood that can contribute to shame among CSA survivors: sexual socialization and racialized gender socialization. In these processes, children typically heavily depend on guidance from caregivers and other adults to learn about sex and sexuality and expectations associated with being a boy or girl within a specific racial or ethnic group. Winnie and the Black survivors in our study received messages during their upbringing and in response to their CSA disclosures that reinforced prejudicial attitudes toward them. Moreover, most survivors in this study felt shame related to gender norms and culturally-specific gender scripts.

Furthermore, given the limited agency children have over institutional involvement, survivors were reliant on supportive responses and the protective actions of caregivers and other adults following disclosure, which are key in mitigating shame (McElvaney et al., 2022). Shame has been proposed as the affective mechanism through which negative disclosure responses encourage future silence among sexual violence survivors (Catton et al., 2023). Our results presented how different disclosure responses can lead to a shared outcome of silencing and reinforcing shame beliefs among survivors. For instance, the spoken and unspoken expectations placed on Asma and Marie by their family to avoid the perpetrator, even within their own homes,

rather than take steps to confront and remove the perpetrator from the family or social circle, sent the message that it is the responsibility of girls to take precautions to avoid being sexually abused, even as children. These messages, as well as those received by Amanda and Aasvhi that girls (but not boys) are considered "dirty" if exposed to premarital sex, undoubtedly originate from patriarchy. Such messages reflect unequal power dynamics that place the responsibility on girls and women to avoid normalized male sexual aggression ("just men behavior", as Asma was told) through adhering to gendered scripts of modesty, dress codes, and submissive behavior (Reddock et al., 2022). Such messages can instigate self-blame in victims who believe they caused the abuse by not meeting these expectations. Moreover, witnessing family members to whom they disclosed and expected protection from maintain relationships with perpetrators, conveyed a painful message to survivors, like Brisa, Cindy, and Asma, that their safety was not prioritized, and thus they themselves were not important nor deserving of safeguarding.

Our results demonstrated how the nexus between patriarchy and ethnicity can uniquely shape survivors' experiences of shame. For example, Asma and Aashvi carried an additional burden of responsibility within their ethnic communities because their family reputation was intricately tied to the virtue of female children, particularly their chastity. As such, disclosing and reporting CSA was perceived as tarnishing the family reputation and bringing shame upon them.

Finally, systemic racism in the media and public institutions contributed to the shame of survivors in this study in several ways. In terms of media, Amanda discussed that the greater media coverage of violence against White children compared to children of color reinforced her perception of being less valued than a White CSA survivor. Winnie described the lack of media coverage on Indigenous issues as maintaining the invisibility of their struggles. These reflections

are supported by a study that confirmed lower rates of media coverage for missing and murdered Aboriginal women compared to missing and murdered White women (Gilchrist, 2010).

Survivors believed that societal prejudice played a role in the discrimination they faced as CSA survivors from personnel in legal, social, and health institutions. Survivors in this study appeared cognizant of the inherent White supremacy and racism in public institutions and society. Several participants felt like their experiences of CSA received less empathy than White victims, and many actually witnessed their White peers receive more empathy and care in the same institutions where they encountered discrimination and dismissal. Moreover, Aashvi described her perception that police had preconceived notions regarding CSA within distinct racial and ethnic communities that influenced their dismissive response to her case. These experiences underscore the ongoing need to examine the systemic processes and institutions perpetuating racism (Choo & Ferree, 2010) and, in effect, stigmatize and silence women CSA survivors from minoritized racial and ethnic groups.

Practice and Social Implications

Professionals across healthcare, legal, social, and therapeutic services should critically assess potential racial biases they harbor toward girls and women from different minoritized racial and ethnic backgrounds, considering participants' perceptions of disparities in professional care between White and racially and ethnically minoritized CSA survivors in all of these institutions. Though this study focused on adult survivors of CSA, this suggestion extends to child welfare workers, as a recent study revealed racial disparities in CSA substantiations (Atkinson et al., 2022).

Several survivors in our study voiced that counseling had significantly helped to reduce their CSA-related shame. To promote positive experiences and mitigate negative counseling

interactions, which were reported by other participants, and to potentially improve the effectiveness of interventions aimed at reducing shame among CSA survivors from minoritized racial and ethnic groups, it is crucial for interventions to be informed by intersectionality to acknowledge the significance of social location in shaping CSA-related shame. Professionals should also enhance their cultural competence – the ability to interact effectively with people of different cultures – by increasing their knowledge of shame in different cultures (Budden, 2009; Gilligan & Akhtar, 2006), and explicitly in the context of CSA, such as the complexity of shame in Indigenous communities as distinct from Western ideas of shame (Hamilton et al., 2016).

On a systemic level, anti-racism interventions should be implemented in healthcare, social services, and the criminal justice system to alert personnel in these institutions of the reality of ongoing racism and other forms of discrimination within these institutions (Bryant-Davis, 2023), in an effort to increase their self-awareness of their own potential biases. Moreover, sexual assault education and training should be provided to all professionals in formal support systems, from clerical staff at the initial point of contact to those providing formal support, as survivors reported shaming interactions with professionals at all these points.

Lastly, media representations, especially in early education, should include positive representations of diverse social groups, particularly those commonly presented in a stigmatizing way in popular culture, such as Black girlhood (Dagbovie-Mullins, 2013). Racialized gender stereotypes appear to become associated with children early on. For example, adults have reported views of Black female children as "less innocent" and more adult-like than White peers of the same age (Epstein et al., 2017). As our findings revealed, awareness of prejudice connected to one's social identities can exacerbate feelings of shame among CSA survivors.

Thus, early efforts to challenge these negative depictions can encourage positive self-perceptions and discourage internalizing harmful stereotypes that can exacerbate shame among youth.

Limitations and Future Directions

Despite the novel contributions of our study in providing detailed insight into the experiences of shame among women CSA survivors from minoritized racial and ethnic groups, there were some limitations. Firstly, participants represented a specific cohort of CSA survivors with experiences at particular intersections of gender, race, ethnicity, and other social identities. As such, caution should be exercised when applying these findings to other CSA survivors, as different intersectional identities may be relevant to their experiences.

Secondly, the small sample size limits the generalizability of the study findings; however, qualitative studies are not meant to be generalizable but rather transferable to other populations with comparable characteristics. IPA traditionally includes small sizes due to the time-consuming analyses meant to generate rich and detailed data on individual experiences, and in fact a sample size of 10 is considered a "larger sample" according to IPA standards (Smith et al., 2022). Nevertheless, future qualitative studies with a greater number and more homogenous sample of participants with similar racial, ethnic, and gender intersections would provide results that are more applicable to CSA survivors with similar intersectional identities. At the same time, it would be important for larger studies to not lose the individualized details that capture the complexity of interactions among social identities and how these shape the shame of survivors.

Conceptualizing all minoritized racial and ethnic groups as one single category without acknowledging their individual experiences has been criticized as othering these groups and reinforcing an implicit norm of whiteness (Black et al., 2023; Choo & Ferree, 2010). Our study indeed focused in-depth on the unique shame experiences of each CSA survivor in relation to

their particular intersectional identities, despite the study being open to women CSA survivors from any minoritized racial and ethnic group. Our study findings demonstrated that different intersectional groups of CSA survivors experienced nuanced challenges that impacted their shame (e.g., stereotypes specifically directed at Black women). Therefore, in line with the previous recommendation, a targeted focus on shame among specific intersectional groups of CSA survivors in future research can lead to more meticulous theoretical insights and practice implications tailored to these groups that expand on those presented in this study.

Conclusions

An intersectional perspective is warranted to inclusively understand the shame experiences of CSA survivors. The findings of this study demonstrate how the social identities of women survivors of CSA from minoritized racial and ethnic groups, and particularly the nexus of race, ethnicity, and gender, and the concomitant systems of oppression, can intricately shape their experiences of shame following CSA. Sexual violence and negative stereotypes have been fundamental to the oppression of women, especially Black and Indigenous women (Hill Collins, 2004). CSA research should prioritize the inclusion of women survivors from minoritized racial and ethnic groups to avoid contributing to their marginalization in and out of CSA scholarship.

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Table 1

Participant Demographics

	Pseudonyms	**Age (years)**	**Racial & ethnic identity**	**Cultural identity**	**Country of birth (age of arrival to Canada)**	**Religious identity**	**Sexual orientation**
1	Amanda	37	Black; Caribbean/ mixed. Ethnic identity is really rooted in Canadian culture	Canadian with a hint of Jamaican, Caribbean	Canada	Atheist	Heterosexual
2	Brandy	33	Black; Caribbean and Euro	Canadian, Dutch, Caribbean	Canada	Christian	Heterosexual
3	Asma	26	Black; African	African, Burundian	Tanzania (4)	Christian/ Catholic	Heterosexual
4	Brianna	25	Black Caribbean	Black Caribbean	Canada	Christian	Heterosexual
5	Marie	46	Chinese Mauritian	Chinese Mauritian	Canada	Jewish	Heterosexual
6	Aashvi	40	Punjabi, Indo-Canadian South Asian, Quebecer		Canada	Sikh	Heterosexual
7	Winnie	26	First Nations Cuban, Indigenous; Middle Eastern, African	Indigenous	Canada	Unsure/ Indigenous	Heterosexual
8	Angela	28	Aboriginal, Italian, and Caucasian	Aboriginal, Italian, and Caucasian	Canada	Agnostic	Heterosexual
9	Brisa	22	half Guyanese, Indigenous North America, and South America (Brazilian)	Indigenous	Canada	Agnostic/ Spiritual	Lesbian
10	Cindy	42	Caucasian; Native (no status)	Canadian	Canada	Agnostic	Heterosexual

Bridging Manuscripts 2 and 3

Clinical trauma literature emphasizes that how shame is experienced and how it is expressed in therapy can differ depending on the type of trauma that it is attached to (Engel, 2015). As such, a comprehensive understanding of shame specific to different trauma populations, such as CSA survivors, better equips counselors and therapists to work with this clientele. Along these lines, the voices of minoritized racial and ethnic survivors of CSA should be centralized when considering how to provide interventions to support these groups of CSA survivors (Sanchez et al., 2019). Manuscript 2 and 3 collectively address these needs and fulfill the purpose of this thesis to explore how women survivors of CSA from minoritized racial and/or ethnic groups experience shame and psychosocial interventions related to CSA.

Manuscript 2 was an IPA study informed by intersectionality theory that explored how the intersecting social identities, and particularly the intersection of race, ethnicity, and gender, of 10 women CSA survivors who identified with a minoritized racial and/or ethnic group impacted their experiences of shame. Manuscript 2 provided detailed descriptions of how shame can be shaped by the intersectional identities of CSA survivors, presented through three Group Experiential Themes: 1) internalized shame tied to intersectional identity; 2) intra-familial reinforcement of shame and silence; and 3) maintenance of shame through systemic racism.

To lead into Manuscript 3, Manuscript 2 presented how several CSA survivors attributed a significant reduction in their feelings of CSA-related shame to their engagement in psychosocial inventions, such as counseling, for the CSA. At the same time, several other CSA survivors reported that their shame was maintained, triggered, and exacerbated through what they perceived to be racialized and/or unsupportive interactions with professionals across diverse institutions, including mental health professionals. One of the practice implications derived from

this study stated, “to potentially improve the effectiveness of interventions aimed at reducing shame among CSA survivors from minoritized racial and ethnic groups, it is crucial for interventions to be informed by intersectionality.”

Manuscript 3 addresses this suggestion by applying intersectionality theory to build our understanding of the psychosocial intervention experiences of women CSA survivors from minoritized racial and ethnic groups. Using an IPA approach with the same 10 women CSA survivors, Manuscript 3 specifically explored how these CSA survivors experienced psychosocial interventions, and how the intersection of race, ethnicity, and gender impacted these experiences. Through detailed participant accounts, the results of Manuscript 3 demonstrate how the intersectional identities of women CSA survivors from minoritized racial and ethnic groups impacted their psychosocial intervention experiences and preferences. Manuscript 2 and 3 collectively fulfil the primary goal of this thesis to demonstrate that the CSA experiences of women from minoritized racial and/or ethnic groups cannot be fully understood without considering how their intersectional identities and the concomitant systems of oppression shape their intersectional experiences.

Chapter 4: Manuscript 3

Identity-Driven Influences on the Psychosocial Intervention Experiences with Women Survivors of Child Sexual Abuse from Minoritized Racial and Ethnic Groups

Rusan Lateef[a], Delphine Collin-Vézina[a], Heather MacIntosh[a], Ramona Alaggia[b],

[a] McGill University

[b] University of Toronto

Abstract

Child sexual abuse (CSA) poses pervasive challenges to the well-being of children and youth worldwide, with profound and sometimes lifelong consequences. Psychosocial interventions, such as counseling and therapy, are one of the most recommended treatments for CSA survivors, showing many benefits related to recovery. However, there is a paucity of research on the psychosocial intervention experiences of CSA survivors from minoritized racial and ethnic groups. This study fills an important research gap by exploring how women survivors of CSA who identified with a minoritized racial and/or ethnic group experience psychosocial interventions. Using an interpretative phenomenological analysis design, ten CSA survivors completed semi-structured interviews that directly explored their experiences with psychosocial interventions, and how the intersection of their race, ethnicity, and gender impacted these experiences. Analysis of interview transcripts produced three Group Experiential Themes: 1) survivor-counselor shared social identities facilitate authentic expression and connection; 2) racial dynamics and microaggressions in counseling lead to detrimental impacts; and 3) counselor cultural competence and humility are perceived as priorities. Psychosocial intervention experiences can be significantly influenced by the intersecting social identities of CSA survivors, but these factors are not regularly taken into consideration in the therapeutic context. Clinical implications are discussed from an intersectional perspective.

Keywords: child sexual abuse; counseling; therapy; psychosocial interventions; intersectionality; racism; race; ethnicity

Introduction

Child sexual abuse (CSA) is a widespread public health problem impacting children and youth around the world (Pereda et al., 2009). CSA can lead to devastating short-term and long-term consequences for survivors. Short-term difficulties can include anxiety, post-traumatic stress disorder (PTSD) symptoms, decreased academic achievement, and inappropriate sexual behavior (MacGregor et al., 2019; Paolucci et al., 2001). Long-term, CSA has been associated with several physical health symptoms, including cardiovascular disease (Jakubowski et al., 2021), different types of bodily pain (Hailes et al., 2019) and difficulties related to pregnancy and childbirth (Brunton & Dryer, 2021). CSA has also been strongly associated with numerous psychiatric diagnoses, including PTSD, borderline personality disorder, anxiety, and depression (Hailes et al., 2019). Moreover, interpersonal difficulties are pervasive among CSA survivors with couple and family distress being high and having the potential for ripple effects to children (MacIntosh & Menard, 2021). Additionally, psychosocial difficulties such as shame (Lateef et al., 2023) are prevalent among CSA survivors and can negatively impact many aspects of their lives (Pettersen, 2013). Evidently, negative consequences of CSA can proliferate throughout the lifetime of survivors if they do not receive adequate support to recover from the abuse. Therefore, it is imperative to examine the effectiveness of existing interventions to determine if they adequately address the treatment needs and healing of all CSA survivors.

Psychosocial interventions, including counseling and psychotherapy, are among the most recommended treatments for addressing the impacts of CSA on adult survivors (Cummings et al., 2012). These have been identified to be effective and well tolerated by CSA survivors (Cummings et al., 2012). This paper will discuss counseling, therapy, and psychotherapy in accordance with the terminology used in the selected literature. Otherwise, for the sake of

conciseness, "counselor" and "counseling" will be used. Individual psychotherapeutic support has been associated with decreased depressive and PTSD symptoms, distorted beliefs, and shame, as well as improvements in self-esteem, self-acceptance, and overall functioning, according to a meta-analysis (Taylor & Harvey, 2010) and systematic review (Price et al., 2001). Meanwhile, a review of group interventions found them effective in decreasing PTSD symptoms, depression, alienation, and sexual problems among women survivors of CSA (Kessler et al., 2003). Other studies have shown group therapy also reduced feelings of stigma, shame, and guilt, among women survivors of CSA (Lundqvist et al., 2006; Sayin et al., 2013).

At the same time, there are certain characteristics of therapy that can facilitate or hinder healing. For example, a systematic review of therapy experiences of adult CSA survivors found that, among other aspects, creating a safe therapeutic space and making survivors feel equal and free from judgement fostered trust and empowerment in therapy (Parry & Simpson, 2016). Conversely, unequal client-therapist power dynamics, having no input on how therapy proceeds, and feeling misunderstood were experienced as negative and at times repeating abusive dynamics (Parry & Simpson, 2016). Thus, despite the many potential benefits associated with receiving psychosocial interventions, it is important to consider the preferences of CSA survivors. It is also just as important to consider whose experiences are not captured in the current evidence base. Parry and Simpson (2016) noted a scarcity of cultural diversity across studies and explicated the need for future research to understand how culture may influence the relational dynamics and recovery process in therapy.

CSA survivors from minoritized ethnic groups who have sought formal support have expressed difficulty finding support services for their respective groups (Gilligan, & Akhtar, 2006). They have further expressed disappointment when support services were not sensitive to

their particular social and cultural contexts (Gilligan, & Akhtar, 2006). Individuals from minoritized racial and ethnic groups have reported harmful experiences in counseling in relation to their social identities. For instance, among 2212 racial and ethnic minority adults who had received counseling at some point in their lives, 81% reported experiencing *at least* one racial microaggression in counseling (Hook et al., 2016). Racial microaggressions are subtle or covert forms of racism consisting of brief verbal, behavioral, or environmental exchanges that send denigrating, hostile, or derogatory messages directed toward people of color, whether intentional or unintentional (see Williams et al., 2021 for an updated racial microaggressions taxonomy). Greater perceived racial microaggressions have been associated with a weaker therapeutic alliance, lower ratings of multicultural counseling competence, and lower counseling satisfaction in relation to White counselors (Constantine, 2007). In contrast, clients' perceptions of cultural humility – ability to engage in ongoing self-evaluation and take an interpersonal stance that is other-oriented in relation to aspects of cultural identity that are most important to clients – among counselors have been associated with fewer experiences of microaggressions in counseling (Hook et al., 2016), greater self-perceived improvement (Hook et al., 2013), and a more positive working alliance (Davis et al., 2016). These findings suggest that racialized dynamics and interactions with counselors contribute to the therapeutic relationship and satisfaction among racially and ethnically minoritized individuals receiving services. As CSA survivors require targeted psychotherapeutic interventions that are individualized to their needs to achieve optimal therapeutic outcomes (Cowan et al., 2020), there is a consequent need to build our understanding about the specific counseling preferences and experiences of CSA survivors who identify with minoritized racial and ethnic groups to better inform psychosocial interventions.

Conceptual and empirical literature on CSA has long centered on the experiences of White survivors (Kenny & McEachern, 2000; McCauley et al., 2019) in Western countries (Russell et al., 2020). Moreover, evidence-based practices for working with sexual abuse survivors have predominantly been developed and evaluated among White women in socially privileged positions (McCauley et al., 2019). Consequently, the training and values of professionals working with CSA survivors are predominantly rooted in Western cultural traditions (Gilligan, & Akhtar, 2006). Considering that mental health professionals in multiple studies have expressed discomfort, lack of knowledge and training, and unpreparedness when working with CSA survivors (Hovey et al., 2014; Kennedy et al., 2021; Nixon & Quinlan, 2023), these concerns may be more pronounced when working with CSA survivors from minoritized racial and ethnicity groups whose diverse needs are not adequately represented in the literature. Indeed, therapists seem to differ in their ability to produce positive outcomes in psychotherapy with racial and ethnic minority clients (Kivlighan et al., 2019), with some therapists being better able to do this with White rather than racial and ethnic minority clients (Hayes et al., 2015).

Sawrikar and Katz (2017) identified that cultural competency is an essential treatment need when working with CSA survivors from ethnic minority communities. To enhance professionals' cultural competence and better tailor services to the needs of CSA survivors from minoritized racial and ethnic groups, research is needed to understand their psychosocial intervention experiences and preferences. Therefore, the purpose of this study was to qualitatively explore the following research question: How do women survivors of CSA from minoritized racial and/or ethnic groups experience psychosocial interventions? Notably, in clinical studies, clients' perceptions of the therapeutic alliance played a more significant role in treatment satisfaction than therapists' perceptions (Sexton & Alexander, 2003). In relation to the

current study, this emphasizes the need to better understand what creates a positive therapeutic relationship and overall psychosocial intervention experience through the personal perspectives of women survivors of CSA from minoritized racial and/or ethnic groups.

This study was informed by intersectionality theory, which proposes that social identities intersect to form qualitatively different life experiences and challenges for individuals in society (Warner, 2008), as a reflection of multiple, converging, and interwoven systems of privilege and oppression, such as racism and sexism (Crenshaw, 1989, 1991). Intersectionality has been proposed as a theoretical framework for understanding sexual violence against girls and women from racially minoritized groups (Armstrong et al., 2018; Crenshaw, 1991). It has also been suggested that intersectionality is an ethical lens to apply in psychotherapy, especially if clients' experiences of oppression are intersectional (Nayak, 2020). Without contextualizing the sexual violence experiences of women of color within the structural axes of sexism and racism in psychotherapy, the risks of unintentional harms are increased (Nayak, 2020). Intersectionality can further inform psychotherapy through consideration of the intersections of therapist and client identities and associated dynamics of power and oppression, and how these influence the therapeutic relationship and process (PettyJohn et al., 2020). Drawing on these recommendations, this study used intersectionality theory to understand how the intersection of race, ethnicity, and gender impacted the psychosocial intervention experiences of women CSA survivors who identified with minoritized racial and ethnic groups. The terms "minoritized racial and ethnic" and "racial and ethnic minority" groups are used interchangeably in this paper, as several study participants used the term "minority" to describe their experiences, and many cited sources similarly used the term "racial and ethnic minority" groups. However, it is important to recognize that being minoritized is a result of social processes and not inherent characteristics.

Methods

This study employed an interpretative phenomenological analysis (IPA) design (Smith et al., 2022). IPA is a qualitative research methodology in which in-depth first-person accounts are analyzed by researchers seeking to understand specific life experiences from the perspective of each participant in a study, while looking for similarities and differences across participant cases (Smith et al., 2022). As such, IPA prioritizes the importance of meaning, context, and nuance (Smith et al., 2022). It involves a dedication to idiographic analysis (i.e., attention to the individual case), and is inevitably interpretative (i.e., involves the researcher's active input; Smith et al., 2022). This project was approved by the McGill Research Ethics Committee.

Data Collection

Recruitment

Ten participants were recruited through three non-profit organizations that serve adult survivors of CSA in two large provinces in Canada. Two of the organizations specifically serve survivors of sexual violence, while the third provides therapeutic services to individuals who have experienced trauma, including CSA. The recruitment flyer that was distributed by these organizations included the inclusion criteria that participants had to be 1) 18 years of age or older; 2) identify as a woman; 3) speak fluent English; 4) identify with a racial and/or ethnic minority group; and 5) currently receiving or in the past year received some sort of psychosocial intervention, such as individual counseling or therapy, for experiences of CSA. Despite being open to both cisgender and transgender women, only cisgender women responded to the flyer.

To participate, potential participants contacted the principal investigator to express their interest in participating in the study. Participants were then directed to complete an online screening questionnaire. Included in this questionnaire was the following question: *Did you*

experience sexual abuse before the age of 18 years old? Participants were permitted to self-identify as having experienced CSA according to this broad criterion. Participants who met all the inclusion criteria were contacted via email to confirm their eligibility and arrange a pre-interview phone call to explain the purpose of the study and what to expect from participation, and, if interested, schedule an interview. This initial phone call was also used as an opportunity to build rapport and ensure participants' comfort with discussing the interview topics. All participants provided signed informed consent prior to the start of the study interview.

Interview and Measures

Participants had the option of completing the in-depth, semi-structured interview through telephone call or Zoom videoconferencing software. Of the 10 interviews, two were conducted via telephone call and eight were conducted via Zoom. The length of interviews ranged from 47 minutes to 2 hours and 46 minutes, with an average interview length of approximately 1.5 hours.

Demographics Questionnaire. As this study was informed by intersectionality theory, the importance of documenting the social location of each participant was imperative. The interviewer, the first author of this research article, asked participants demographic questions that allowed them to define their race and ethnicity, and other aspects of their social identity, as they chose, rather than constraining them to identity with fixed categories that may not align with how they identify (Windsong, 2018). There were no options provided to participants for any category. Participants were advised that they could be as descriptive as they wanted in their responses. Following demographics questions, participants were asked about the type(s) of psychosocial intervention(s) they were receiving or had received and the duration of these interventions at time of the interview (in months). Participants were also asked about certain aspects of their

experiences of CSA (i.e., age of onset, duration of abuse, perpetrator relation, age of first disclosure, recipients of disclosures).

Interview Guide. The interview guide was informed by intersectional principles, with a focus on using broader language meant to allow individuals to describe their experiences as they choose. Open-ended, exploratory questions that reference intersections are suggested as a helpful method to gather responses in intersectional research (Warner, 2008), and this was incorporated into the guide. Survivors were asked a series of questions that inquired how their race, ethnicity, and other aspects of their social identity have influenced their counseling and therapy experiences. At the end of each interview, participants were offered a resource list for their respective province.

Data Analysis

Transcripts were analyzed according to the steps of IPA outlined by Smith et al. (2022). IPA analysis requires each participant's case to be analyzed in-depth as a single case through five steps, before moving onto the next case. First, the transcript was read multiples times to allow the researcher to become immersed with the data. The second step involved an exploratory examination of the language use and semantic content of the transcript, using the margins to make exploratory notes on any preliminary interpretations of how the participant described their experiences. Third, the extensive exploratory notes were turned into experiential statements that aim to capture the most important aspects of participant experiences based on the participant's original words and exploratory notes that reflect the researcher's interpretation. The next step was to search for connections across experiential statements and to cluster together statements that were closely aligned. Finally, each cluster of experiential statements was given a title that captured its characteristics, and these become the participant's Personal Experiential Themes. A

table was created that included each Personal Experiential Theme and all the instances in the transcript in which this theme was apparent along with the respective page and line numbers.

Following the independent analysis for each participant, convergences and divergences in Personal Experiential Themes across participants were assessed. Based on the convergences observed across cases, Group Experiential Themes were identified that highlight the shared and unique features of the experience across the majority of participants. With a large sample (i.e., 10 or more), a Group Experiential Theme should be endorsed by at least half of study participants or be a distinctive concern of a subset of participants to be considered valid (Smith et al., 2022).

Validity Strategies

Dependability of the data was ensured through digital recordings and verbatim transcription of the interviews (Drisko, 1997). As much as possible, paralinguistic cues were captured in the transcription to enhance reliability, as Creswell and Poth (2018) suggest "the recording needs to be transcribed to indicate the trivial, but often crucial, pauses and overlaps" (p.264). Creswell and Poth (2018) suggest using at least two validation strategies in any given study to enhance the trustworthiness of findings. The following validation strategies were used: (1) providing a rich description of participants and findings; (2) engaging in reflexivity (a strategy for exploring how one's own preconceptions and experiences influence the process of understanding the experiences of research participants; Smith et al., 2022); and (3) having peer review of the data and research process. All demographic information that was collected is not presented in this article to protect participant anonymity; however, the age, race, and ethnicity specified by CSA survivors will be included next to the first use of each participant's pseudonym in each theme and social identities that were significant to the counseling experiences of survivors will be described. Confirmability of themes was established through direct quotes from participant

interviews (Drisko, 1997). Each participant quote follows their respective pseudonym so that readers can assess the potential transferability of the experience based on their description.

IPA requires the researcher to take an active role in the research and analysis process (Smith et al., 2022). The principal investigator (first author) developed the interview guide, conducted the interviews, and completed the analysis. The principal investigator identifies as a woman from an ethnic group minoritized in Canada. She has a decade of experience in CSA research, with a particular interest in the experiences of CSA survivors from minoritized racial and ethnic groups. As researchers may have preconceived conceptions of the phenomenon being studied, it is critical for researchers employing IPA to engage in a process of reflexivity to produce a credible interpretation of participants' experiences (Smith et al., 2022). The principal investigator kept a reflexive journal through the research process to remain cognizant of potential ways that personal biases may have been interfering with the interviews or analyses. Moreover, throughout the research process, the principal investigator engaged in peer debriefing with three researchers (co-authors on this paper). Although the three co-authors do not identify with minoritized racial or ethnic groups, they all identify as women and some as members of other marginalized communities, including the LGBTQ+ community and minoritized linguistic groups. All three co-authors have recognized expertise in CSA research. The peer debriefing process offered opportunities for the principal investigator's perspectives, assumptions, and interpretations to be revealed and challenged. Examples of such feedback from these researchers included input on research design, identifying potentially leading questions in the interview guide, and reviewing and confirming the findings.

Study Participants

Among the 10 participants, six were visible racial and/or ethnic minorities (i.e., visibly presented as non-White) and four were non-visible ethnic minorities (i.e., presented as White, or White-passing, but self-identified as an ethnic minority). Distinguishing between participants who were visible or non-visible minorities became a relevant factor in participants' counseling experiences, as will be elaborated in the results.

Counseling experiences

In terms of counseling experiences, eight participants were currently receiving individual counseling and two participants had received individual counseling within the past year. One participant was, at the time of the interview, concurrently attending group therapy for adult women CSA survivors, while three participants had previously attended group therapy for CSA.

Abuse characteristics

The age of onset of the first incident of CSA was between 4 years to 15 years of age, with an average age of onset of 9.3 years. Duration of CSA ranged from a one-time occurrence to 11 years. Two participants had experienced two separate CSA experiences (i.e., CSA by two different perpetrators at different times) and three participants had experienced three separate CSA experiences (i.e., CSA by three different perpetrators at different times). Experiences across participants consisted of both intra-familial and extra-familial CSA.

Results

Three Group Experiential Themes emerged from the data that highlighted how women survivors of CSA from minoritized racial and/or ethnic groups experienced psychosocial interventions, and the identity-driven influences on the quality of these experiences: 1) survivor-counselor shared social identities facilitate authentic expression and connection; 2) racial

dynamics and microaggressions in counseling lead to detrimental impacts; and 3) counselor cultural competence and humility are perceived as priorities. In order to accurately present participants' experiences, language used by participants to describe their social identities (e.g., Black, White, Caucasian, etc.) and therapeutic interventions (e.g., counseling, therapy, counselor, therapist) are used in the results. In line with IPA principles, the experiences of each participant will be presented as distinct, idiographic case studies to discuss their experiences in-depth.

Survivor-Counselor Shared Social Identities facilitate Authentic Expression & Connection

The majority of participants (n = 9) had preferences related to the social identities of their counselors. Most participants had an initial preference for a woman counselor, though some participants noted that they had had positive experiences with a male counselor. Seven survivors indicated a preference for a woman counselor from a racial or ethnic minority group.

Amanda (37, Black Caribbean) initially indicated a preference for a woman counselor, and then elaborated that specifically having a counselor who was a Caribbean woman would make it easier for her to open up about the CSA as she assumed that this counselor likely had a history of sexual abuse herself (thus, also sharing the sexual abuse survivor identity): "Women, for me, are much easier, and if they're Caribbean, because a lot of Caribbean women go through sexual abuse." As Amanda discussed a past experience with a Black woman counselor, it became clear that, in addition to a counselor being matched in gender and ethnicity, it was also therapeutically beneficial when her counselor was of the same race, as this fostered a unique sense of mutual understanding and support:

> I really, really liked it. Um because, I don't know how it is for other races, but when Black people see each other, we have an understanding. We don't know each other, but

it's like "I respect you. I get it. I've been there," you know. And so, I felt that with her, it's just like home.

Use of a word such as "home," alongside her sense of feeling seen, emphasized the extent of connection that Amanda felt when working through the CSA with a Black female counselor.

Similarly, when **Brianna** (25, Black, Caribbean) discussed her preference for a female therapist from the same ethnic background, she used the word "family" to indicate the level of comfort she predicted she would feel with a therapist she shared gender and ethnic identities with: "I think if I had a therapist from the same ethnic background, yeah it would make me more comfortable. Yeah, cause I would feel she is like, um, I want to say, family, cause of the ethnic background, yeah." Beyond comfort, Brianna discussed the heightened understanding she anticipated if she were to have a racially-matched woman counselor compared to a White woman counselor: "Most definitely it would look different, because I think she would understand what I was saying, and there would be a flow. Yeah. So, I think she would yeah, understand me more, most definitely." Brianna switched between expressing her interest for a female therapist whose racially matched and ethnically matched, and oftentimes discussed her racial and ethnic identities together. Brianna went on to express that "it would be more helpful" to her therapeutic experience if she had a therapist matched in gender, ethnicity, *and* religion as beliefs attached to all of these identities had shaped how she thought of her experience of CSA.

Asma (26, Black, African) discussed the relevance of both her racial (Black) and ethnic (African) identities in shaping her CSA experiences, and particularly her recovery from CSA. As such, being unable to speak about CSA in the context of her social identities in previous therapy sessions made her feel the need to compartmentalize herself and discuss her experiences void of the very relevant social context in which they occurred:

> race is such a big part of who someone is, um and if you can't tap into that, then you're always kind of surface level with a lot of things. And a lot of my therapists before, I felt like I was very surface level. […] I didn't always know how to pinpoint what the issue was. But if I can put it collectively together, it was feeling like I brought myself as one person, and I didn't bring myself as a full person in all these sessions.

Asma explained that speaking to a therapist whom she can relate to racially and ethnically would allow her to speak and share more authentically, as she expected being inherently understood:

> I do think the experience would have been… a bit more smooth. I think that when you talk to someone who you don't have to – even sometimes bring it…I don't know how to say it. Like there's a certain language that you can just go into directly, like you can say like "you know how parents get" or "you know how moms get," so, or "you know how the aunties" and stuff. Like you have a bit of a cultural thing where we know how our entourage work, how our community work.

Indeed, when she had a Black therapist in the past, Asma expressed feeling a greater sense of being understood and not needing to provide education on her racial and ethnic background in order to be understood, as the therapist already presented an awareness of how the different interconnected aspects of Asma's identity had likely contributed to her CSA experiences:

> I've only had a Black therapist once […] I had to do a lot less explaining in terms of what it feels like to be a Black girl or an East African girl in those situations. I think that part she got very quickly, and she understood that there's also an added layer of being the elder, the eldest daughter, and feeling like you have a responsibility to show a certain path for your siblings.

For Asma, being the eldest daughter of an immigrant family played a pivotal role in her CSA disclosures and choices to seek support for the CSA, and this was a unique aspect of her experience that she felt was readily understood when working with a Black female therapist.

Brandy (33, Black, Caribbean, Euro) described an underlying sense of connection when discussing CSA with counselors who are visibly from racial or ethnic minority groups. She implied that the empathy expressed by these counselors felt genuine, as she presumed these counselors had likely experienced traumas themselves and encountered relatable challenges:

> There's such a connection when the empathy is coming from someone that resembles you […] That says "hey, I've experienced those things" without even saying it, right, like, because you just know […] for me and the counselors that I've worked with that are even brown […] it is something that you first notice

Brandy elaborated that part of this sense of empathy and understanding that she expected from visible racial and ethnic minority counselors comes from cultural differences in how key issues related to CSA, such as shame and sexuality, are experienced in non-Western cultures. She explained that, for these reasons, she would prefer a Black, Brown, or Indian counselor:

> Um or like Brown, Indian. Also, the culture of like rape culture […] and how a lot of that is very different in like Western society versus like intr – integrity and kind of values that are withheld in um a lot more of the more different cultures. How the body's viewed and sexuality. So, you know, some of the shame, I think, there's a fine line of certain things that I still think are more shameful than White counselors.

When Brandy participated in group therapy with other women who had suffered interpersonal traumas, she found that hearing the stories of other women whom she related to in gender, age, ethnicity, and race, supported her recovery and helped her remove self-blame for her own abuse:

> The group stuff was nice because it was other women. There were really, like, women that I could familiarize a little bit more with on age, ethnicity, and race. And then it's interesting cause when they say what happened it's like "that is so not your fault, like that person." […] So, I think, having that kind of relativity of similar people going through similar things really allowed me to see that I was that person in the situation.

When comparing her experiences with a White therapist and a visible ethnic minority therapist, **Marie** (46, Chinese Mauritian) remarked on the immediate difference she felt:

> I've had therapists from a different ethnic background […] so, then I had something to compare it to and I did tell them, the first therapist that I had there, experience like "wow, it's like it's a different experience that you are um from a visible minority group." Like it's um… I didn't have to go and find something that made it relat – relatable. It was like kind of obvious, right, like um. And they just understand that piece of it of like… you know, immigrating from Canada and having to, you know, uh integrate and how does that look

The fact that Marie said that she "didn't have to go and find something that made it relat – relatable" indicated that it was important for her to be able to relate to her therapist in some way. In Marie's case, she felt increased comfort when working with a therapist from *any* minority background: "For me there is a comfort level knowing that the, the therapist is from a visible minority, or from any minority, because it just gives them a different perspective." When she had received services from such therapists, Marie was able to talk "explicitly about race or like how I grew up or, you know, the stigma and stuff like that" and anticipated to be understood.

When reflecting on her experience attending group therapy with other women CSA survivors from visible racial and ethnic minority backgrounds, Marie remarked that

conversations related to how their racial and ethnic backgrounds impacted their CSA experiences "naturally came up […] And it was, it was something that we *all* could relate to." She elaborated:

> the participants were all from a visible minority background. Um… I think we understood each other on a different level, like the cultural aspect of, you know, fear-based parenting, shaming your kids to, to be compliant, having expectations of what path you would take in life, the secrecy of sexual abuse and shoving it under the rug um… really made it relatable. And even the aftermath of all of this.

Marie compared this to an experience where she was the only visible ethnic minority in a therapy group: "I was like the only visible minority out of a group of like 12 people […] The focus was more on trauma and […] So, we didn't get as intimate." This seemed to echo Asma's previously noted sentiments that therapy remains very "surface level" when unable to discuss aspects of CSA that are more fully understood within the racial and ethnic context of the survivor.

Notably, despite her positive experiences with counselors and group therapy attendees from minoritized racial and ethnic groups, Marie shared an unsatisfactory experience with a counselor who she described as a half-Mauritius woman:

> I thought we would have more in common, actually. But um I think because her dad was, or is, White [Canadian], she grew up with a different, a very different view of things, right, like. I think it was much more… she had a different sense of belonging.

For Marie, being a second-generation immigrant intersected with her identities as a Chinese Mauritian woman in shaping her CSA experience in terms of beliefs and familial disclosure responses. As this case shows, even if counselors are ethnically matched with survivors, other intersecting social identities can impact a survivor's sense of relatability with their counselor.

Unlike the other five survivors who were visible minorities, **Aashvi** (40, Punjabi, Indo-Canadian, South Asian) did not express a specific preference for a counselor from a racial or ethnic minority group. Aashvi indicated multiple times in the interview that "I think of myself as a Quebecer" (a person born and raised in Quebec, a Canadian province). This strong attachment to her Canadian identity was not expressed by the other visible racial and ethnic minority participants, and so it may be that other participants identified more closely with their minoritized racial and/or ethnic group. Aashvi did acknowledge, however, that having an ethnically-matched counselor would facilitate greater understanding and discussion of culturally-relevant aspects of her experience:

> Again, she'd probably be somebody that's also experienced um sexual abuse. Um because I think that's the way things should go. […] to open up with details and stuff, it's nice to open up with somebody who's gone through it. So, from a South Asian perspective, I can bring up certain […] You know, when you have that connection with somebody on a cultural aspect, cultural level.

As she indicated in the above quote, the priority for Aashvi would be to have a counselor who has experienced CSA themselves, and so sharing the "survivor" identity would be her primary preference. She expressed the sense of connection she felt with other CSA survivors, irrespective of their social backgrounds, when she participated in group therapy with other women survivors:

> you're talking with other people that have gone through it, it's a beautiful feeling. It's a beautiful feeling to be like, "hey, what did you do? How did you do it?" […] we talk about different things, but we both are survivors, so that connects us

She contended that the internal difficulties that are experienced by CSA survivors can only be deeply understood by other survivors as opposed to counselors who have not experienced CSA:

> I remember the difference to being in a group with women who actually have gone through childhood or teenage sexual abuse, than to be in a group with professors and people who haven't gone through a cup-a-feel […] Makes a huge difference, because it's so, it – the emotions, the body sensations, the thoughts, the process is so, is so internal and to be with somebody else […] like I get it.

Brisa (22, White, Indigenous) admitted that her Indigenous identity did not play a role in her CSA experiences, though she would be interested in exploring Indigenous ways of healing in the future. Rather, her queer identity had shaped her feelings around one of her past CSA experiences. When asked about her counselor preferences, Brisa responded, "it would be cool to have an Indigenous counselor one day or like maybe someone who relates to like queerness." She also identified that having a woman counselor would help her open up more, as opposed to a male counselor, based on her past experiences: "it's really awkward to talk to guy counselors sometimes. Um I had this one guy counselor, like a great guy, but just ugh [sigh] like you can't talk, you can't talk to him about everything." Brisa remarked on sharing social identities with counselors: "I think it is very beneficial when you have things in common with your counselor, because […] they can relate to small things. Like it just feels… it, it feels nice, I guess."

When asked about her social identity preferences for a counselor, **Angela** (28, Caucasian, Aboriginal [5]) responded:

> I would ask for a woman um and I would ask for somebody of color. To me, it doesn't really matter their ethnicity, it's just an assumed, I guess it's my assumption that at some point in their life they had tough experiences too.

[5] In Canada, "Indigenous" is generally the preferred umbrella term that collectively refers to First Nations, Métis, and Inuit groups. The terms "Aboriginal" and "Native" were used only when participants described their identities with these terms.

The lack of elaboration in her responses suggested that Angela may have responded in a way that she thought the researcher expected (participation bias), rather than a genuine preference. Still, her response echoed the expectation that Amanda, Brandy, and Aashvi had that a woman counselor from a racial and/or ethnic minority background has likely experienced CSA or other trauma themselves, which seemed to increase survivors' comfort to share about the CSA.

Lastly, **Cindy** (42, Caucasian, Native[6]) initially preferred a woman counselor; however, she had had positive experiences with male counselors, and so she no longer had any strong preferences related to the social identity of counselors: "I would say in the beginning I had a preference to female, but now, as long as they do their job properly, it doesn't really bother me."

Overall, when discussing their social identity preferences for their counselors, the responses from participants from non-visible ethnic minority backgrounds (Brisa, Angela, Cindy) lacked the depth and contemplation that was evident in the responses from the visible minority participants. Most survivors from *visible* racial and ethnic minority backgrounds in this study preferred women counselors with whom they shared the same or similarly minoritized racial and/or ethnic backgrounds. They had experienced or anticipated several benefits of sharing social identities, including validation and normalization of their experiences, an increased sense of relatability and being understood, and a reduced need to provide extensive contextual details of identity-related aspects of their CSA experiences to be understood.

Racial Dynamics and Microaggressions in Counseling lead to Detrimental Impacts

The four survivors in this study who identified as Black women reported racial dynamics that negatively impacted their counseling experiences through power differentials exacerbated by race, perceived racism in the form of negative treatment, and microaggressions. Some of the

[6] See footnote 5.

negative impacts of these racial dynamics included bringing a superficial self to counseling, censoring aspects of their CSA experience related to their racial or ethnic identities, feeling misunderstood and judged, and being discouraged from continuing counseling altogether. In contrast, the four White-passing participants described their outward appearance as White women, and thus the invisibility of their minoritized ethnic identities, as a protective factor against racism.

Amanda (37, Black Caribbean) reported negative counseling experiences that she believed were fueled by racism, including several incidents with White male counselors. Amanda recalled one of her first counseling experiences with a White counselor and an Asian psychiatrist. She felt a lack of empathy from both professionals, and consequently became conscious that this may be due to her race: "the White counselor was uh talking to me, I don't know if he might have looked at me like I was less than him or something." Similarly, the rushed and dismissive manner in which the psychiatrist asked her questions made Amanda feel like she was viewed as unimportant, and made her question if racism influenced how she was treated:

> the psychiatrist himself came in. He's like "okay, we gotta speed this up" – an Asian guy. He's like "what's this, what's that?" And I was just like, am I not important enough for you to take the time to ask me the questions properly? […] I feel unheard. And it almost feels like what you have to say is not important because you're a woman, and possibly because I'm darker skin, because that's a huge thing in Asia.

Amanda felt cautious when speaking with White counselors about race and generally avoided race-related discussions: "when I speak to White counselors, I'm a bit more careful with how I say things. I don't want to offend them, you know." This was detrimental to her recovery from the CSA as there were certain aspects of her experience that were intricately tied to race. For

example, the fact that the person who abused her was a White man was significant to her experience, as she felt this had had long-term impacts on her relationships. She stated that she would only disclose and discuss the relevance of the race of the perpetrator if she had a Black counselor, as she would expect a type of support that is uniquely shared between Black people:

> I don't really talk about the race of it all. But with a Black person, I'd probably say that and then maybe there would be like, excuse me, um, like that kind of like "us against them" thing, like "I've got you," you know, they, "they damaged you, but I got you. We're, we're part of the same tribe." So, I feel like I would more readily tell them about the race of my uh rapist and molester.

Amanda had not had the opportunity to address this aspect of the CSA in counseling, which had maintained her shame surrounding this aspect, indicated by her seemingly feeling self-conscious sharing this in the study interview, clarifying afterwards, "which is weird, right? That's weird."

In **Asma**'s (26, Black, African) experience, some White therapists avoided discussions of social identities altogether or attempted to generalize experiences unique to her social identities as things that everyone experiences, rather than acknowledging the uniqueness of her challenges:

> you're being treated, but not as an individual. You're being treated as a sexual assault victim. And not a sexual assault victim that happens to be this young Black girl of a Christian background in an African household. Um I'd say things and they wouldn't really hold on to them. I'd talk about my community. I talked about being an immigrant, and those aspects of me would not be touched upon at all, or they would be like fluffily received, like "aww, well, all families go through this" and "mothers and daughters relationships are so complicated." Yeah, but I'm not talking to you about every mother and daughter. I'm talking to you about a mother that was raised in a certain country, and

> that came here as a refugee and that had me at age 20 […] feeling like the dismissal of those things, you start dismissing them as well.

These experiences can be described as a racial microaggression called color-blindness – when counselors do not want to acknowledge race – that can lead individuals to feel that their unique racial experiences are invalidated, and the relevance of their social identities are undermined. The frustration she felt following dismissals of important CSA-related experiences that were connected to her social identities eventually led Asma to avoid these types of discussions with therapists. Moreover, when she attempted to share about certain experiences common in her ethnic group with one of her White therapists, she was left feeling judged:

> sometimes I wanted to tell her like you don't get it. […] And when I would tell her things, then she'd be like super scared like, "are you sure that this isn't like abuse?" I'm like "no it's not, it's not abuse. It's just how parents in this community work, function." I know what's crazy and what's not crazy um.

This judgmental response by Asma's therapist represented another type of racial microaggression she experienced, called "pathologizing minority culture or appearance" wherein appearance, behaviors, or traditions that differ from Western, White culture are seen as not ideal.

Similar to Asma, **Brianna** (25, Black, Caribbean) found it unsettling when a White counselor disregarded the relevance of her social identities and applied her own beliefs to Brianna's experience: "I think her background has some different beliefs, and she was trying to infuse that to the whole scenario, whole situation. That wasn't something I liked. I didn't feel comfortable with it." These culturally insensitive suggestions seemed to have been experienced as microaggressions, in which the counselor prioritized her own beliefs. Unfavourable racial dynamics between Brianna and her counselor almost led Brianna to discontinue counseling:

> [Race and ethnicity] has played a big role and impact cause at first, I wasn't able to relate with my counselor because of the fact that she was not of the same ethnicity as I was. That was really not good cause I almost stopped going for the sessions. I, I just didn't know how to continue with it. But I was able to just cope with having a White counselor.

Brianna's use of the word "cope" signified the extent to which it was difficult for her to remain with a White counselor who did not seem to have the cultural competence skills to sensitively facilitate conversations related to race and ethnicity, without imposing her own personal beliefs.

Brandy (33, Black, Caribbean, Euro) expressed an almost hyper-awareness of the stereotypes surrounding Black women and adjusted her behavior in order to avoid discrimination, including in counseling and particularly when she had a White counselor: "even in *counseling*, I've learned how to not be racially profiled or like discriminated against." For example, although anger related to the CSA was something that Brandy struggled with, she chose to conceal this anger in (and out of) counseling because she did not want to be labelled with the "angry Black woman" stereotype:

> I think understanding the stereotypical Black woman and anger […]. So, it was being like *extremely* gracious, and *extremely* calm, and like the *extreme* of everything else in mannerisms […]. I don't think she understands why it might be – or would understand why it might be challenging as a Black woman in society to express any notion of anger or frustration. So, I do think that there might be a barrier in that sense.

Brandy further indicated that she feels the need to adjust her appearance when engaging with White counselors to be "perceived more on the White spectrum of acceptance": "Like when I have to go to counseling, if it's a, especially a White person [chuckles] like, I, like I – my hair was not like this before the interview. My hair was out and curly […] felt the need." Evidently,

Brandy did not feel as though she can bring her authentic self to counseling with a White counselor, felt the need to constantly shift her self-presentation to meet the perceived demands of her social surroundings, and even adjusted her appearance before the interview for this study in case the interviewer was a White person. Moreover, Brandy described how the racial dynamics between her and her counselors can lead to racialized interpretations of comments made by counselors from different racial backgrounds, which can elicit disparate feelings:

> So, if I sat in a room with my counselor who was White and said something like "oh, and then he did this," and her response was "well he's a man" … would be very different um interceded or understood if I sat and said it to the Black woman, and she said, "well, he's a man." Because one sparks fear, and one sparks privilege. So, the same response from a counselor, White counselor, kind of when they say it, reminds you of the patriarchy…in a powerful way. But when a Black counselor says it, it reminds you of the deception and fear of what those men are capable of.

Therefore, even if a counselor is well-intentioned, racial dynamics within the therapeutic relationship can provoke uncomfortable sentiments within CSA survivors due to societal and historical forces related to race, potentially hindering the efficacy of the therapeutic process.

Cindy, Angela, Brisa, and Winnie all recognized that they outwardly present as White, despite identifying as having an Indigenous background. Cindy, Angela, and Brisa admitted that their Indigenous background was not a pivotal component of their upbringing or life experiences, including the CSA. All four participants recognized the invisibility of their Indigenous identity and being perceived as a White woman as social privileges that extended to counseling. They all believed that they would be treated less well if their Indigenous identity was visible or revealed. Indeed, two survivors had negative experiences after revealing their Indigenous identities.

Angela (28, Caucasian, Aboriginal) expressed confusion when asked in the study interview about whether her Indigenous identity had played a role in her counseling experiences, indicating that this was not something that she had previously thought of nor was significant to her: "I don't know that it's played a large um part in my counseling. Um, yeah, I, I don't really know how to answer that. I don't, I don't think it's really played like a large part." At the same time, when asked if she thought a visibly Indigenous woman CSA survivor would be treated differently, she responded: "I 100% think that there be would a difference in the treatment there. […] I feel like the Aboriginal population aren't – they're just not taken as seriously as somebody whose White." Angela further elaborated: "people think, 'oh that happens all the time to Aboriginal people, you know, cause of this, cause of that.' All of these excuses are made up for people who are Aboriginal when it should be the exact same treatment."

Similarly, **Cindy** (42, Caucasian, Native) did not feel as though her Indigenous identity had ever played a role in her counseling due to its invisibility: "even though I am Native, I don't think it played a role because everyone sees me as Caucasian." She recognized her privileged treatment in counseling as someone who looks Caucasian compared to visibly Indigenous:

> I'm viewed as Caucasian even though I have black hair and I have olive color skin. They don't see me as Native. So, because, don't get me wrong, I see the Native community and how they're treated, and… [pause] I'm not treated like that.

Brisa (22, White, Indigenous) also admitted that her minoritized ethnic identities have not impacted her counseling experiences because she looks "completely White." She recognized this as a social privilege that her visibly Indigenous "brothers and sisters" do not have:

> I mean, I, I look White. Like I know I look [chuckles] completely White, so I've never really experienced things that I know like my brothers and sisters have. Um so I don't know if it necessarily played a role in my counseling.

Brisa contrasted her usual counseling interactions, wherein she does not reveal her social identities, with a negative experience she had after disclosing her Indigenous background:

> *typically,* you know, look at a White person, some people just don't think you have struggles […] I mean it's *perceived*, but I feel like sometimes after I disclose that, like it's a little like "*ohh*, so of course" – I feel like judged after that, because then it's like "oh, of course, you have problems." I guess. I don't know how to put it. It's like…you, you, you're not White, of course, like you're not, you don't have like the best life, I guess.

After this experience, Brisa became wary of sharing her other minoritized identities, including her ethnic identities, due to fears of anticipated discrimination related to these social identities.

In **Winnie**'s (26, Indigenous) experience, when she openly identified as Indigenous in counseling, she felt that she was automatically viewed in a negative, stereotypical way from that point forward:

> There is a definite discord, where, when you disclose especially being Indigenous, you know, every single one stereotype that you can imagine comes up […] that level of care and service goes right down the drain, because that person has a preconceived notion about you and your family and where you come from and everything else.

Counselor Cultural Competence and Humility are perceived as Priorities

More than half of the CSA survivors in this study (n=6) identified the importance of cultural competence and humility (although some did not explicitly use those terms) amongst counselors who work with CSA survivors. Through personal experiences and reflections, the anticipated and

experienced benefits of these skills included a stronger therapeutic relationship and greater comfort discussing culturally relevant material, irrespective of the counselors' backgrounds.

Amanda (37, Black Caribbean) talked about a positive counseling experience she had with a White counselor with whom she was able to discuss racially relevant information, highlighting the benefit of counselors who are adept at fostering such open dialogue: "she was a White female, and I felt like I could open up to her, *no* problem, with *anything* – Black, White, didn't matter." She elaborated that she was able to open up about these aspects because the counselor showed a genuine interest in everything Amanda shared: "maybe because we were closer in age, you know, she always seemed like she cared." Later in the interview, however, when asked how she would feel if a White counselor were to try to directly ask her about her race and its relevance to her CSA experience, Amanda strongly affirmed that she would *not* be comfortable with this:

> Totally uncomfortable. And actually quite rude [little laugh]. […] if it was a White counselor and he's like "oh, you know, like how does your race?" [mocking voice]. I'd be like "get the hell out of here, okay" [laughs] "onto the next question."

Therefore, even if well-intentioned, Amanda would feel uncomfortable being asked directly about race by a White counselor. There may also be a sense of superficialness felt if she were to be asked about race in this straightforward way, as implied by Amanda using a mocking voice to imitate a White counselor asking about race in this way. Amanda seemed to be leaning toward a preference for a counselor who practices cultural humility, showing a genuine curiosity to learn about clients' experiences and creating a safe therapeutic space for clients to be able to share.

Asma (26, Black, African) emphasized the importance of both cultural competence and humility in her counseling experiences. Asma recognized that some of her counselors had a

"one-size-fits-all" approach that didn't consider her race, ethnicity, or other factors that were important to her CSA experiences because "I think they sincerely did not know how to approach it and so they figured let's not go to some place we don't know how to dig deeper." Asma also had several experiences with White therapists who expressed a superficial understanding of the experiences of CSA survivors from her racial and ethnic groups, which left her feeling frustrated:

> I didn't like the corny things that other therapists would do and say, like, "I understand as a minority, and you must be –" like, it, it felt very verbatim from a book, and I was like I don't like that because you *don't* understand actually.

Asma contrasted these unpleasant experiences with the positive experience she has had with her current White therapist, who she described as "genuinely caring that my identity is not something we kind of push away when we're talking about it, and we're not fluffily putting in catch words in the way that we talk about it has been very helpful." Asma considered her current therapist to be culturally competent and discussed specific interactions that made her think this:

> In some of our sessions, I was like I know you can't quite tell me what that's like, or you can't quite feel it, and she would be honest, and she's like, "yeah, I don't know that. I have a lot of patients or like clients who are Black, and they these, these, these emotions, are shared." She was able to validate my experiences without being very weird about it.

Asma expressed how her current therapist's display of comfort with race-related discussions and her ability to not take them personally resolved Asma's worries about somehow offending her therapist by discussing race, and allowed her to express her experiences without any restrictions:

> when I saw she was comfortable and she could do it, I was able to say "well, I don't like the fact that as a Black woman, this is what's happening to me and da da da da," and not feel like somehow it's offending her or making her upset or confusing her in any way.

Asma's therapist had even been able to educate her on some of the social issues impacting Black women, which helped Asma further understand her experiences and have her feelings validated. For example, Asma recalled the following display of cultural competence, when her counselor remarked, "it's normal for you to feel that way, especially society hasn't caught up to X, Y, and Z.' And she made it a point to also make some research and be able to give me some facts."

Brandy (33, Black, Caribbean, Euro) became readily aware of which counselors had a lack cultural competence and, specifically, a lack of knowledge about how Black women survivors of sexual violence are treated in society:

> my initial contact in counseling was still my marriage counselor whose White. And um…the why, the questioning and – "I don't understand why no one is helping? I [don't] understand why they're not taking this more serious with me so often, or I don't understand why they're not doing this to him and why they are allowing this to happen." This, this constant "I don't understand" was coming out. And once I spoke to somebody of different ethnicity, there's no surprise. There's *no* shock. Zero shock value. You can tell the same story, it was "*and*? What did you expect?" [laughs] Right?

Brandy was able to better understand her experiences and alleviate self-blame when she spoke with counselors who were aware of the discrimination experienced by Black women survivors.

Brianna (25, Black, Caribbean) emphasized the need for counselors to develop their knowledge on clients' cultural, ethnic, and religious backgrounds, and their related "different beliefs, different values," to enhance the therapeutic relationship and encourage survivors to keep attending therapy:

> as a counselor, or as a therapist, understanding your client's ethnic background should be like the basic number one thing you do before going deep into the session, so you don't

> have misunderstandings, you know. Oftentimes people stop coming to the sessions because of this, yeah.

Brianna made it clear that "there's a difference between knowing and understanding." She clarified, "you might not really have the understanding, but just having the knowledge about it and a little bit of understanding. Just a little bit will go a long way." Brianna's perspective came from her personal counseling experiences where she was left feeling misunderstood and judged when she tried to bring up the relevance of race and ethnicity in the context of her CSA experiences: "often it's really difficult because um she doesn't really understand it. So, you just have to keep talking and then try and make her understand what you're trying to say."

Marie (46, Chinese Mauritian) also emphasized that all therapists, irrespective of their backgrounds, should develop the appropriate skills to ask clients about the relevance of their social identities and present an openness to these conversations, to facilitate a sense of comfort in CSA survivors who may want to discuss these aspects but feel uncomfortable doing so:

> it would be good no matter what the, the therapists' background is, right, is to just um…create the openness and uh… to make it explicit that it's okay to talk about. […] Like letting the client know that it's acceptable to talk about it like if that's something they want to explore, that the therapist is open to it.

Marie gave examples of how therapists can approach this:

> if topics come up, that you can sort of like put in a question about how, you know, your background, how do you think it affected it? Or like how you were raised. Like it sort of opens the door.

Marie's views came from her personal experiences with both White and racial and ethnic minority counselors. In the case of White counselors, she felt she had to spend a considerable

amount of time providing context and constantly needed to check their understanding, which she suspected might be lessened if counsellors had some knowledge on her cultural background:

> with a White counselor, I might have to explain the context […] it may not have been a given for them. But I feel like, you know, talking to someone who is a visible minority, it's kind of, I assume that they likely had something similar and, yeah, maybe wouldn't have to go into the details. And I would um, I would talk about stuff and then just see, like, okay, do I feel like they got that without me having to get into the details of it?

Winnie (26, Indigenous) preferred a counselor whose knowledgeable about Indigenous history, regardless of their background, describing the need for both cultural competence and humility:

> I think again it comes back to the individual. Because there are White people, you know, there are mixed individuals for one. Number two, there are, you know, Caucasians who can offer that knowledge, that insight, that understanding, or you know a Caucasian who might be like, "Hey? I don't know shit, can you educate me because I'm curious and I really want to know."

Winnie emphasized that counselors should educate themselves on the racial and ethnic groups that clients identify with, instead of placing that responsibility solely on clients: "it's not on us to educate the system and society. It's really on the system and society to educate themselves."

Overall, participants did not expect counselors to completely understand their unique experiences as CSA survivors from minoritized racial and ethnic groups. Rather, participants indicated that they would appreciate if counselors increased their cultural competence by acquiring background knowledge on their racial and ethnic groups and the social issues related to sexual violence against women belonging to these groups. They predicted that these efforts

would facilitate a greater understanding of their experiences, lessen the need for them to provide extensive contextual details, and prevent feelings of frustration. At the same time, participants emphasized the importance of cultural humility through counselors expressing a genuine curiosity about survivors' experiences, while refraining from assuming an understanding when they do not share the same identities as clients.

Discussion

This study provided novel insights into the psychosocial intervention experiences of women survivors of CSA from minoritized racial and ethnic groups. Analysis of interviews with CSA survivors revealed three Group Experiential Themes that signify identity-driven influences on the quality of these experiences: 1) survivor-counselor shared social identities facilitate authentic expression and connection; 2) racial dynamics and microaggressions in counseling lead to detrimental impacts; and 3) counselor cultural competence and humility are perceived as priorities. The study findings highlight how the intersecting social identities of CSA survivors and counselors, mainly the intersection of race, ethnicity, and gender, impact their therapeutic experiences. This was especially relevant for CSA survivors with visible minoritized identities.

All CSA survivors in this study with visible minoritized racial and ethnic identities anticipated that a racially and ethnically matched counselor would better understand their CSA experiences and its impacts within the context of their racial and ethnic backgrounds. When survivors had had matched counselors, they were able to share about their CSA experiences more authentically and comprehensively. They felt greater ease in discussing racialized aspects of their experience, using vernacular language, and elaborating beyond the "surface level." The findings of this study support mental health research showing that racial and ethnic matching between clients and mental health service providers was associated with clients reporting a better

therapeutic working alliance, more favorable perceptions of service accessibility and quality of care, and overall greater satisfaction with treatment (Chao et al., 2012; Gamst et al., 2003; Meyer & Zane, 2013). Additional quantitative research has found that racial matching and perceived disrespect within healthcare settings varied by racial group and concluded that other race-specific factors need to be considered in what shapes clients' perceptions of their treatment (Blanchard et al., 2007). Accordingly, the descriptive accounts of participants in this study expand on the findings of these quantitative studies by revealing how the intersectionality of women CSA survivors' race, ethnicity, and gender contribute to their preferences for shared social identities, and often shared intersectional identities, with counselors, and the reasons for their preferences.

Participants with invisible minoritized ethnic identities did not express a strong preference for a matched counselor, as these identities were not central to their CSA experiences. They expressed that the invisibility of their ethnic identities and White-passing appearance shielded them from potential discrimination they might have faced if these identities were visible, highlighting the possible social privilege associated with being perceived as White in counseling. In a study with African American clients engaged in counseling, Ward (2005) found that a racial match with counselors was more important to individuals who described their Black identity as a salient aspect of their lives, relative to their other identities. Thus, it may be that the importance of a racial and ethnic match with counselors varies according to CSA survivors' connection to their racial and ethnic identities, and relatability based on other identities may be more relevant to some survivors.

It is important for counselors to conceptualize the CSA experiences of survivors within the context of their multiple intersecting identities (Singh et al., 2013). Many survivors in this study discussed how their therapeutic engagement was impeded when they felt like they were

being treated as a general CSA survivor rather than a CSA survivor who identifies with multiple intersecting identities that were relevant to their personal experiences of CSA. In fact, supporting the recovery of CSA survivors with consideration of their intersectional identities may be therapeutically beneficial, as Black women CSA survivors have reported that integrating their multiple identities facilitated their healing from CSA (Sanchez et al., 2019; Singh et al., 2013).

Unfortunately, many survivors in this study reported feeling like their lived realities were dismissed through a variety of microaggressions and perceived racism. Racial discrimination can impede the healing process of CSA survivors (Singh et al., 2010, 2013), and microaggressions have been found to intensify the positive relation between sexual violence and PTSD symptoms among Black women (Eshelman et al., 2024). In this study, unfavourable racial dynamics caused CSA survivors to feel misunderstood and judged, and censor important aspects of their CSA experiences that related to race and ethnicity. Ward (2005) found that African American clients engaged in an assessing process of three dimensions throughout counseling: client-therapist match of multiple characteristics, beginning with race and ethnicity; safety in therapy; and counselor effectiveness. Assessments were used to monitor and manage their self-disclosing in counseling along a continuum ranging from no disclosing to superficial disclosing, to selective disclosing, and finally to open disclosing (Ward, 2005). Our study found evidence of these varied levels of disclosure, but also CSA survivors presenting either an authentic or superficial self in counseling depending on the race, ethnicity, and gender match with counselors and racial dynamics.

The racial dynamics in counseling may determine the extent to which CSA survivors feel they must manage their presentation and discussions with counselors, a concept known as identity shifting. Identity shifting refers to self-altering strategies employed by individuals to

meet the perceived expectations of their social surroundings in relation to their race and ethnicity (Loyd et al., 2023). Racially and ethnically diverse individuals have reported identity shifting in six areas – behavioral, linguistic, cognitive, physical, food, and affect – in different ways, depending on whether they were interacting with a White individual or individuals with the same racial and ethnic identity as themselves *(*Loyd et al., 2023). These shifts were done to either avoid perceived risks, such as discrimination, or to obtain perceived rewards, such as wanting to relate to those within their identity group (Loyd et al., 2023). Several of these identity shifts were conveyed by survivors in this study. These shifts during interactions with White counselors involved a shift to a compartmentalized, restricted, and less authentic self.

Furthermore, metastereotype awareness (awareness of negative stereotypes of one's group) can fuel minoritized CSA survivors' censorship in counseling. Racially minoritized survivors may be more likely than White survivors to present themselves and share their experiences in ways that avoid confirming stereotypes about their racial identity groups (Contrada et al., 2001). For example, endorsement of the "strong Black woman" archetype (expectation that Black women will present as physically and mentally strong despite stressors) has been found to impede the healing and therapeutic experiences of Black women CSA survivors (Singh et al., 2013; Subhan & Johnson, 2022). Our study found that the "angry Black woman" stereotype (Ashley, 2014) can also lead Black women survivors to monitor their demeanour and take extra caution to not express anger, to avoid confirming this stereotype. Anger is an important emotion in the context of sexual victimization (Walker et al., 2021), and so the omission of expressions of anger due to stereotype confirmation concerns may impede the exploration of a crucial aspect of survivors' healing.

Clinical Implications

The preferences of CSA survivors should be incorporated in counseling to increase the chances of a positive experience. If possible, CSA survivors should be given choices about the racial and ethnic background of the counselor that they will be assigned, as having choices in treatment can enhance the effectiveness of interventions with survivors (Ryan et al., 2005). This is also important as there can be within-group differences in preferences among clients who identify with the same race or ethnicity. It should not be assumed that all clients from minoritized racial or ethnic groups prefer matched counselors. For instance, CSA survivors from certain ethnic communities prefer ethnically matched or non-matched providers depending on their culturally-related fears about confidentiality and shame for seeking help (Sawrikar, & Katz, 2017). CSA survivors in this study expressed preferences for counselors from various marginalized groups, including women, minoritized racial and ethnic groups, and those who identify as queer. Thus, organizations serving CSA survivors should aim to employ diverse staff, including counselors from minoritized racial and ethnic backgrounds, to ensure that clients have access to a broad range of counselors who can resonate with their varied identities (Sawrikar, & Katz, 2017).

Power differentials are inherent in the therapeutic relationship, with counselors in a position of greater privilege than the individuals seeking support from them. The extent of the power differential can be further shaped by the social locations of the counselor and client (PettyJohn et al., 2020). For example, a White therapist working with a Black client can be considered “doubly empowered” by race and their professional position (Watts-Jones, 2010). Unequal client-therapist power dynamics are sometimes experienced as repeating abusive dynamics among CSA survivors (Parry & Simpson, 2016). Our study also presented several

detrimental impacts of unequal dynamics related to the different intersectional identities of CSA survivors and counselors. PettyJohn et al. (2020) offer a model for approaching conversations about intersectionality in therapy, which includes self-assessment questions that therapists should ask at the beginning of and throughout therapy. Self-assessment questions concern, among other areas, therapists' assessment of the intersectional identities of both their clients and themselves, their level of understanding of clients' identities, their comfort level addressing aspects of clients' identities, and how clients' intersectionality may be impacting their presenting problems. Therapists who disregard disparities in privilege can unintentionally reinforce structures of power and oppression in therapy (PettyJohn et al., 2020). As such, it has been suggested that therapists disclose their social locations to clients to invite discussions on how their identities influence clients' feelings in therapy (Watts-Jones, 2010).

These suggestions align with participants' voiced need for cultural competence and humility among counselors working with survivors from minoritized racial and ethnic groups. Culturally competent interventions warrant counselors to create a level of interpersonal safety that allows CSA survivors to express themselves without fear of being stereotyped or judged (Ashley, 2014). Several survivors in this study voiced the need for counselors to demonstrate openness and comfort with discussions of race and ethnicity. Moreover, like racially minoritized CSA survivors in other studies (Singh et al., 2010, 2013), the CSA experiences of survivors in this study were shaped in different ways by their social identities, leading them to recommend that counselors learn about the backgrounds of CSA survivors that they work with, including the history of sexual violence against women from these backgrounds. This can help counselors to not dismiss the relevance of these aspects, through microaggressions or otherwise, when brought

up by clients. Counseling that fails to acknowledge sexism, racism, and other oppressions faced by CSA survivors overlooks the crucial social context of their experiences (Singh et al., 2013).

Buchanan and colleagues (2020) have suggested moving beyond the concept of cultural competence and instead to a framework of intersectional cultural humility, which our study supports. The purpose of intersectional cultural humility is "deepening awareness of a complex array of many structures and systems and increasingly accurate analysis [of] their impact on lived experiences" (Buchanan et al., 2020, p.239). This framework brings attention to power, encourages practitioner's reflection on their privilege, and acceptance that mastery of a culture different from one's own may never be achieved, and so to remain open to continuous learning. This framework is in line with suggestions related to cultural competence and humility from CSA survivors in our study, such that counselors should not display a presumed expertise or understanding of client's identities that they do not share, but rather learn about their backgrounds and create an openness for clients to be able to discuss social identities, as relevant.

Overall, trauma-informed care should integrate practices that recognize and address the social realities of racism and other forms of oppression, including intersecting oppressions, which can themselves be experienced as traumatic (Bryant-Davis, 2023; Gutowski et al., 2022). Gutowski and colleagues (2022) provided an integrated approach to trauma-informed care that incorporates relationally oriented, gender-sensitive, and racially and culturally responsive care to apply in practice with women with marginalized identities who have survived interpersonal and racial trauma. The three tenets of this approach can be summarized as follows: 1) develop awareness of systemic inequities, gender-based violence, racial trauma, and oppression faced by women of color; 2) develop a healthy therapeutic alliance that embodies safety, transparency, empowerment, choice, and attention to power; and 3) avoid harmful reenactments of

interpersonal trauma and social oppression (Gutowski et al., 2022). These recommended practices are in line with the clinical implications discussed in this paper specific to racially and ethnically minoritized women CSA survivors. Altogether, these recommendations prioritize the interpersonal skills of the counselor and the safety they create within the therapeutic relationship, which have indeed been found to be more important to the healing process of CSA survivors than the type of therapeutic modality (Parry & Simpson, 2016).

Limitations and Future Directions

Firstly, the sample size in this study was small, which may limit generalizability of the findings. As with any qualitative inquiry, however, the study findings are not meant to be generalizable, but instead are transferable to other populations with comparable characteristics. Moreover, the study sample size is considered a "larger sample" by IPA standards (Smith et al., 2022). IPA studies are commonly conducted with small sample sizes as IPA is committed to providing a detailed interpretative account of each case and producing an in-depth examination of the phenomenon of focus (Smith et al., 2022). Secondly, all participants were recruited from organizations that they were currently receiving services from or had received services from within the past year, and so participants may have hesitated to describe negative experiences with service providers. To mitigate this, survivors were reassured of the anonymity and confidentiality of their participation, and the different ways that this would be ensured. Thirdly, this study focused on women only, as keeping gender constant allowed for a more focused examination of how race and ethnicity intersected with being a woman CSA survivor to impact experiences. A comparable study that examines the psychosocial intervention experiences of male CSA survivors from minoritized racial and ethnic groups is needed to explore their

intersectional experiences and needs, as existing research on male CSA survivors has been criticized for centring on the experiences of White men (Bowleg et al., 2017).

Finally, two interviews were conducted via telephone and eight were conducted via Zoom. Although different interview formats could introduce variability in data collection and possibly affect response depth and consistency, the interviewer (first author) did not find this to be the case. This aligns with findings from other researchers who offered these two interview options (Lindsay, 2022). Nevertheless, non-verbal and visual cues, detectable via Zoom as all eight of these participants used cameras, facilitated the gauging of participant comfort and follow-up questions based on these cues, which may have positively impacted rapport.

Research has reported on the importance of rapport building and utilizing study interviewers from minoritized racial and ethnic backgrounds, which can go hand in hand, when conducting research with participants from racial and ethnic minority groups (Fryer et al., 2016). In this study, as previously mentioned, the principal investigator who conducted all the study interviews identifies as a woman from a minoritized ethnic group. In several Zoom interviews, particularly with CSA survivors who were visible racial and/or ethnic minorities, the visibility of the study interviewer as an ethnically minoritized woman may have facilitated greater comfort among participants in discussing experiences of racism, sexism, and intersectional challenges related to being a woman from a minoritized racial and ethnic group. Indeed, several Zoom participants verbally expressed being comforted by the visibly relatable social identities of the interviewer. Their shared identities as women from minoritized racial and ethnic groups may have bridged some of the social distance between the researcher and participants, and thus lessened the power differential felt by participants (Britton, 2020; Fryer et al., 2016). Therefore, future research with CSA survivors from minoritized racial and ethnic groups would benefit

from in-person or Zoom data collection methods that may facilitate greater rapport building, as well as interviews being conducted by trained interviewers from minoritized racial and ethnic backgrounds.

Conclusions

This study provided novel insights into the psychosocial intervention experiences of women CSA survivors from minoritized racial and ethnic groups, and how their intersecting social identities influenced their counseling preferences and experiences. It is important to create a welcoming therapeutic atmosphere for all CSA survivors. In Western countries that encompass growing multicultural populations, it is important to expand research on the perspectives of CSA survivors from minoritized racial and ethnic groups. The inclusion of these voices, which have long been marginalized in CSA research, must be prioritized to enrich counseling practices to be more inclusive and better meet the needs of diverse CSA survivors.

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Chapter 5: Discussion and Conclusions

The purpose of my thesis research was to expand the current understanding of how women survivors of CSA from minoritized racial and/or ethnic groups experience shame and psychosocial interventions related to the CSA, with a particular focus on the intersection of race, ethnicity, and gender. The goal of this thesis was to demonstrate that the experiences of women CSA survivors from minoritized racial and/or ethnic groups cannot be fully comprehended without considering their intersectional experiences and the sociohistorical and cultural context of sexual abuse against girls and women from these groups. Each chapter of this thesis has thus far collectively contributed to this goal, and each manuscript has filled important gaps in the CSA knowledge base. In this concluding chapter, I will highlight my key findings, discuss practice, research, and social implications, and provide directions for future research. I will also share some of my personal reflections conducting my thesis research in relation to these discussions.

Manuscript 1 was a scoping review of 101 empirical research studies published in the past 30 years (1994-2024) that investigated or produced findings related to shame following CSA. The results of the scoping review presented that shame is a common outcome of CSA, increases the risk of other negative outcomes, is a deterrent to CSA disclosures, and is a critical aspect of the recovery process for CSA survivors across the lifespan. The findings also revealed that survivor characteristics may influence how shame is experienced and that several groups are understudied, including CSA survivors from minoritized racial and ethnic groups. Manuscript 2 explored how the intersecting social identities of 10 women CSA survivors who identified with minoritized racial and/or ethnic groups, and particularly the intersection of race, ethnicity, and gender, impacted their experiences of shame. The analysis resulted in three Group Experiential

Themes: 1) internalized shame tied to intersectional identity; 2) intra-familial reinforcement of shame and silence; and 3) maintenance of shame through systemic racism. Manuscript 3 explored how the same 10 women CSA survivors experienced psychosocial interventions for CSA. The following three Group Experiential Themes resulted from the analysis, which signified identity-driven influences on the quality of their experiences: 1) survivor-counselor shared social identities facilitate authentic expression and connection; 2) racial dynamics and microaggressions in counseling lead to detrimental impacts; and 3) counselor cultural competence and humility are perceived as priorities.

The findings from my thesis research collectively highlight that while it is important to understand the individual experiences of CSA survivors, it is also important not to individualize the issue of sexual abuse. As Armstrong et al. (2018) emphasized, "sexual violence does not only result from individual deviancy" (p. 101). There is a need to recognize and address the broader societal, cultural, and systemic factors that contribute to CSA, such as the different systems of oppression that interact to influence the vulnerability and treatment of CSA survivors with marginalized identities. This perspective encourages collective responsibility and systemic change, rather than solely focusing on the experiences of individuals involved. As this thesis and other researchers (Armstrong et al., 2018; Crenshaw, 1991; Whittier, 2016) have argued, an intersectional lens facilitates a deeper examination of power and oppression in the context of CSA, and sexual violence more broadly.

Sexual violence has been conceptualized as a mechanism of inequality that reproduces disparities across gender, race, ethnicity, class, age, sexuality, ability status, citizenship status, and nationality (Armstrong et al., 2018). As addressed in the literature review of this thesis, through consideration of both the historical treatment and current experiences of individuals

from minoritized racial and ethnic groups who are sexually victimized, sexual abuse can be seen as a means of maintaining various forms of oppression, including racism and sexism. In the case of CSA specifically, there is a need to further consider that children are in a subordinate social position because of their age and being a minor, and so age is an intersectional dimension that needs to be considered in all cases of CSA (Whittier, 2016). As can be derived from the findings of Manuscript 1 and more explicitly discussed in Manuscript 2, being a CSA survivor should be viewed as an aspect of identity that contributes to feelings of shame on its own, but also intersects with other social identities to shape how different CSA survivors view themselves and are treated by others and within various systems.

Part of the shame associated with being a CSA survivor arises from CSA and rape myths that were discussed in the literature review of this thesis. Cromer and Goldsmith (2010) examined CSA myths in the public media (partly due to the lack of empirical studies on CSA myths to conduct a review of empirical literature) and found many myths exist. One such myth category related to the extent of harm CSA poses, with some myths minimizing harm and others exaggerating harm, such as "sexually abused children are scarred or damaged forever" (p.623). It is easily conceivable how these types of myths can stigmatize and thus shame CSA survivors as they are characterized as indefinitely damaged as a result of their trauma. This myth relates to a common rape myth, which has been applied to CSA survivors, that those who are sexually abused are "damaged" either psychologically or physically (Woodiwiss, 2014). These myths are tied to gendered notions of fragility and are differentially applied based on the gender, race, and age of CSA victims, who are perceived with varying degrees of vulnerability based on their intersectional identities (Powell et al., 2017). Even in the context of CSA, more empirical literature exists on rape myths rather than CSA myths (Cromer & Goldsmith, 2010), possibly

because some researchers consider CSA myths to be rape myths as there is overlap between the two (Nickell et al., 2023). The terminologies used in the different studies are used in this discussion.

Recent studies are optimistic in that most participants reportedly do not believe CSA myths (Ferragut et al., 2022). At the same time, men and people with lower education levels have been shown to hold more CSA myths (Collings, 2003; Ferragut et al., 2022). Moreover, men, and even more so men who have not experienced trauma or have greater social proximity to a perpetrator of sexual violence, have been shown to be less likely to believe adult disclosures of CSA compared to women (Cromer & Freyd, 2007; de Roos & Jones, 2022). Women were more likely to know a victim of sexual violence compared to men (de Roos & Jones, 2022), and their trauma history did not impact their judgements of CSA disclosure believability (Cromer & Freyd, 2007). These and other studies (Idisis et al., 2007) suggest that the theory of "defensive attribution" (Bell et al., 1994) applies to the believability of CSA victims, wherein people tend to attribute less blame to people with whom they identify and more blame to those they perceive as different from them.

A recent study presented that CSA myths were reported as less believable than rape myths (Nickell et al., 2023). At first glance, this finding may seem advantageous for CSA survivors, but it is actually concerning as both CSA and rape myths have been used to discredit CSA survivors (Denne et al., 2023; St. George et al., 2022). Whereas participants directly interviewed in studies have reported limited agreement with CSA myths (Ferragut et al., 2022), other recent studies have found that both CSA and rape myths are still being used to discredit victims who report CSA, particularly in legal settings (Denne et al., 2023; St. George et al., 2022; Powell et al., 2017). Therefore, the question arises whether participant responses in more

recent studies are influenced by social desirability bias, as it is generally not socially acceptable to openly adhere to these myths at this point in society (Nickell et al., 2023). People may continue to hold CSA and rape myths privately, even if they do not openly admit it (Ullman & Townsend, 2007). Similar claims have been made about people holding implicit racial biases that they may be reluctant to acknowledge due to the stigma of being seen as racially biased (Stevens & Abernethy, 2018). As such, these myths and biases can still influence how others treat CSA survivors, potentially responding more negatively to survivors with social identities different from their own, which can exacerbate survivors' shame.

Findings from the three manuscripts of this thesis also demonstrated that CSA myths and related stigma and shame continue to impact CSA survivors. Studies included in Manuscript 1 (Chapter 2) presented how children whose abuse met the criteria for what was once known as "participant victims" (Rogers & Weiss, 1953), in line with several CSA myths, experienced heightened shame. For example, Hershkowitz et al. (2007) found that children more often expressed shame when perpetrators were familiar rather than strangers, and if the abuse was repeated than when it had occurred only once. Manuscript 2 (Chapter 3) included experiential accounts of how shame is experienced by CSA survivors, including how some participants internalized shame beliefs that there was something inherently wrong with them when they were victimized by more than one perpetrator or when the perpetrator was not a stranger. Manuscript 2 also demonstrated how stigma associated other social identities intersected with stigma associated with CSA to shape how shame was experienced by CSA survivors. Manuscript 3 (Chapter 4) discussed how psychosocial interventions can be one avenue through which stigma and shame can be addressed and alleviated, though this was not the case when CSA survivors'

subjective intersectional experiences were disregarded and counselors attempted to instead address their experiences as archetypal CSA survivors, which did not align with their concerns.

An examination of research on CSA and sexual abuse survivors' experiences in different institutions also points to the reality that CSA and rape myths continue to impact the treatment of survivors who disclose and/or report the abuse; however, this is often done in a more veiled manner compared to historical times when general society and professionals more openly shamed CSA survivors. For example, in a study of police officer perspectives on sexual abuse, some officers believed that a significant percentage of female victims fabricate these reports or report sexual abuse for attention or revenge (Venema, 2016). These negative perceptions of CSA survivors seem to impact how police officers interact with youth reporting CSA, as adolescent survivors have described emotionally overwhelming interactions with police officers who they perceived as insensitive and indifferent throughout the process (Greenson et al., 2014). Moreover, female survivors who reported sexual abuse to police continue to be questioned about their prior sexual histories and even asked if they had a sexual response (i.e., orgasm) during the abuse (Campbell, 2005), implying that their culpability is being questioned.

Being shamed for experiencing CSA due to related myths and stigma provides only a partial understanding of the experiences of CSA survivors from minoritized racial and ethnic backgrounds, as it fails to account for how other dimensions of identity, such race and ethnicity, can also influence the extent to which they are shamed and mistreated. For example, Black women have been reported to be subject to "a double dose of rape myths" (Donovan & Williams, 2002, p. 98). It has also been argued that negative stereotypes have been central to the oppression and excusableness of sexual abuse of girls and women from minoritized racial and ethnic groups, such as Indigenous women (Anderson, 2016) and Black women (Hill Collins, 2004). In

alignment with these assertions, several CSA survivors in Manuscripts 2 and 3 reported how different stereotypes and sexual stigma linked to their intersectional identities influenced their feelings of shame and, from their perspective, how they were treated in different systems.

Indeed, it has been argued and demonstrated that institutions and their actors "commit and permit violence against children differentially, according to race and class" (p. 96) and children who are sexually abused have little to no influence on the institutional responses to their CSA disclosures (Whittier, 2016). Rape victim advocates have reported that societal attitudes, including denial of rape, together with race, class, gender, sexual orientation, and disability biases, were barriers to service provision in several social systems from which sexual abuse survivors sought help (Ullman & Townsend, 2007). One rape victim advocate described her experience as follows:

> I've never heard a person who wasn't of color told: "Well, you can take it back if you want, you know if you tell me that you made it up, then we'll let you go if you try to press charges." They bully young people and particularly young people of color by saying, "I'm giving you a chance to take this back." (Ullman & Townsend, 2007, p. 419-420)

This demonstrates how the intersection of CSA survivorhood, age, and race influenced which survivors were less likely to have their CSA experiences validated and more likely to be discouraged from seeking justice. Other research has similarly presented that CSA survivors received varied responses as a result of their race and class, and that practices in the criminal justice system "reproduce children's oppression and broader systems of inequality" (Powell et al., 2017, p. 459). Overall, CSA survivors from marginalized groups face multiple sources of stigmatization and devaluation by social institutions and continue to be oppressed and shamed by

CSA and rape myths, as well as prejudice attached to their intersecting marginalized identities, which discredit them as valid CSA survivors worthy of attention, support, and justice. Conclusively, sexual abuse as a tool of oppression intersects with other axes of oppression to maintain the subjugation of marginalized groups.

Implications

Several practice, research, and social implications can be derived from the findings of the thesis manuscripts and the larger discussion of this thesis, in addition to those that were discussed in Manuscripts 1, 2, and 3.

Practice Implications

First and foremost, there is a need to raise self-awareness of different biases among counselors, therapists, and other professionals working directly with CSA survivors. Therapists have displayed similar levels of blame attribution in rape cases as non-therapists, with both presenting a slight tendency to blame victims of rape (Idisis et al., 2007). Moreover, among both groups, there was a general tendency to blame female compared to male victims; however, women attributed less blame to female victims than did men, whereas men attributed less blame to male victims than did women (Idisis et al., 2007). Though these findings were based on hypothetical adult rape cases, these findings nonetheless suggest that therapists may also be vulnerable to believing those that they identify more closely with (as per the theory of defensive attribution discussed earlier). Given that therapists and counselors likely work with CSA survivors with diverse social identities, it is crucial for these professionals to engage in self-reflection to avoid biases that may lead to disbelieving survivors whose social identities differ from their own. Professionals working with CSA survivors should educate themselves on CSA and rape myths to ensure that they do not subscribe to or perpetuate these myths, while also

staying informed about the latest empirical literature on the experiences and needs of diverse CSA survivors, which can promote more evidence-based practice.

Beyond assessing for biases related to CSA in general, it is important for professionals working with CSA survivors to acknowledge their biases and perceptions of CSA survivors from different minoritized racial and ethnic groups. Like CSA and rape myths that individuals may superficially deny, despite alternate research presenting that they continue to impact how CSA survivors are treated, racial biases have also been implicitly detected in research. For example, Kurinec and Weaver (2021) found that speakers whose voices were rated as more highly stereotypical of Black Americans were more likely to be associated with negative stereotypes of Black Americans. Moreover, Maddox and Perry (2018) reviewed research findings that together presented that people with facial characteristics more stereotypical of their racial group experienced greater discrimination compared with their less stereotypical counterparts. These findings add to the thesis discussion in presenting that racial stereotypes and prejudice can guide judgement and behavior toward individuals from stigmatized groups. In the CSA context, there is a need for practitioners to be made aware of stereotypes and prejudices that were created to discredit, stigmatize, and silence CSA survivors from different minoritized racial and ethnic groups, and educate themselves on how these may consciously or unconsciously influence how they perceive and treat these clients. As Manuscripts 2 and 3 presented, CSA survivors suspected that many of their negative interactions with various professionals, including counselors and therapists, were shaped by negative biases toward women survivors from their racial and/or ethnic group. This fueled feelings of shame among many CSA survivors and caused them to conceal aspects of their racial and ethnic identity in an attempt to prevent discrimination, which inevitably negatively impacted their healing and therapeutic experiences.

Shame may be a barrier to overcoming racial biases that one may harbor, as it forces individuals to confront an undesirable aspect of themselves (Stevens & Abernethy, 2018). As a defense mechanism against shame, people may subconsciously avoid conversations that require them to confront their racial biases (Stevens & Abernethy, 2018). This can be detrimental when applied to counselors and therapists working with CSA survivors from minoritized racial and ethnic backgrounds, as it may contribute to practitioners avoiding discussions with CSA survivors that relate to their racial, ethnic, or intersectional identities. Adult CSA survivors have reported testing out therapist comfort as they elaborate on their CSA history and could sense when therapists were uncomfortable with certain discussions, which caused them to withdraw from therapy (McGregor et al., 2006). Findings from Manuscript 3 suggest that CSA survivors also assessed counselors' comfort with discussions of racially and ethnically relevant aspects of their CSA experiences, and often discontinued sharing if they felt a counselor was unable to engage with or understand such concerns. To avoid superficiality, counselors should indeed not feign understanding of experiences unique to minoritized racial or ethnic clients, just as CSA survivors have expressed frustration and wanting to withdraw when therapists who are not openly CSA survivors themselves pretend to understand their experiences (McGregor et al., 2006). Rather, counselors and therapists should recognize their own shame, both in relation to those triggered by CSA (Sanderson, 2006) and those evoked as a White counselor or therapist working with clients from minoritized racial and ethnic groups (Parker & Schwartz, 2002). All professionals serving CSA survivors, regardless of their background, can benefit from self-assessments to enhance their self-awareness of potential biases towards CSA survivors from minoritized racial and ethnic groups, as practically everyone is exposed to societal racial biases that can influence their perceptions (Stevens & Abernethy, 2018). It is important for counselors

and therapists to apply strategies for facilitating discussions of CSA, shame, and the relevance of social identities in ways that are informed by the empirical literature and insights shared by CSA survivors from the social groups that they are working with.

Furthermore, practitioners working directly with CSA survivors should educate themselves on the history of CSA and sexual abuse against different racial and ethnic groups and keep up-to-date with empirical literature on their current experiences. An awareness of the history of racism in the context of sexual abuse can support counselors and therapists to have a more realistic appreciation for the current racism that continues to affect CSA survivors from minoritized racial and ethnic groups, as accurate knowledge of historically documented racism has been associated with less denial of current racism (Nelson et al., 2013). This comprehensive knowledge background can enable practitioners to better appreciate the importance of acknowledging the intersectional experiences of CSA survivors and how these shape different symptoms, such as shame. Such insight would also enable practitioners to provide this education to CSA survivors from diverse groups, as appropriate, to challenge their feelings of shame that arise from historically created sexual stigma and stereotypes against groups with which they identify. Indeed, psychoeducation and consciousness-raising about historical and contemporary oppression and marginalization have been regarded as necessary in the psychotherapeutic care of women of color impacted by interpersonal traumas, especially since oppression can manifest as internalized oppression if left unexamined (Bryant-Davis et al., 2024). Consistent with these recommendations, CSA survivors in Manuscript 3, as well as CSA survivors in other studies (Lateef et al., 2023), have reported on the helpfulness of relevant psychoeducation in reducing their shame.

A cross-country inquiry into the help-seeking behaviors of youth survivors of CSA led to the recommendation to tailor interventions based of the specific contexts of and attitudes toward sexual violence among different cultural communities (Pereira et al., 2020). While not specific to CSA survivors, Bryant-Davis (2023) provided a summary of various individual and group healing interventions specifically designed for girls and women of color who have survived different traumas, including gendered racism, with some interventions tailored to specific racial and ethnic groups. These interventions recognize the importance of broadening the types of experiences considered traumatic to include experiences of oppression and emphasize the relevance of addressing intersectional oppressions for the healing of women of color. This is in line with clinical implications in Manuscript 1 and suggestions from previous authors (e.g., Sawrikar & Katz, 2018) that therapists should take an intersectional approach that acknowledges the unique struggles of CSA survivors from minoritized racial and ethnic communities.

Studies conducted directly with CSA survivors from racially and ethnically minoritized groups can provide valuable insight to practitioners working with this clientele, such as the importance of their intersectional identities in shaping common symptoms like shame (Manuscript 2) and their identity-related preferences within psychosocial interventions (Manuscript 3). Findings from such studies can be incorporated into trainings for mental health professionals, who have voiced differing levels of comfort addressing ethnic and racial differences in psychotherapy (Knox et al., 2003; Maxie et al., 2006). The ability to have these conversations may be especially important for White mental health professionals working with Black, Indigenous, and other racially and ethnically minoritized CSA survivors wherein the racial dynamics in the therapeutic context are historically marked by oppression, including in the context of sexual abuse. As the findings in Manuscript 3 presented, despite CSA survivors

generally voicing a preference for shared social identities with their counselors, as this usually facilitated more authentic self-expression and connections, many survivors were able to form strong therapeutic relationships with White counselors and therapists who demonstrated cultural competence and humility. A strong therapeutic alliance has the potential to positively influence treatment outcomes among adult survivors of CSA (Parry & Simpson, 2016; Price et al., 2001; Smith et al., 2012). As such, it is important to continue learning directly from CSA survivors from marginalized groups what their preferences are when engaging in psychosocial interventions, to encourage positive therapeutic alliances and experiences.

Research Implications

The CSA and shame experiences of many groups with intersectional marginalized identities remain understudied in the CSA literature, and CSA scholarship could evolve through increased use of intersectionality in its study designs. This could include conducting studies beyond Western countries in a culturally informed manner to better capture the diversity in conceptualizations and experiences of CSA; strategizing how to increase the participation of CSA survivors whose experiences remain understudied due to increased censorship within their communities, distrust of research, or recruitment limitations; and gathering data through methods that are respectful of traditional ways of story sharing in different groups. It is important to comprehend that incorporating intersectionality in a research study involves more than including participants from marginalized groups alongside those from socially privileged groups and focusing on differences, as doing so risks reinforcing the implicit norm of the dominant group as the normative standard (Choo & Ferree, 2010). As Crenshaw (1989) stated, the solution to the exclusion of marginalized women is not to simply include them within already established analytical structures that were formed without intersectionality. Rather, studies should bring

attention to how the experiences of marginalized groups are influenced by their intersecting social identities, different systems of power and oppression, and the institutions and their actors that reinforce these oppressions. The proper use of intersectionality can bring attention to how systems of oppression create disparate circumstances for diverse CSA survivors, which would address the longstanding criticism by marginalized communities that they are regularly positioned in research as defective, and rarely given a voice in scholarly work outside of this context (Hooks, 1990; Tuck & Yang, 2014).

A critical intersectional lens should be employed when conducting and reviewing CSA research. In this regard, the social identities of researchers conducting interviews with research participants may influence what participants feel comfortable discussing based on their particular social, cultural, and historical context (Hunter, 2010). Greater social distance in terms of social position between researchers and participants may produce unequal power relations already inherent in the researcher-participant dynamic (Britton, 2020). Racial asymmetry may lead participants to avoid discussions of racism to avoid self-stigmatization or making White researchers uncomfortable (Wojnicka & Nowicka, 2023). In my personal experience conducting my thesis research, I felt as though being a woman whose visibly from a minoritized ethnic background encouraged participants to share their experiences more transparently with me. Two factors made me feel this way. First, several participants mentioned their fears of offending White people if they talk about race or racism (as described in Manuscript 3 in terms of sharing racialized experiences with White counselors), which was not a barrier in my case as a non-White researcher. Second, many participants told me that I made them feel comfortable to openly share their experiences, with some explicitly revealing that this was because of my outward appearance. For example, one participant said, “you having black hair or dark hair, dark eyes,

and dark eyebrows, it – right away I felt like I related to you a little bit more at the beginning of, like, first glance, cause it is something that you first notice." Another participant who had confirmed my ethnic background during the interview, soon after sharing that she was cautious of how she said things to White people due to fears of offending them, later said, "when people show that side, I open up, like you," referring to opening up to people who seem to care. The discussion in Manuscript 3 about shared social identities facilitating greater sharing can also apply to research. Thus, research with CSA survivors from minoritized racial and ethnic groups may benefit from using study interviewers from these groups, as this can facilitate easier rapport building with participants and encourage them to share more openly and honestly (Dwyer & Buckle, 2009; O'Connor, 2004).

The social identity of the researcher may also influence data analysis and what is extracted from participant responses, particularly in the case of qualitative research (Bowleg et al., 2017). Irrespective of their social locations, all principal investigators, study interviewers, and other research team members involved in the design, analysis, and reporting processes of research studies employing intersectionality, should practice critical reflexivity as an "intersectional methodological tool" (Esposito & Evans-Winter, 2021, p. 17). Critical reflexivity in the intersectional research process has been defined as "a conscientious effort on the part of the researcher to examine their own personal biases, motives, beliefs, and thought processes in relationship to the research study," (p.17) as well as considering how multiple and interlocking oppressions may have similar or different relevance for the researcher and research participants (Esposito & Evans-Winter, 2021). This can help mitigate personal biases at each step of the research process and increase the objectivity of interpretations.

Relatedly, another key consideration in intersectional research with CSA survivors from minoritized racial and ethnic backgrounds is the importance of establishing a credible interpretation of the data, and thus conveying participants' experiences as they intended. As Patricia Hill Collins (2000) stated in her book *Black Feminist Thought*, "the primary responsibility for defining one's own reality lies with the people who live that reality, who actually have those experiences" (p.35). Moreover, Aileen Moreton-Robinson (2021), who identifies as an Indigenous woman and academic analyst, discussed the issue of representations of Indigenous women in the publications and teachings of White Australian women often contrasting with how Indigenous women represent and understand themselves. Several validation strategies should be used to enhance the trustworthiness of findings in qualitative studies, though Creswell and Poth (2018) have suggested using at least two strategies in any given study. The validation strategies used in Manuscripts 2 and 3 (i.e., providing a detailed description of participants and findings, discovering disconfirming evidence and negative case analysis, peer review and debriefing of the data) should be considered in future qualitative studies that apply an intersectionality framework to understand CSA survivors' experiences. Other validation strategies should also be considered (see Creswell & Poth, 2018 for a list of strategies that can be used in qualitative research). One such strategy is member-checking with participants which involves sharing findings with them to confirm accuracy. This allows participants to provide feedback on how representative the findings are of their experiences and better ensures that their standpoint is accurately reflected in the results that are disseminated.

Qualitative studies have been suggested as a better option to "assess issues of intersectionality than quantitative methods, specifically in terms of qualitative methods' greater allowance for the complexities and multiplicity of experience" (Warner, 2008, p.458). In line

with this, I preferred a qualitative methodology, and specifically IPA, in my thesis research to be able to obtain and disseminate in-depth accounts of participants' experiences, and share each of their individual experiences in their own words as much as possible. Using this methodology, coupled with being an ethnically minoritized researcher, challenged longstanding issues of epistemic injustice in research in which White researchers are regarded as having the sole authority to speak, know, and create knowledge (Okoroji et al., 2023; Pillow, 2003; Roberts et al., 2020).

In her examination of the symbolic violence of the academy, Hooks (1990) shared her perspective on how academics treat the stories of marginalized groups:

> No need to hear your voice when I can talk about you better than you can speak about yourself. No need to hear your voice. Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. (p.343)

Hooks (1981) gave the example of how some White women described Black women as "strong" for facing intersecting oppressions, which did not align with how Black women perceived their "strength" or struggle against intersecting oppressions. Hooks (1981) pointed out that having to be "strong" and continue to endure intersecting oppressions was not the goal for Black feminists, but rather the goal was to *overcome* these oppressions. To empower study participants from marginalized groups, it is important to create the space for them to speak of their marginalization, resistance, and so forth as they choose and disseminate their stories without adjusting them to fit an agenda or to ease potential discomfort for readers outside of these groups. This is one of many ways we can challenge epistemic injustice and ensure that CSA survivors from minoritized racial and ethnic groups have a central role in creating knowledge relevant to their groups (Okoroji et al., 2023). However possible, this knowledge should be used

in ways that promote positive outcomes and increased justice for these groups, so as to eventually overcome longstanding (and justified) mistrust that individuals from minoritized racial and ethnic groups harbor towards research (Okoroji et al., 2023; Scharff et al., 2010).

Systemic and Social Implications

As discussed, and presented through participants' accounts in Manuscripts 2 and 3, on a systemic level, CSA survivors have reported shameful experiences within a variety of systems from which they sought support. Some of these shaming experiences may have been driven by myth-bound perceptions of CSA and different social groups that professionals continue to harbor despite empirical evidence that refutes these. Even within rape crisis centers that specialize in providing support to victims of sexual abuse, racism has been noted as an organizational problem that manifests in different ways (Ullman & Townsend, 2007). Some of these issues included predominantly White staff, lack of evaluating everyday practices for racism, racism experienced by racialized workers, and geographic inaccessibility of services for women living in predominantly ethnic minority neighbourhoods (Ullman & Townsend, 2007). Organizations and institutions that serve CSA survivors, who inevitably come from diverse social backgrounds, should take several measures to promote an inclusive and safe environment for workers and CSA survivors alike who identify with marginalized groups. Some of these measures can be: conducting a critical self-examination of everyday practices for inclusivity; providing education to staff on the CSA experiences and histories of violence against individuals from different marginalized groups, including prevalence rates and literature that raises awareness of their vulnerability and ongoing experiences of discrimination across different systems; raising self-awareness of CSA and rape myths and other biases that all members of society are exposed to and thus may be influenced by; and delivering adequate training on how to interview and provide

services to CSA survivors that do not perpetuate CSA and rape myths nor other forms of prejudice that impact CSA survivors facing various forms of oppression.

On a societal level, our current society has seen an increase in social movements and awareness surrounding the prevalence of sexual violence, including CSA. Social movements such as #MeToo have gained considerable attention in the past seven years and attempted to reallocate shame for sexual abuse from victims to perpetrators. Survivors have commented that #MeToo helped them disclose the abuse for the first time in their lives and implied that it helped reduce their feelings of shame about the abuse (Alaggia & Wang, 2020). Positive perceptions of the #MeToo movement have also been associated with more supportive responses to CSA disclosures (de Roos & Jones, 2022), which is important for the healing and alleviation of shame among CSA survivors. At the same time, men are more likely to perceive the movement as threatening compared to women (de Roos & Jones, 2022), potentially reflecting enduring gendered differences in the willingness to accept sexual abuse as a widespread problem.

The MeToo movement has sparked similar movements world-wide, including in areas where survivors were previously socially invisible (Ghadery, 2019). Even so, the MeToo movement has faced criticism for perpetuating the same pattern observed in first- and second-wave feminism of centering on the experiences of White women (Phipps, 2019). The social movement has been criticized for its lack of intersectionality and the invisibility of race (Onwuachi-Willig, 2018) and low-income women (Fitzgerald, 2019) and LGBTQ inclusion (Rodriguez-Cayro, 2017) – again, the marginalization of sexual abuse survivors facing intersecting oppressions. The founder of MeToo, Tarana Burke (2017), has herself commented:

> What history has shown us time and again is that if marginalized voices — those of people of color, queer people, disabled people, poor people — aren't centered in our

> movements then they tend to become no more than a footnote. I often say that sexual violence knows no race, class or gender, but the response to it does. (para. 11)

The marginal attention to the CSA and sexual violence stories of racially minoritized women, among other marginalized groups, reinforces the importance of intersectionality as a part of the MeToo movement to combat sexual abuse against marginalized groups, which was the primary aim of the MeToo campaign started by Burke in 2006 (Leung & Williams, 2019).

There is a continued need to eradicate the idea that there is a certain "type" of CSA victim that should be listened to, and instead embrace the outlook that the stories of all CSA survivors matter. When victims come forward who don't fit the description of who's expected to be a sexual abuse victim, their stories are not respected and sometimes even publicly joked about (Bradley, 2018; Dagbovie-Mullins, 2013). So, even with these seemingly positive societal changes that aim to reduce the shame and stigma surrounding sexual abuse, victim shaming persists and is also publicized, which could encourage silence and shame among CSA survivors.

One of the avenues through which awareness of CSA experiences of girls and women from minoritized racial and ethnic groups (and other marginalized groups) can be increased is through the media. The way that CSA cases are presented in the media have been shown to impact peoples' perceptions of CSA (Collings, 2000; Collings, 2002). Disappointingly, however, research presents that there continues to be racialized hierarchies of attention and media coverage of CSA, positioning Whiteness at the center and marginalizing the stories of minoritized racial and ethnic survivors (Dreher & Waller, 2022; Patel, 2018; Rajiva, 2022). These implicit societal messages that CSA against the social groups to which one belongs does not matter can deepen shame-based beliefs of CSA survivors that they do not matter and thus maintain their silence. Indeed, the impact of less media coverage of violence faced by racially

minoritized compared to White individuals was reported by several CSA survivors in Manuscript 2 as influencing their shame-based beliefs of being considered less important.

Racially biased media coverage perpetuates white supremacy (Dreher & Waller, 2022) and risks maintaining the historical and ongoing societal focus on CSA against White girls, while ignoring and minimizing the extent of CSA affecting children from minoritized racial and ethnic groups. According to the availability heuristic (Tversky & Kahneman, 1973), people tend to believe that a phenomenon is more frequent or likely to happen based on how easily they can recall such information. This can be influenced by how often people see or hear about something, such as through the media (Moghtaderi, 2018). Therefore, general society, whose perceptions of CSA may be largely shaped through what is reported in the media than actual prevalence rates or empirical literature, may inaccurately believe that CSA and sexual abuse predominantly affect White girls and women, while overlooking these issues in marginalized groups. Therefore, on a societal level, greater efforts need to be concentrated in social movements and different forms of media to decenter Whiteness and bring awareness to the reality that CSA affects children from all sociodemographic backgrounds, with several marginalized groups being at an increased risk of CSA and suffering in unique ways following the abuse.

Limitations and Future Research Directions

The limitations of each thesis manuscript and relevant future research directions were described within their respective discussions, and these will not be repeated here. Considering all the literature covered in this thesis, there are other important limitations to consider and areas in need of future research that can build on the findings from my thesis research. As a start, it is important to remember that the findings presented in the empirical manuscripts of my thesis were

based on the experiences of participants with particular intersectional identities and should not be assumed to represent the lived experiences of *all* individuals from these groups, as there may be within-group differences (Nash, 2008). In terms of the discussions in my thesis as a whole, most literature that exists describes differences based on one specific social category (e.g., race) rather than multiple categories; therefore, readers should keep in mind that these single categories should be considered "one of a number of social inequities … that interact to create complex positionalities within a nexus of power relations" (Dean et al., 2017, p.33).

While focusing on race, ethnicity, and gender in my thesis, I am aware that many aspects of survivors' identities could intersect with these factors to produce unique experiences with shame, such as religious affiliation (Katzenstein & Fontes, 2017), LBGTQ+ identity (Scheer et al., 2020), geographical context (Pasura et al., 2013), and so forth. Likewise, psychosocial intervention needs may differ among CSA survivors who identify with the LGBTQ+ community (Walker et al., 2012), as immigrants in Western countries (Singh et al., 2010), or with various other intersectional groups. Nevertheless, this thesis demonstrated how intersectionality can be used to better understand shame and psychosocial intervention experiences and preferences among adult CSA survivors with diverse social locations. Future research should adopt a methodology similar to the empirical studies in my thesis, with a focus on homogenous samples of CSA survivors who share intersectional identities representative of different marginalized groups who continue to be understudied despite showing a higher risk of CSA. Such research could provide valuable insights into their overall experiences of CSA, including how shame related to CSA is influenced by their various intersecting social identities, as well as their healing and treatment needs.

Moreover, the empirical articles (Manuscripts 2 and 3) of my thesis research centered on the experiences of adult CSA survivors. Considering that age is an important intersectional dimension in CSA, the findings from these studies should not be generalized to child or youth survivors without caution as different age groups may have distinct experiences and needs. The scoping review (Manuscript 1) included CSA survivors across the lifespan, and included studies that demonstrated that ethnicity (e.g., Feiring et al., 2001), geographic and sociocultural context (Nguyen et al., 2021), and gender (Kellogg & Hoffman, 1997) can produce different outcomes related to shame and CSA among child and youth survivors. Therefore, separate qualitative studies with male and female child and youth survivors of CSA from minoritized racial and ethnic backgrounds, using a similar methodology to Manuscript 2 but with language adapted to the developmental level of children and youth, could provide valuable insights into how their intersectional identities influence their experiences of shame. These insights could potentially inform more tailored and effective interventions and supports for child and youth CSA survivors from minoritized racial and ethnic groups.

Similarly, in terms of psychosocial interventions, the authors of a review of therapeutic interventions with child and adolescent survivors of sexual abuse concluded that "little is known about treatment responses for CSA survivors specific to cultural, racial, ethnic, religious and gender identities" (Narang et al., 2019, p. 8) and that further research is needed in this area. Future research on the psychosocial intervention experiences of child and youth survivors of CSA representing various intersections of gender, ethnicity, and race would specifically address this important research gap.

Lastly, research is needed on the perspectives and experiences of counselors, therapists, and other mental health professionals working with adult CSA survivors from minoritized racial

and ethnic groups to understand potential challenges, barriers, and facilitators to providing support to these populations. These findings would complement those obtained in Manuscript 3 in supporting the development of culturally competent and inclusive therapeutic practices. Such a study could also identify important gaps in training and education for mental health professionals that need to be addressed at organizational and institutional levels.

Conclusions

CSA needs to be understood within the sociohistorical and cultural context of survivors, rather than assuming that knowledge gained from CSA survivors belonging to one racial or ethnic group could be transferred to those from dissimilar groups (Tyagi, 2002). The three thesis manuscripts collectively increased knowledge on the centrality of shame in CSA, how shame following CSA can be uniquely shaped by the intersectional social identities of CSA survivors, and how the intersectional identities of CSA survivors can influence their psychosocial intervention experiences and preferences. Shame is central to CSA, and the treatment environment must be ideal for CSA survivors to be able to open up, including eventually about their shame, which may only be revealed once they feel secure within the therapeutic relationship. Therefore, it is important for research to continue to build our knowledge of both shame and the treatment needs of CSA survivors with different intersecting marginalized identities who have been understudied. Ideally, increased empirical attention to the experiences of CSA survivors from marginalized groups will enhance awareness of their realities and replace mythical and stereotypical perceptions of them among professionals, within various systems that reinforce their oppression, and society at large, helping to end the mistreatment and stigmatization of these CSA survivors.

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Appendix 1: McGill University Research Ethics Board Approvals

McGill

Research Ethics Board Office
James Administration Bldg.
845 Sherbrooke Street West. Rm 325
Montreal, QC H3A 0G4

Tel: (514) 398-6831

Website: https://mcgill.ca/research/research/compliance/human/reb-i-ii-iii

Research Ethics Board 2
Certificate of Ethical Acceptability of Research Involving Humans

REB File # 21-10-009

Project Title: Adult Survivors of Child Sexual Abuse Receiving Psychosocial Interventions: The Influences of Race, Ethnicity, and Shame

Principal Investigator: Rusan Lateef

Department: School of Social Work

Status: Ph.D. Student

Supervisor: Professor Delphine Collin-Vézina

Funding: Joseph-Armand Bombardier Canada Graduate Scholarship (CGS) Doctoral Award

Approval Period: March 11, 2022 – March 10, 2023

The REB 2 reviewed and approved this project by Full Board review in accordance with the requirements of the McGill University Policy on the Ethical Conduct of Research Involving Human Participants and the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.

Georgia Kalavritinos
Ethics Review Administrator

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* Approval is granted only for the research and purposes described.
* Modifications to the approved research must be reviewed and approved by the REB before they can be implemented.
* A Request for Renewal form must be submitted before the above expiry date. Research cannot be conducted without a current ethics approval. Submit 2-3 weeks ahead of the expiry date.
* When a project has been completed or terminated, a Study Closure form must be submitted.
* Unanticipated issues that may increase the risk level to participants or that may have other ethical implications must be promptly reported to the REB. Serious adverse events experienced by a participant in conjunction with the research must be reported to the REB without delay.
* The REB must be promptly notified of any new information that may affect the welfare or consent of participants.
* The REB must be notified of any suspension or cancellation imposed by a funding agency or regulatory body that is related to this study.
* The REB must be notified of any findings that may have ethical implications or may affect the decision of the REB.

McGill University
Research Ethics Board Office
www.mcgill.ca/research/research/compliance/human

REB File Number:	21-10-009
Project Title:	Adult Survivors of Child Sexual Abuse Receiving Psychosocial Interventions: The Influences of Race, Ethnicity, and Shame
Principal Investigator:	Rusan Lateef
Department:	Social Work, School of
Supervisor:	Professor Delphine Collin-Vezina

Approval Expiry Date: **10-Mar-2024**

- The *REB-2* reviewed and approved the Continuing Review application for the above project on 27-Feb-2023.
- Approval is granted only for the research and purposes described.
- The PI must inform the REB if there is a termination or interruption of their affiliation with the University.
- An **Amendment** form must be used to submit any proposed modifications to the approved research. Modifications to the approved research must be reviewed and approved by the REB before they can be implemented.
- Changes to funding or adding new funding to a previously unfunded study must be submitted as an Amendment.
- A **Continuing Review** form must be submitted before the above expiry date. Research cannot be conducted without a current ethics approval. Submit 2-3 weeks ahead of the expiry date. A total of 5 renewals are permitted after which time a new application will need to be submitted.
- A **Termination** form must be submitted to inform the REB when a project has been completed or terminated.
- A **Reportable New Information** form must be submitted if any unanticipated issues that may increase the risk level to participants or that may have other ethical implications or to report any protocol deviations that did not receive prior REB approval.
- The REB must be promptly notified of any new information that may affect the welfare or consent of participants.
- The REB must be notified of any suspension or cancellation imposed by a funding agency or regulatory body that is related to this study.
- The REB must be notified of any findings that may have ethical implications or may affect the decision of the REB.

Appendix 2: Recruitment Poster

McGill

Invitation to Participate:

Experiences Receiving Psychosocial Interventions for Child Sexual Abuse

Are you:

- 18 years old or older?
- Identify as a woman?
- Speak fluent English?
- Identify with a racial/ethnic minority group?

Are you currently receiving (or in the past year received) some sort of psychosocial intervention, such as individual counselling or therapy, for experiences of child sexual abuse?

Do you have 1 hour of your time for an interview?

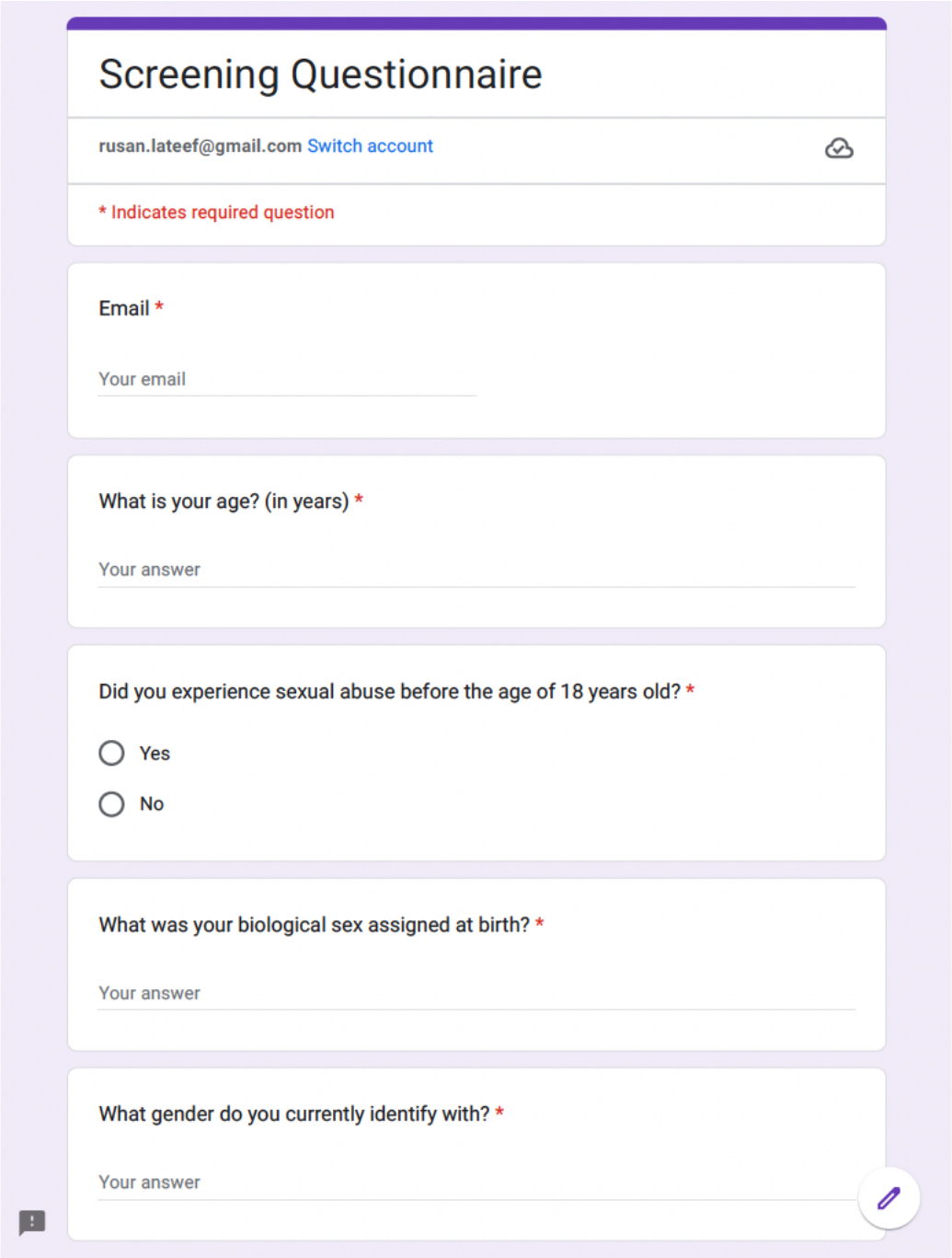
If yes: I would like to invite you to participate in an individual interview to discuss your experience of receiving psychosocial support for child sexual abuse.

You will be compensated for your time with a $20 grocery or coffee gift card if you decide to participate.

Please contact Rusan Lateef, PhD Candidate, to learn more about the study and to answer your questions:
Rusan.Lateef@mail.mcgill.ca

Doctoral supervisor: Delphine Collin-Vézina, Professor, McGill University

Appendix 3: Online Eligibility Questionnaire



Screening Questionnaire

rusan.lateef@gmail.com Switch account

* Indicates required question

Email *

Your email

What is your age? (in years) *

Your answer

Did you experience sexual abuse before the age of 18 years old? *

- Yes
- No

What was your biological sex assigned at birth? *

Your answer

What gender do you currently identify with? *

Your answer

How would you describe your racial, ethnic, and/or cultural identity? Please feel free to indicate more than one identity. *

Your answer

Do you consider yourself a **visible** racial/ethnic minority? *

- ◯ Yes
- ◯ No

Are you currently in counselling, therapy, other psychosocial intervention for the child sexual abuse? *

- ◯ Yes
- ◯ Not currently, but I have received such services within the past year
- ◯ Not currently, and I have not received such services for over a year

If you answered yes (or received within the past year), does this include individual counselling/therapy?

- ◯ Yes
- ◯ No

If you answered that you have not received such services for over a year for the previous question, please indicate how long it has been (in years) since you last received some sort of psychosocial intervention for child sexual abuse. If this does not apply to you, please skip this question.

Your answer

Are you able to participate in the interview in English? *

- Yes
- No

Will you be able to participate in a Zoom interview? (This will be a video interview, but only audio will be recorded) *

- Yes
- No

How did you hear about this study?

Your answer

Submit Clear form

Never submit passwords through Google Forms.

Appendix 4: Telephone Screening Script

Hello, am I speaking with [name]?

Hello [name]. This is Rusan calling about the research study. How are you?

Is this still an okay time to talk?

I won't take too much of your time, but I wanted to introduce the study and check in if you have any questions before we book an interview.

Thank you for your interest in this research study and taking the time to speak with me today.

As I've introduced before: My name is Rusan, a PhD Candidate at the School of Social Work at McGill University, and the Principal Investigator of this study. I am interested in learning more about the experiences of receiving psychosocial support among women who are survivors of child sexual abuse.

Are you interested in hearing more about this study?

I would like to hear from women who are survivors of child sexual abuse about their experiences receiving psychosocial support (such as, individual counselling/ therapy, etc.) for the abuse.

More specifically, I'm interested in exploring how shame, race, ethnicity, other aspects of social identity influence the professional support experiences of women survivors who identify with a racial and/or ethnic minority group.

The perspectives of survivors from diverse backgrounds will provide valuable insight into the diversity of emotions, experiences, and support needs among women survivors who engage in psychosocial interventions.

The voices of women survivors in this study will fill an important gap in research and the goal is that their voices will be considered and will inform psychosocial interventions that they are receiving.

Given your experience as a survivor of child sexual abuse, you represent someone with valuable information to share for this study.

Do you have any questions at this point?

Participation would involve a 60-minute individual interview on a date and time that is convenient for you. You will have the option of completing the interview via Zoom (a free videoconferencing software), through phone call, or in-person.

So, although we are recruiting participants from organizations that provide support to survivors, these organizations and their staff are not informed in any way about your participation. So, they will not know who has participated in this study and your participation will have no influence whatsoever on the services you receive.

Although you're connected with this support, I also want to make sure that, if you are interested, that now is a good time for you to participate in terms of your feeling emotionally in a good place. If not, I can always contact you at a later date to schedule an interview. If you feel you are ready to participate, please know that I will not be asking about the actual acts of abuse and I will have a comprehensive resource list available for you at the interview. What do you think?

If you are interested, then I will email you the information and consent form that we provide to all participants in this study. You will be asked to sign this form before the interview, or on the date of the interview if you prefer.

You will be offered a $20.00 grocery or coffee gift card as compensation for your time to participate.

If you know that you're interested in participating, we can schedule a date and time now. Or you can take some time to review the study information and consent form and send me an email whenever you are done If you are still interested in participating, and we will schedule an interview then.

*If schedule: I will email you with the date and time, and I will call you or send you a zoom link before the interview.

You have my email: rusan.lateef@mail.mcgill.ca. Please contact me if you have any more questions or would like more information about the study.

Thank you very much!

Appendix 5: Participant Consent Form

Participant Consent Form

Researchers: Rusan Lateef, PhD Candidate, McGill School of Social Work, Rusan.Lateef@mail.mcgill.ca

Supervisor: Dr. Delphine Collin-Vézina, McGill School of Social Work, Delphine.Collin-vezina@mcgill.ca

Title of Project: Adult Survivors of Child Sexual Abuse Receiving Psychosocial Interventions: The Influences of Race, Ethnicity, and Shame

Sponsor(s): Joseph-Armand Bombardier Canada Graduate Scholarship (CGS) Doctoral Award

Purpose of Study:
We would like to hear from women who are survivors of child sexual abuse about their experiences receiving psychosocial support (e.g., individual counselling, individual therapy, etc.) surrounding the abuse. More specifically, we would like to explore how race, ethnicity, and shame influence the professional support experiences of women survivors and, overall, how your different characteristics influence your experience. We are interested in the perspectives of both survivors who do and do not identify with a racial and/or ethnic minority group. We believe that the perspectives of survivors from diverse backgrounds will provide valuable insight into the diversity of emotions, experiences, and support needs among adult survivors of child sexual abuse.

What will study participation include?
If you decide to take part in this study, an individual interview will be scheduled at a time that is convenient for you. The interview is estimated to be 60 minutes long. You will have the option of participating in this study through Zoom videoconferencing software or a phone call interview.

At the beginning of the interview, the researcher will complete a brief questionnaire with you to gather demographic information. This should take a maximum of 5 minutes to complete. The demographics questionnaire will ask about the following: Age, gender identity, racial and/or ethnic identity, cultural identity, religion, country of birth, how many years you have lived in Canada, sexual orientation, relationship status, whether or not you identify as having a disability, whether or not you have children and their ages and gender if you have children, current occupation, your highest level of education, and the types of psychosocial interventions you are receiving. You will also be asked a few questions about your experiences of child sexual abuse: age of onset of sexual abuse; duration of sexual abuse; relation to the perpetrator (ex. family friend, sibling, etc.); age of first disclosure and to whom you have disclosed. Other than these questions, you will not be asked to share any further details of the sexual abuse. This data will be used to describe the who participated in this study. The demographic information for all participants will be combined for reporting purposes, and your identity will be protected.

The interview portion will focus on your feelings of shame related to the child sexual abuse, your comfort engaging in counselling/therapy/other psychosocial intervention, the relevance of your race and/or ethnicity to your experience receiving psychosocial support.

With your consent, interviews will be audio-recorded. If you decide to participate via Zoom, you will have the option of leaving your camera off. If you decide to leave your camera on, please be reassured

that only the audio portion of interviews will be used. Audio recordings will be transcribed verbatim for data analysis purposes. All identifying information will be removed to protect your identity.

Voluntary Participation:
The decision to participate is completely voluntary. If you choose to withdraw during or right after the study, all information obtained up until that point will be destroyed unless you specify otherwise at the time of withdrawal. Once data have been combined for publication, it may not be possible to withdraw your data in its entirety. We can only remove your dataset from further analysis and from use in future publications. Withdrawal of data is not possible once the link between your identity and the data has been destroyed. Identifiable data will be kept for 3 years. You will need to contact the principal investigator by email to notify them of your decision towithdraw.

This study is not affiliated with the organization from which you are receiving services and learned about this study. No staff at the organization from which you receive services will be aware of whether or not you chose to participate in this study. Your choice to participate or not in the study will not impact services from the organization from which you learned about this study in any way.

Potential Risks:
There is a risk that you will become upset or distressed as you reflect on your counselling experiences. We hope that this will be minimized by focusing on the topics discussed rather than details of the sexual abuse. You are free to choose whether or not you want to answer a question or participate in a topic of discussion, without any negative repercussions. You can take a break, if needed, at any time, for self-care. You will also be given a list of organizations and phone lines, including 24/7 services, that can provide crisis services in the event that you feel you require additional support. In the case of Zoom interviews, although all reasonable precautions are taken, there is always the possibility of third-party interception when using communications through the internet.

Potential Benefits:
There are no direct benefits for volunteering to participate in the study. An indirect benefit is that you may feel a level of satisfaction that you have made valuable contributions that will advance our understanding of how shame, race, ethnicity, and overall social identities influence the counselling experiences of adult survivors of child sexual abuse. These contributions will help inform ongoing practice guidelines, policy development, and other activities intended to promote awareness of the experiences of and needs of diverse survivors of child sexual abuse.

Compensation:
You will be given a $20 gift card for a grocery store or coffee as appreciation for your time to participate in the study. Compensation will be provided at the start of the individual interview, after the consent form has been signed.

Compensation will not be affected if you choose to terminate an individual interview before completion, or if you indicate to the Principal Investigator by phone or by email your decision to withdraw from the study within a week of the interview date.

Confidentiality:
Each participant will be assigned a unique identification number and their name will not be used in any materials. Individuals' transcripts will be identified with their unique identification number.

Identifying information will be removed during the transcription process to ensure all personally identifiable information is removed. Transcripts will be stored on an encrypted, password-protected server on password-protected computer. All data will be de-identified during the transcription process.

Demographics collected on the demographics questionnaire will also be associated with participants' unique identification numbers, and not with their names A master list of all participants and their unique identification codes will be stored on encrypted password- protected server on a password-protected computer that only the principal investigator has access to.

Names will only be noted on the consent form. All consent forms will be scanned and uploaded to an encrypted, password-protected file that will be stored on a password-protected computer. Hard copies of consent forms will be stored in locked filing cabinets in locked offices at the McGill School of Social Work.

Audio recordings of interviews will be transcribed and uploaded to NVivo software for data analysis. Audio recordings will be destroyed once transcripts have been verified for accuracy. Audio recordings and transcripts from interviews will be de-identified and stored on encrypted, password-protected server on a password-protected computer that only the principal investigator has access to.

All reports, journal articles, and presentations will not reveal the identities of any participants. To further ensure confidentiality, the names of organizations from which participants were recruited will not be identified in any dissemination materials. No information will be shared that would disclose your personal identity. Identifiable information will be destroyed after 3 years. All data will be destroyed (shredded or deleted) 7 years after the study has been completed.

Only the primary investigator and her doctoral supervisor, on an as-needed basis, will have access to any identifiable study information.

Limits to Confidentiality

While all information collected will be treated as confidential, a limit to confidentiality is the requirement to report where a minor (individual under 18 years of age) is a victim of/or is at serious risk of becoming a victim of physical or sexual abuse.

How will study results be shared?

Information collected will be analyzed and findings from the study will be disseminated through articles in scholarly journals, professional newsletters and websites, and research conference presentations.

Who do I contact if I have any questions about the study?

If you have any questions about this study, you may contact Rusan Lateef, Principal Investigator, by email at Rusan.Lateef@mail.mcgill.ca.

If you have any ethical concerns or complaints about your participation in this study, and want to speak with someone not on the research team, please contact the Associate Director, Research Ethics at 514-398-6831 or lynda.mcneil@mcgill.ca citing REB file number #21-10-009

Please sign below if you have read the above information and consent to participate in this study. Agreeing to participate in this study does not waive any of your rights or release the researchers from their responsibilities. To ensure the study is being conducted properly, authorized individuals, such as a member of the Research Ethics Board, may have access to your information. A copy of this consent form will be given to you and the researcher will keep a copy.

☐ I consent to the individual interview being digitally recorded (only audio is used).

☐ I am willing to be contacted in the future (within the next 3 years) for any follow-up questions **(optional)**.

☐ I would like to be informed when the results of the study are published. I could be reached for this purpose at the following email address (leave box unchecked if you are not interested in this):

_____

Participant's Name: (please print): _____

Participant's Signature: _____ *Date:* _____

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

Rusan Lateef
PhD Candidate
Principal Investigator
McGill School of Social Work
Rusan.Lateef@mail.mcgill.ca

Appendix 6: Demographics Questionnaire and Interview Guide

Demographics Questionnaire

The following questions allow us to better understand the backgrounds of participants of this study. This is important so we understand who the findings of this study represent.

As a reminder, all information obtained in this study will be held confidential and will be attached to a participant number rather than a name.

- Age: _____
- Gender identity: _____
- Racial and/or ethnic identity: _____
- Cultural identity: _____
- Religion: _____
- Country of birth: _____
    - If applicable, age at arrival in Canada: _____
- Sexual Orientation: _____
- Relationship Status: _____
- Children (yes/no): _____
    - If yes, what are their ages and gender? _____
- Current occupation: _____
- What is the highest degree or level of education you have completed? _____
- Do you identify as having a disability (If yes, please specify)? _____
- Any other aspects of identity important to you: _____
- Type(s) of psychosocial intervention(s) being received and duration at time of this interview (in months): _____

The following questions concern your experiences of childhood sexual abuse. You could describe up to 3 experiences of child sexual abuse, starting with the earliest first and then subsequent experiences after that. So, if you experienced childhood sexual abuse from more than one perpetrator, these experiences could be described in chronological order starting from the earliest to most recent experience.

Earliest experience of child sexual abuse

- Age of onset of sexual abuse:
- Duration of sexual abuse:
- Perpetrator relation (e.g., father, stepfather, mother, family friend, etc.):
- Age of first disclosure:
- Recipient of first disclosure (i.e., mother, sibling, counselor, teacher, friend, etc.):
    - Was this disclosure positive or negative?
- Who else have you disclosed this abuse to and at what age?

If applicable: Experience #2

- Age of onset of sexual abuse:
- Duration of sexual abuse:
- Perpetrator relation (e.g., father, stepfather, mother, family friend, etc.):
- Age of first disclosure:
- Recipient of first disclosure (i.e., mother, sibling, counselor, teacher, friend, etc.):
    - Was this disclosure positive or negative?
- Who else have you disclosed this abuse to and at what age?

If appliable: Experience #3

- Age of onset of sexual abuse:

- Duration of sexual abuse:
- Perpetrator relation (e.g., father, stepfather, mother, family friend, etc.):
- Age of first disclosure:
- Recipient of first disclosure (i.e., mother, sibling, counselor, teacher, friend, etc.):
    - Was this disclosure positive or negative?
- Who else have you disclosed this abuse to and at what age?

Interview Guide

Preamble:

Thank you for agreeing to participate in this study on the experiences of women survivors of child sexual abuse receiving psychosocial interventions. As a reminder, the overall goal of this study is to explore how race, ethnicity, other social identities, and shame influence the experiences of survivors receiving psychosocial support.

We'll first cover shame overall and how this plays out in the therapeutic context. We will then go into how your race, ethnicity, or other social identities are relevant to your intervention experience.

I want to remind you that this interview will be attached to a participant ID number and not your name. All identifying information will be removed from transcripts, and we will keep your identity and participation confidential (other than the limits of confidentiality discussed in the consent form).

The interview will be about one hour long and will be conducted in a conversational style using a set of questions that will be asked for you to share your thoughts, insights, and perspectives. Please be reminded that you can pass on any questions you do not wish to answer or are irrelevant to your situation.

I also want to remind you that you have consented to the interview being digitally recorded so I will start the recording just before we begin the interview. If you need a short break at any time, I will stop the recording and will resume recording when the interview resumes.

There are no right or wrong answers, I'm just genuinely interested in your perspective on these topics

Do you have any questions before we begin?

Part 1: Shame in Counseling/Therapy

1. What does shame mean to you?
2. How would you describe your shame related to the child sexual abuse?

Now thinking a bit more about your counseling/therapeutic experience in which you're receiving support for the child sexual abuse:

3. **A.** What types of feelings, thoughts, topics, or experiences related to the abuse do you feel most uncomfortable discussing or have never brought up in counseling, even though they were a concern of yours?

   B. Why do you think what you've described are the most uncomfortable to share?
4. What characteristics of counselors make it easier or harder for you to open up and discuss the topics you feel are most difficult to share?
5. Do you feel as though shame has been a focus of your counseling/therapy? Please elaborate.

Part 2: Intersectionality of Gender/Race/Ethnicity/Survivorhood in Counseling

For the next set of questions, we will focus on your race, ethnicity, and overall identity.

6. What role do you feel your racial and/or ethnic identity play in your counseling/therapy experience?
7. Do you feel like being a **woman of color survivor** impacts how you are treated in the counseling setting?
8. What other aspects of your identity have influenced your counseling/therapy experience?
9. Do you feel as though your racial and/or ethnic identity are taken into consideration in your counseling/therapy experience and by your counselor/therapist?

10. Has the fact that your racial and/or ethnic identity was/was not (*depending on response to above question*) considered had any impact on:

A. Your therapeutic relationship with your counselor/therapist?

B. Your satisfaction with counseling/therapy?

C. Your feelings of shame related to the abuse?

11. Can you tell me a bit about your current counselor and how you think they identify?

12. How do you think the race/ethnicity of your counselor/therapist impacts your therapeutic experience with them?

13. Do you feel like you have experienced racism or any other forms of discrimination within the therapeutic relationship?

14. Do you have any suggestions for how race/ethnicity could be better acknowledged or incorporated into the counseling/therapy experience for survivors of CSA?

Part 3: Interconnections between Race/Ethnicity, Shame, and Counseling/Therapy

To tie everything that we have discussed together:

15. How has your racial and/or ethnic identity impacted your experiences of shame overall *and* within counseling/therapy?

16. Have other aspects of your identity contributed to your shame overall *and* within counseling/therapy? Ask to describe.

17. A. You have mentioned _____ (*all social identities mentioned*) as impacting your experience of shame. Do you see these different identities as being tied together in terms of how you think about your experience of shame overall *and/or* within counseling/therapy?

B. Which identities do you see being tied together the *strongest* in terms of how you experience shame overall and/or within counseling/therapy?

At end of interview: Would you like me to send you the resource list for Ontario, or you don't need this?

Appendix 7: Quebec Resource List

Designated Centres

Montréal Sexual Assault Centre/ Centre pour les victimes d'agressions sexuelle à Montréal

- Bilingual
- Monday to Friday 8 to 5pm (except holidays)
- 514-934-0505 ext. 7456
- Services offered by the MSAC:
    - Medical and legal – ages 18 +
    - Clinical follow up – ages 18 +
    - Provincial helpline (listening, support and referral) – all ages; see below

Community Organizations

CALACS (Centre d'aide et de lutte contre les agressions à caractère sexuel/ Sexual Assault Centres)

- Bilingual (check with specific centres)
- Different centres across Quebec. A list of centres by location and their contact information could be found at: http://www.rqcalacs.qc.ca/the-calacs.php
- Centres offer support to women and female adolescents who have been sexually assaulted, as well as telephone support, support groups, accompaniment, and support services for victims (police, hospital, etc.) and services for close friends and family members of victims.

Mouvement contre le viol et l'inceste (Movement against rape and incest)

- French
- During COVID-19, three telephone numbers available:
    - 514-278-9383 (usual phone number)
    - 450-704-2250
    - 450-704-2260
- Services for adolescent girls and women survivors of violence and sexual abuse (child and adult sexual abuse), including diverse women such as immigrant women, refugees, and racialized women. Services include help and support, prevention, visibility and awareness and defense of rights.

Telephone Lines (24/7 lines included)

Provincial Helpline for Victims of Sexual Assault (24 hours a day, 7 days a week)

- Run by the Montreal Sexual Assault Centre, this toll-free telephone service has offers bilingual, confidential, and anonymous services free of charge across all of Quebec
- Services are available for all victims of sexual assault: adults, children, adolescents, incest survivors, the victim's family and friends, and practitioners.

Tel-Jeunes

- Bilingual
- 24/7 virtual support services for youth ages 20 and under, including:
    - Telephone line: 1-800-263-2266
    - Texting: 514-600-1002
    - Live online chat with a counselor: https://www.teljeunes.com/Tel-Jeunes

Info-Santé 811

- Bilingual
- 24/7, 365 days a year
- Connects callers to a nurse to evaluate their health situation and suggest appropriate resources
- Dial 811

Écoute Entraide

- French
- 8 a.m. to 10 p.m., 7 days a week
- Free and confidential telephone listening and referral service for anyone experiencing distress for all of Quebec.
- Montréal: 514 278-2130
- Sans frais: 1-855 EN LIGNE (365-4463)

Suicide Action Montréal

- Bilingual
- 24/7 free and confidential telephone service for those who are distressed, anxious, bereaved, or having thoughts of suicide
- 1-866-277-3553

Additional Resources

List of additional resources for victims of sexual abuse/assault in Quebec, by region:
https://www.quebec.ca/en/family-and-support-for-individuals/violences/help-and-resources-for-sexual-assault-victims-and-sexual-assailants/community-organizations-that-help-victims-of-sexual-assault/

List of additional resources in Montreal for victims of sexual abuse/ assault, by age and Francophone/Anglophone:
http://agressionsexuellemontreal.ca/urgence/centres-designes

- **PDF version:**
  https://santemontreal.qc.ca/fileadmin/fichiers/actualites/2019/02_fevrier/References_victimesagressionsexuelle_MAJ13fev2019.pdf

Appendix 8: Ontario Resource List

Community Organizations

Toronto Rape Crisis Centre/Multicultural Women Against Rape

- Counselling, legal advice, support groups and a list of hospitals where staff can administer rape kits.
- Monday to Friday 9am to 5pm
- 24-hour crisis line: (416) 597-8808
- Chat support service (Wednesdays to Sundays 7pm – 12am): https://trccmwar.ca/chat-support/
- Email: crisis@trccmwar.ca

Durham Rape Crisis Centre

- Individual and group counselling, counselling for support people of survivors
- 24-hour crisis and support line: 905-668-9200
- Email: info@drcc.ca

Sexual Assault/Domestic Violence Care Centre

- Medical care for adults who have experienced sexual assault or domestic violence.
- Nurses are available 24 hours a day, 7 days a week. No appointment needed.
- Location: Women's College Hospital, 76 Grenville St., Toronto Room 1305
- Phone number: (416) 323-6040

Barbra Schlifer Commemorative Clinic

- Legal services, counselling and translation for women who have experienced violence.
- Monday to Friday 9am – 5pm
- Location: 489 College St., Toronto
- Phone Number: (416) 323-9149

The Gatehouse

- Provide a range of support services for individuals impacted by childhood sexual abuse
- Phone number: (416) 255-5900
- Location: 3101 Lakeshore Blvd W Toronto (in-person services varying due to COVID-19)

24-Hour Telephone Support Lines

Assaulted Women's Helpline

- 416-863-0511
- 1-866-863-7868
- A 24-hour telephone and crisis line for all woman who have experienced abuse, providing counselling, emotional support, information, and referrals.

The Toronto Rape Crisis Centre/Multicultural Women Against Rape

- (416) 597-8808
- Provides a free 24 hours a day, 7 days a week crisis line service. The crisis line is a private and confidential crisis intervention/support service.

Distress Centres of Greater Toronto

- 416-408-HELP (4357)
- Provide telephone support to callers in distress 24 hours a day, 7 days a week.