Exploring shame, mental health, compassion, identity, and help-seeking in Black women who have experienced sexual violence

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ABSTRACT

Background: Women of African and Caribbean descent are more likely to experience sexual violence than their counterparts and less likely to access mental health support post-sexual violence. Black women navigate a distinct sociopolitical and cultural context that creates a unique intrapsychic and systemic experience of sexual violence. This can impact their mental health, identity, feelings of shame and help-seeking experiences, however, there has been little empirical exploration of this within the UK.

Aims: To investigate the associative, predictive, and moderating relationships between shame (internal and external), self-concept, self-compassion, psychological distress, and psychological wellbeing in Black women who have experienced sexual violence. To explore how Black women understand their identity in relation to sexual violence and the factors that hinder and facilitate help-seeking experiences.

Methods: A mixed-methods design was employed to quantitatively explore relationships between shame (internal and external), self-concept, self-compassion, psychological distress, and psychological wellbeing via an online survey (N= 37). Five participants took part in semi-structured interviews to discuss identity and help-seeking experiences post-sexual violence.

Results: Higher levels of shame were associated with lower psychological wellbeing. Higher levels of self-compassion were associated with and predicted higher levels of wellbeing. However, self-compassion did not moderate the relationship between external shame and psychological distress. The 'Strength Paralleling Vulnerability' and ' "Not Designed for Us" ' themes showed help-seeking experiences were influenced by narratives of strength and obstructed by systemic barriers.

Conclusions: The quantitative findings suggest that Black women's psychological wellbeing is particularly compromised following sexual violence. The 'strong Black woman' narrative can influence Black women's sense of identity and help-seeking. Help-seeking experiences were shown to be complex, silencing and influenced by sociocultural and political factors. The study's findings have multilevel systemic clinical, policy and research implications.

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LIST OF ABBREVIATIONS

CFT = Compassion Focused Therapy

CI = Confidence Interval

DA = Discourse Analysis

DASS-21 = The Depression, Anxiety and Stress Scale

GT= Grounded Theory

IPA = Interpretative Phenomenological Analysis

K-S = Kolmogorov- Smirnov

M = Mean

OAS = The Other As Shamer Scale-2

PIS = Participant Information Sheet

PTSD = Post-Traumatic Stress Disorder

Rku = Kurtosis

SCC= Self-Concept Clarity

SCCS = The Self-Concept Clarity Scale

SCS = The Social Comparison Scale

SD = Standard Deviation

SK = Skewness

SSCS = The Short Self-Compassion Scale

TA = Thematic Analysis

WEMWBS= The Warwick Edinburgh Mental Health Wellbeing Scale

1. INTRODUCTION

1.1. Overview

The prevalence of sexual violence is outlined to highlight gender-related disparities. Black British women's sociopolitical and historical contexts are explored to understand their unique experiences of sexual violence and the consequent psychological impacts and relationship to help-seeking.

The relevance and applicability of constructs such as shame and self-compassion, frequently associated and considered important for survivors of sexual violence are critically discussed in relation to Black British women survivors. Two literature reviews focused on the experiences of psychological distress and help-seeking are presented, which identify key gaps and provide a rationale for the study aims and framing of the research questions.

1.2. Constructs and Terminology

The language surrounding sexual violence is political and subject to cultural influences (Healicon, 2016; Weitsman, 2008). Certain language can marginalise and pathologise human experience (Brinkmann, 2016). Therefore, all language was carefully considered to acknowledge the influence of relevant context and avoid pathologisation.

To support the application of terms in this thesis, several concepts are defined below:

1.2.1. Sexual Violence

Historically, legal terminology defined sexual violence literature. Terms such as ‘rape’ and ‘sexual assault’ were commonly utilised (Campbell & Townsend, 2011). Legal conceptualisations used within research underestimated prevalence and dismissed the impact of a wide range of sexually violating behaviours (Basile & Smith, 2011) as individuals may not have categorised their experience within the limited terminology provided (Kilpatrick, 2004). Sexual violence was developed as a

term to encompass a range of non-consensual sexual behaviour (Hearn et al., 2007). These acts can include:

- completed or attempted penetration of the vulva or anus by the penis, hand, finger, or any other object
- penetration of the mouth with the penis or any other object
- non-penetrative sexual contact (e.g., intentional touching of the groin)
- non-contact sexual abuse (e.g., exposure to pornography)
- sexual coercion (e.g., asserting pressure via non-physical methods to force a person to engage in sexual activity)

Within this thesis, the term sexual violence will be used to represent a range of non-consensual sexual experiences and acknowledge the impact of acts outside of legal conceptualisations.

1.2.2. Woman/Women

Gender is often used as a euphemism for biological sex (Haslanger, 2000). However, gender is not an expression of genetics, but a socially constructed set of behavioural, psychological and cultural expectations placed on individuals (Torgrimson & Minson, 2005; Zalewski, 2010). Therefore, gender identity development is socially and cognitively nuanced (Martinez et al., 2020) and biological sex may not align with gender identity (Atkinson & Russel, 2015; Davy & Totze, 2018).

Gender constructs are not always consistent as sociocultural and political landscapes shift (Zalewski, 2010). Nevertheless, there are material consequences to gender constructs which can prevail over time to disadvantage some whilst privileging others (Bonvillain, 2021; Jayachandran, 2015). The conceptualisation of ‘woman’ as a gender identity is situated within a complex historic, ideological and structural oppression that impacts the life experiences of those born female that identify as women (cisgender women; Haslanger, 2000).

Within this thesis, the use of the term woman or women will refer to cisgender women.

1.2.3. Race and Culture

The words race and culture are commonplace within modern society and are often mistakenly amalgamated (Ballard, 2002). These complex concepts have nuanced

histories which cannot be fully addressed here. Simplified definitions are used here to outline how the terms will be applied.

Race has been used to superficially categorise people by physical attributes such as skin colour, although there are no genetic or biological determinants of this (Omi & Winant, 2020). Historic colonial practices used these categorisations to create societal hierarchies that resulted in the oppression of those not in the 'superior race', which for a large portion of time was 'White' (Durrheim et al., 2009; Sussman, 2014). Consequently, society placed racial meaning to people with the associated attributes regardless of whether individuals identified with that race (Omi & Winant, 2020). This racialisation operated to create and maintain racism via harmful stereotypes (Gonzalez-Sobrino & Goss, 2019).

Culture refers to a set of values, behaviours and beliefs shared by individuals with a collective history and communication system (Spencer-Oatey & Franklin, 2012). Culture is frequently used to describe group differences (Patterson, 2000). This is problematic as this can lead to cultural stereotypes. For instance, culture can be viewed as the sole reason marginalised people may not seek mental health support (Mintah, 2022).

1.2.4. Black Women

As discussed, there is a complex social, cultural, and political history that constructs gender (Zalewski, 2010) and race (Durrheim et al., 2009; Sussman, 2014). Black Women's interaction with the world is both racialised and gendered within this intricate history, making their experience distinct from that of women of other races (Atewologun & Singh, 2010; Kanyeredzi, 2018; Winkle-Wagner, 2009).

Within this thesis, Black women will refer to women whose identity has been constructed within a postcolonial legacy of slavery, societal racism, and migration.

1.2.5. Psychological Wellbeing

Many models attempted to conceptualise mental health resulting in various terminology that have been used interchangeably (Vaillant, 2012). Early contributions to this field focused on the presence or absence of what was deemed 'mental illnesses' (Westerhof & Keyes, 2010), with particularly positive mental health being 'above the normal' (Vaillant, 2012). Although this approach provided significant

psychiatric information, it gave a parochial and arbitrary viewpoint of the complexity of psychological phenomena (Westerhof & Keyes, 2010).

Contemporary explorations disregard the notion that 'mental health' and 'mental illness' are mutually exclusive in favour of a multi-dimensional approach (Bergsma & Veenhoven, 2011). 'Psychological wellbeing' has been argued to capture the range of phenomena existing outside of mental 'illness' or 'dysfunction' (Winefield et al., 2012). Sustained psychological wellbeing does not equate to the absence of painful or distressing emotions (e.g., shame or anxiety). Such emotions are acknowledged as a part of life, only compromising overall psychological wellbeing when enduring and unmanageable, impacting an individual's daily functioning (Huppert, 2009).

Common conceptualisations within the literature suggest that psychological wellbeing consists of states of positive affect such as happiness (the hedonic component) along with optimal individual and social functioning (the eudemonic component; Deci & Ryan, 2008). Investigations into measures of psychological wellbeing have found hedonic and eudemonic variables positively correlate with psychological wellbeing thus supporting this conceptualisation (Winefield et al., 2012).

Within this body of work, the term psychological wellbeing will describe the presence of hedonic and eudemonic emotions that support daily functioning.

1.2.6. Psychological Distress

Depictions of mental health diagnoses suggest there is an internal biological or psychological dysfunction responsible for an individual's presentation (Wakefield, 1992). Unlike the application of clinical mental health diagnoses, psychological distress is more flexible and is viewed as an indicator of global psychological wellbeing (Drapeau et al., 2012). The term recognises distress to be a common human response emerging from an external stressor (Horwitz, 2007) and can be present, fluctuating in severity, over time once exposure to the stressor has reduced or disappeared (Wheaton, 2007).

Psychological distress within this thesis will describe the presence of emotions that can be psychologically stressful but do not necessarily fall into the realms of clinical diagnosis. However, when discussing the literature, language will remain consistent with the conceptualisation used by the authors.

1.2.7. Victim/Survivor of Sexual Violence

The most appropriate way to describe individuals that have experienced sexual violence is highly debated. The term ‘victim’ is commonly used and has utility when navigating the criminal justice system (RAINN, 2019). ‘Survivor’ can represent an empowering albeit difficult journey following sexual violence (SAKI, 2015). It is important to recognise that the term victim is not synonymous with perpetual weakness just as survivor does not equate to unwavering strength (SAKI, 2015). The journey following sexual violence can encompass periods of strength and fragility that can be valuable, powerful, and meaningful.

The term survivor will be used to move away from legal definitions. However, there will be use of other terminology corresponding to any literature being discussed.

1.3. Rates of Sexual Violence

Sexual violence is a highly prevalent global public health and human rights issue (Sardinha et al., 2022; WHO, 2021). In the year ending March 2022, 1.1 million people aged 16 and above within England and Wales experienced sexual violence (Office for National Statistics [ONS], 2023). Although men are included in national statistics, women comprise the overwhelming majority. An estimated 798,00 women experienced sexual violence in the year ending March 2022 compared to 275,000 men (ONS, 2023). Sexual violence is an underreported crime; therefore, these statistics may not reflect its true extent (Dartnall & Jewkes, 2013).

It is important to recognise that sexual violence statistics are generally collected within a gender binary framework. This is an oversimplified perspective on gender and thereby excludes individuals with gender identities outside of the binary man or woman (Dolan, 2014). Nevertheless, the statistics indicate that women have a higher likelihood of experiencing sexual violence than men, suggesting it to be a gendered issue. Cross-cultural and intracultural studies have found complex contextual factors contribute to the prevalence of sexual violence against women (Borumandnia et al., 2020; Kalra & Bhugra, 2013).

Racial disparities have been found in the prevalence of sexual violence. The Crime Survey for England and Wales (CSEW) reported that Black women are significantly

more likely to be subject to sexual violence than their counterparts (ONS, 2021). These findings did not include rape; however, other reports have stated that Black women are disproportionately impacted by rape compared to the general population in London (Mayor of London Office for Policing and Crime [MOPAC], 2016). Despite the higher risk of sexual violence, Black women are reportedly less likely to access support services (Hester et al., 2012) which may disproportionately expose them to the consequences of sexual violence.

1.4. Sexual Violence: A Gendered Issue

Given the gender disparity displayed in the statistics, literature has stated that sexual violence is a gendered crime, thus the cause, expression, and consequences are determined by gender-related issues (Canan & Levand, 2019). Therefore, exploring the discourse and theory surrounding gender inequality within the context of sexual violence is important.

1.4.1. Feminism

Feminist theories have arguably provided a greater contribution to the general understanding of sexual violence than any other theoretical perspective. Feminist theories offer an alternative understanding of sexual violence that was previously governed by male-centred perspectives (Rennison, 2014).

A broad spectrum of Feminist ideologies has been developed and conceptualised by 'waves' (Genz & Brabon, 2009). Each wave varies in its approach to outlining and addressing the conceptual and/or material entities that create and perpetuate gender inequality for women on both a micro, interpersonal level and, macro sociocultural-political level (Canan & Levand, 2019). Radical Feminism and Intersectional Feminism will be the focus, as both have significantly shifted conversations about the oppression of women. Radical Feminism laid the foundation for thinking about the impact of patriarchal power whilst Intersectional Feminism expanded this thinking and considered how holding multiple identities can create a unique experience of subjugation (Brewer & Dundes, 2018; Messerschmidt, 2009).

The following sections will outline the theories' principles, explanations of sexual violence and note their strengths and limitations.

1.4.1.1. Radical Feminist Theory: Radical Feminist Theory focuses on the impact of patriarchy. Patriarchy refers to a social system that places value on traditional masculine norms and permits men to have disproportionate levels of societal power (Canan & Levand, 2019; McPhail, 2016). This theory thus states that patriarchy is at the root of gender inequality and sexual violence (Whisnant, 2017). This perspective expanded the historic views of sexual violence, highlighting that it is a form of social dominance over women and should be considered as such rather than individual incidences of violence (Rennison, 2014). The shift from individualistic to systemic explanations of sexual violence highlighted the nuanced threat that exists on various societal levels. The pervasive threat of sexual violence creates a continuum of fear which subjugates women's minds and bodies (Rennison, 2014).

Despite this theory's merits, it has been criticised for its single-factor approach, viewing patriarchy as a universal concept immune from temporal changes and cultural influence (McPhail, 2015). An apparent issue with Radical feminism is that it conflates intragroup differences and assumes that all women have the same experience of patriarchy. In many contexts, including that of sexual violence, this homogenisation can be problematic in its dismissal of difference (Crenshaw, 2006). Therefore, to solely apply this theory's explanation of sexual violence to Black women would be futile as it would overlook the additional oppressions that subjugate women of African and Caribbean heritage.

1.4.1.2. Intersectional Feminist Theory: Crenshaw's (1989) Intersectionality framework explains how societal inequalities relate to the different facets of an individual's identity and are intrinsically linked to their experience within the world.

Intersectional Feminist Theory holds Crenshaw's framework at its core. The perspective recognises that a woman can hold multiple identities outside of their gender identity which can combine to privilege or further marginalise them. This combination of identities can make a woman's experience of sexual violence different to other women who do not hold the same social characteristics (Canan & Levand, 2019; Kanyeredzi, 2018).

Intersectional Feminist literature recognises race and class to be important facets of identity, uniquely linked to gender (Brah & Phoneix, 2004). The legacy of Black women's gender and racial oppression interact to create a disadvantaged social

position incomparable to that of White women (Zounlome et al., 2019). Ingroup differences such as socioeconomic status and ability mean that Black women may not be equally disadvantaged (Nash, 2008). However, their general societal positioning creates a unique experience of and vulnerability to violence (Canan & Levand, 2019; Crenshaw 1991).

In addition, Black women have been considered to face double victimisation where they experience the actual sexual violence followed by the blame and shame placed upon them via the systemic response (Collins, 2000; Kanyeredzi, 2018). Thus, viewing sexual violence from an approach that focuses on the experience of White women further marginalises Black women. This becomes problematic when considering the professional infrastructures designed to support survivors. These services can be blind to the cultural, historic, and societal factors that limit help-seeking.

To summarise, failure to recognise how sociocultural and historic context (Kanyeredzi, 2018; Norwood, 2018) intersect and impact the experiences of Black women perpetuates their political, structural, and interpersonal vulnerability (Crenshaw, 2006).

1.5. The Impacts of Sexual Violence

People who experience sexual violence are at risk of a range of potential health consequences including reproductive, sexual, physical, and psychological difficulties (Ellsberg et al., 2008; Garcia-Moreno et al., 2006; Macdowall et al., 2013). Mental health will be the focus here, however the researcher acknowledges the complex and inseparable relationship between physical and mental health (Ohrnberger et al., 2017).

1.5.1. Psychological Impacts

Not all survivors will go on to receive clinical mental health diagnoses. Nevertheless, research suggests that sexual violence has a significantly higher and broader impact on psychological wellbeing than other types of traumatic events (Dworkin et al., 2017). The psychological consequences are reported to be both immediate and long-term (Jina & Thomas, 2013; Leserman, 2005; Tavara, 2006).

The acute impact of sexual violence can include anxiety, hyperarousal, negative affect and thought intrusion (Jina & Thomas, 2013). Garcia- Esteve et al. (2021) found that approximately two-thirds of women who had experienced sexual assault within the previous month experienced significant acute distress. Such findings highlight the immediate psychological impact of sexual violence.

The long-term effects of sexual violence have been extensively researched (Gewirtz-Meydan & Finkelhor, 2019). Research has mainly been conducted through a diagnostic lens and found sexual violence to be associated with; anxiety, depression, post-traumatic stress disorder (PTSD), low self-esteem, and self-harm (Machado et al., 2011; Vandemark & Muller, 2008). Additionally, survivors are reportedly 13 times more likely to attempt suicide and 26 times more likely to experience substance misuse difficulties (Brooker & Durmaz, 2015). The prevalence and severity of mental health difficulties observed in the research suggests that the psychological wellbeing of survivors can be compromised.

Research has focused on participants' experience of sexual violence in relation to specific diagnoses. Whilst the correlations displayed have utility, they are limited in their ability to explore the complex underlying processes and context that may be involved in the psychological distress experienced by survivors. Understanding the psychological phenomenon at the core of mental health difficulties may enable professionals to develop the lexicon and techniques to support survivors experiencing psychological distress (Trumbull, 2020).

1.5.2. Impact on Identity

Identities consist of "*the traits and characteristics, social relations, roles, and social group memberships that define who one is*" (Oyserman et al., 2012, p. 69). An individual can hold multiple identities such as gender identity and racial identity (Gaither, 2019) which allow them to make meaning of the world as well as motivate behaviours and future endeavours (Thoits, 2012). The composition of multiple identities can intersect to make a unique experience of the world (Warner & Sheilds, 2013). For example, Black cisgender women will have a unique experience of support structures following sexual violence compared to White cisgender women or Black transgender women.

Theorists have agreed that identity is a dynamic cognitive structure influenced by varying contextual factors for example, life stage, culture and socioeconomic status (Oyserman & James, 2011; Oyserman et al., 2012). However, there are differences in what context refers to, whether that be distal or proximal context (Oyserman et al., 2012).

Macrolevel factors including historical, social and cultural epochs have been argued to be influential. Research has observed effects at this level when investigating how sense of identity changes across life stages (Deci & Ryan, 2012) and when a person migrates to a new cultural setting (Zou et al., 2007).

Similar types of empirical analyses have observed the impact of midlevel factors such as family, neighbourhoods and schools (Osyerman & Yoon, 2009). The more proximal microlevel factors such as daily interactions also have been found to have an effect. For example, feedback and appraisal from others can either reinforce or challenge a person's identity (Oyserman et al., 2012). In summary, identity does not develop within a vacuum, it is socially constructed by what is relevant and positively reinforced at the time (Oyserman et al., 2012; Showers & Zeigler-Hill, 2012).

A strong and coherent sense of identity is in line with a consistent set of beliefs, values, and goals (Schwartz et al., 2010). Within the literature, a stable coherent sense of identity paired with confidence in one's attributes is conceptualised as Self-Concept Clarity (SCC; Lassri et al., 2022).

Investigations suggest SCC has a protective element to it, low SCC has been associated with psychological distress (Cicero, 2017). In contrast, higher levels of subjective wellbeing (Ritchie et al., 2011), psychological adjustment (Campbell et al., 2003) and lower levels of psychological distress have been evident in those with high SCC (Schiller et al., 2016).

As discussed, identity is susceptible to contextual influences, able to be developed and moulded by individual circumstances. Traumatic events, such as sexual violence, violate and disturb an individual's schema of the world thus challenging established cultural expectations, self-narratives, beliefs and values that make up identity (Boyle, 2017). As individuals can hold multiple identities, it is possible that differing contextual factors can intersect to impact SCC and this can be disrupted by trauma in a unique way. Thus, there is scope to explore how disruption to identity

from sexual violence impacts SSC and may be a mechanism through which psychological distress emerges (Hayward et al., 2020).

1.6. Sexual Violence and Shame

Gilbert's (2006) Biopsychosocial model of shame suggests that shame is precipitated by interpersonal experiences. This is relevant to sexual violence, as it is a form of interpersonal violence. The model suggests that as human relationships are crucial for wellbeing, individuals are inherently motivated to seek attachment from caregivers and groups (Baumeister & Leary, 1995; Bowlby, 2005). Therefore, being accepted and connected to others positively impacts emotional regulation and disables threat responses (Caccioppo et al., 2000). Rejection and criticism on the other hand enable threat responses and have detrimental impacts on behaviour and affect. Thereby, shame can represent negative appraisal from others and trigger distress (Aakvaag et al., 2016; Burmeister et al., 2018; de Hooge et al., 2010; Muris et al., 2015; Rodriguez Mosquera et al., 2008; Semb et al., 2011; Trumbull, 2020). Consequently, individuals may be motivated to socially withdraw to protect themselves from exclusion (Burmeister et al., 2018; Rodriguez Mosquera et al., 2008). In addition, in accordance with Social Rank Theory, those with a perceived lower social status are suggested to have higher shame experiences and associated submissive behaviour (Gilbert, 2000).

Any crime can evoke feelings of shame in survivors; however, this emotion is particularly salient and enduring following crimes of a sexual nature (Feiring & Taska, 2005; Weiss, 2010). Vidal and Petrak (2005) suggested that 75% of women in their study were ashamed of themselves following experiences of sexual violence, which has been supported in numerous other studies (Bhuptani & Messman-Moore, 2019; Bhuptani et al., 2021; Felson & Pare, 2005; Goodarzi et al., 2020) as well as in studies comparing survivors of crimes of a non-sexual and sexual nature (Feiring & Taska, 2005).

Greater experiences of shame after sexual violence are linked with elevated short- and long-term psychological distress (DeCou et al., 2017; Sarkar & Sarkar, 2005; Timblin & Hassija, 2022; Vidal & Petrak, 2007). Unfortunately, literature exploring

shame related to sexual violence has reduced or dismissed the impact of social context (Weiss, 2010). Emotions and elicited behaviours do not exist within a vacuum (Aranguren, 2016). Emotions are social constructs, intricately linked to and shaped by society and culture (Aranguren, 2016; Weiss et al., 2010). Furthermore, the proneness, source and expression of emotions are tied to other social constructs which apply to the individual (Mascolo, 2020).

1.5.1. External and Internal Shame

Shame can be divided into two discrete categories, external and internal shame (Matos et al., 2021). External shame is activated when the individual perceives judgement, criticism or persecution from others (Callow et al., 2021; Gilbert & Woodyatt, 2017). Experiences of external shame can result in negative perceptions of oneself, referred to as internal shame. Internal shame can be a recurrent experience for Black women who navigate a society that casts aspersions upon them and attempts to dictate the parameters of their womanhood via insidious racist and sexist beliefs (Johnson, 2020). This exposure to shaming discrimination can influence Black women's sexual expression, relationship towards sex (Bond et al., 2021) and sense of self (Kanyeredzi, 2018). This internalised shame has been associated with increased psychological distress (Johnson, 2020; Johnson & Urizar, 2021) and limited motivation to seek support following sexual violence (Zinzow et al., 2021). Whilst considering internalised shame it is important to recognise the distal origins within the wider contexts (e.g., sexism and racism) to implement macrolevel interventions and avoid pathologising Black women (Carr et al., 2013).

1.7. Self-Compassion: An Antidote to Shame

Self-compassion as conceptualised by Neff (2003), refers to the non-judgemental and kind response to one's failures, pain and inadequacies. The individual that practices self-compassion views their distressing thoughts and feelings as a part of the human condition, something to be mindful of but not to over-identify with. Self-compassion can improve psychological wellbeing and connection with others (Allen et al., 2012; Gilbert & Irons, 2008; Mckay & Walker, 2021; Zessin et al., 2015).

Compassion Focused Therapy (CFT) was developed as an intervention for those that experience elevated levels of shame and self-criticism (Gilbert, 2009). Rooted in Buddhist philosophy and integrated with neuroscience and evolutionary principles, Gilbert (2009) conceptualised three emotion regulation systems key to CFT:

- Threat system: identifies and responds to environmental dangers (e.g., interpersonal interactions) and triggers emotions (e.g., anxiety) that motivate self-protection
- Drive system: motivates the acquisition of resources and rewards which then provides positive feelings
- Soothe system: operates when no threat is detected and there is no need for additional resources. This system promotes wellbeing.

CFT aims to promote wellbeing through the development of the soothe system via compassion. Those who experience high levels of shame are proposed to have difficulty accessing the soothe system and thus can benefit from CFT (Gilbert, 2009). Compassion for oneself and others has been proven a powerful alleviator of shame in different populations (Craig et al., 2020).

1.7.1. Self-Compassion Following Sexual Violence

Within a context of sexual violence, a survivor's psychological wellbeing can be safeguarded from the impact of shame if self-compassion is encouraged. Self-compassion has reduced shame related to experiences of rape in women and subsequently protected them from psychological distress (Bhuptani & Messman, 2021). Self-compassion can also moderate psychological distress in survivors (Close, 2013) and this effect can be observed across different types of sexual violence (McLean, 2020). Therefore, self-compassion can be considered an effective antidote to shame experiences, which can be heightened for sexual violence survivors navigating systems steeped in sexist shaming.

Although self-compassion can be powerful, one should not assume that developing this skill is the same for all. Overcoming internal shame may be particularly difficult for populations that face system levels of discrimination, such as racism, which also fosters shame (Bains, 2010). For such individuals compounded shame may impede cultivation of self-compassion. In these circumstances, external sources of compassion can be valuable. When working with survivors, compassionately

challenging expressions of shame, self-criticism or invalidating societal messages can be effective in reducing shame (McLean et al., 2018). In addition, CFT within a group format can allow survivors to experience self-compassion and a meaningful experience of compassion from others (McLean 2021). This suggests that interpersonal compassion can challenge shame and allow the individual to experience a reduced sense of individual responsibility and increased sense of belonging, both key outcomes of compassion (Gilbert & Irons, 2009). For Black women interpersonal compassion may be a valuable experience in a world that shames and blames them for experiences of sexual violence due to harmful narratives surrounding their racial identity (Collins, 2000; Kanyeredzi, 2018). Solely placing the onus on Black women to be 'self-compassionate enough' disregards the systemic factors that can influence the levels of shame experienced by them.

1.8. Black Women's Experience of Sexual Violence

Black women may experience the impact of sexual violence differently due to racialised and gendered shaming narratives (Kanyeredzi, 2018) which affects their identity, psychological wellbeing (Nnawulezi & West, 2018) and experiences of help-seeking (Thiara & Roy, 2020). The following sections will explore the relevant sociohistorical context and its influence on Black women's experiences of sexual violence and help-seeking.

1.8.1. The Sociohistorical Context

When exploring Black women's experience of sexual violence, understanding the relevant sociohistorical context is vital (McNair & Neville, 1996). Black women's lives are rich, diverse and transcend historic subjugation. Nevertheless, legacies of slavery and oppression continue to influence the treatment and depictions of Black women globally. Exploration of this is key to understanding; the sexual violence enacted on Black women, subsequent systemic responses, barriers to help-seeking, professional support structures and how these impact their psychological wellbeing (Mintah, 2022).

During slavery, the sexual victimisation of Black women was legal. Sexual violence was used as a tool of oppression and morally justified as Black women were

branded as sexually uninhibited (Tillman et al., 2010). Forced breeding and sexual exploitation of Black women ensured the future of enslaved workers, further legitimising sexual violence through the commodification of Black people (Leung & Williams, 2019). There were widely held attitudes and beliefs that blamed the survivor for the violence enacted on them. These beliefs have been conceptualised as rape myths (Edwards et al., 2011). Stereotypes and rape myths created in this era have implications still evident in the present day.

Although all women can be stigmatised by rape myths, Black women have an additional burden of stereotypes that perpetuate the myths (Donovan & Williams, 2002) and control the contemporary depictions of Black women (Hill Collins, 1990; Kanyeredzi, 2018; Lueng & Williams, 2019).

1.8.2. Perpetuating Oppression via Controlling Images

Hill Collins (1998) explained that Black women's subjugation is perpetuated and justified via negative stereotypes known as Controlling Images, some of which date back to the slave trade. Images of the African American woman that dominated the mainstream narrative included: the 'Mammy' and 'Jezebel'.

1.7.2.1. The Mammy: In attempts to disguise the cruelty of slavery, slave traders promoted a paternalistic relationship between slaves and slave owners creating an image of mutual care and love. Images of caring African American women were widespread, and these women were called 'Mammies' (McEyla, 2007). This image developed over time into the 'Matriarch'.

Deriving from 1960's US government reports examining Black families, the Matriarch depicted the hyper-independent, strong, aggressive Black woman that took leadership of the family household, emasculating Black men in the process (Donovan & Williams, 2002). Some Black women have embraced this notion of inherent strength to safeguard themselves from the systemic harm that exists around them, which often goes amiss in contemporary media portrayals of Black women (Kanyeredzi, 2018; Romero, 2000).

Several documented accounts from Black women highlight a theme of the 'strong Black woman'. This narrative imposes the idea that Black women must overcome

adversity alone without displaying signs of distress. Failure to do so would be shameful and represent a loss of Black womanhood (Ashley, 2013).

The strong Black woman narrative is paradoxical. On one hand, it can promote resilience and ambition; on the other hand, it is linked with psychological distress in those that attempt to embody the narrative (West et al., 2016). Sexual violence experiences may also evoke a sense of shame as, for some, a 'victim' status does not align with the strong Black woman narrative (Kanyeredzi, 2018).

1.7.2.2. The Jezebel: A more contemporary controlling image is the Jezebel. Jezebels are described as provocative, sexually insatiable, promiscuous Black women (Hill Collins, 2000; Kanyeredzi, 2018) and are considered morally bankrupt (Donovan & Williams, 2002). This image painted Black women as sexually available and was utilised as a justification for the sexual violence enacted upon them (Nash, 2009). The Jezebel image has transformed into the 'gold digga', 'hood rat' and 'crack whore' in modern media (Donovan & Williams, 2000; Kanyeredzi, 2018). Such images continue to underscore the depictions of Black women in music and media, where the hyper-sexualisation of Black women is simultaneously glorified and despised. Portrayals of sexual violence towards Black women are condoned or boasted about (Rebollo-Gil & Moras, 2012) and deemed reasonable due to the Jezebel image (Donovan & Williams, 2000).

Although the described Controlling Images derived from the US involved women of mainly African descent, the European Atlantic slave trade had influences on economics and culture within the UK (Adkinson-Bradley et al., 2009). Consequently, the same stereotypes influence the experiences of Caribbean and African women in the UK. This is exemplified in Fielden et al. (2010)'s exploration of sexual harassment in a workplace setting. The Black women within the study were assumed to be more sexually liberal by men and this was deemed to explain their experience of sexual harassment. This suggests that controlling images and stereotypes of Black women's sexuality is present within the UK and exploration of its impact on Black women within this context is warranted.

1.9. Help-Seeking

The concepts discussed can also influence Black women's experience of help-seeking following experiences of sexual violence. This section will outline the importance of help-seeking before exploring the cross-cultural barriers, issues particularly relevant to Black women's experience of seeking help and their experiences within professional services.

Access to and engagement with professional support can be protective for survivors (Hegarty et al., 2016). Without appropriate and effective provisions, women can be left vulnerable to the psychological consequences that can compound over time (Tillman et al., 2010). As research commonly homogenises racialised women (Aspinall, 2020), it is difficult to get a true representation of their service use. However, data suggests that Black and other racialised women are less likely to help-seek despite their increased likelihood to experience sexual violence (Imkaan, 2020; Love et al., 2017).

Black survivors may be particularly hesitant to access support for their psychological wellbeing. Discriminatory experiences and insufficient professional support structures can discourage Black women from seeking help (Mantovani et al., 2017). This means that many are vulnerable to the psychological distress associated with sexual violence, which could be further compromised when considering the psychological impacts of sexism and racism that Black women face daily (Bryant-Davis et al., 2010).

When the decision-making process surrounding seeking psychological support is contextualised several factors can be considered to facilitate or hinder the choice to help-seek and stay engaged with any support accessed. Professionals need to understand the factors that go into these decisions so that psychological wellbeing services can develop and cater to diverse needs (NHS England, 2017).

1.9.1. Secondary Revictimisation

Survivors can experience systemic barriers to help-seeking that are not necessarily rooted in racism. Secondary revictimisation caused by victim-blaming can be an example of this.

Related to rape myths, victim-blaming is the process in which an individual implicitly places the responsibility of the violence on the survivor, through questions about their character or behaviour (Eigenberg et al., 2008). These victim-blaming attitudes can be ascribed to survivors, resulting in additional trauma for the individual (Campbell & Raja, 1999). Research has indicated that an overwhelming number of women have experienced revictimisation within professional agencies including mental health services (Balsam et al., 2010; Campbell, 2005; Campbell et al., 2001), which accounted for disengagement within services (Ahrens, 2002).

1.9.2. Stereotypes

Although victim blaming and revictimisation is problematic for all women, when considered in conjunction with controlling images, the implications for Black women navigating support pathways become more apparent. The controlling images that subjugate Black women not only provide a pseudo justification for the sexual violence enacted upon them but also act as a barrier to their help-seeking (Donovan & Williams, 2002). These prevalent stereotypes may influence; service providers perception of Black survivors, how survivors perceive themselves following sexual violence, how they navigate help-seeking and their experiences within services once support is accessed (Tillman et al., 2010).

American studies have examined how Black women's awareness of the intersects of their identity and their connection to the strong Black woman narrative impacts the likelihood of them disclosing experiences of sexual violence (Washington, 2001). In their literature review, Tillman et al. (2010) described the complex intrapsychic factors that contribute to the statistics showing that African American women are the least likely subsection of women to disclose sexual violence experiences, whether formally via services or informally via friends and family.

1.9.3. Culturally Insensitive Services

The contemporary realities of Black women are situated within an oppressive historical context that can be perpetuated within services. For decades, many Black people have been exposed to the detrimental effects of institutionalised racism within UK-based services (Papadopoulos et al., 2004). For example, Black people have been found to be more likely to experience restrictive forms of mental health treatment, such as compulsory admission to inpatient settings under the Mental Health Act, than their White counterparts (Keating, 2002). Additionally, in a recent

survey, 65% of the 2051 Black respondents stated that they had experienced racial prejudice from healthcare professionals (Lacobucci, 2022). Black women's understandable concern about being misunderstood and overlooked is a common theme highlighted in the research (Washington, 2001). For instance, British Black women shared that their pain was dismissed by professionals due to a preconceived notion of their 'strength'. They also spoke about how their cultural needs were not considered within therapeutic spaces which left them feeling more distressed than before they sought support (Pusey, 2020). This dismissal is a common occurrence nationwide that contributes to the under recognition of psychological distress among Black women, limiting the support provided to those in need (Cole, 2018; Edge & MacKian, 2010).

The awareness of systemic discrimination has fostered a distrust of services discouraging racialised people from seeking support (Tillman et al., 2010). Black women are required to establish psychological and social boundaries to protect themselves from further traumatisation following a catalogue of intergenerational trauma and oppression (Tyagi, 2001). This has been suggested to extend to a hesitance to speak to service providers whose limited cultural knowledge could prejudice treatment options (Sue, 2001).

1.10. Summary

Sexual violence's psychological impact is well documented (Garcia- Esteve et al., 2021; Jina & Thomas, 2013; Leserman, 2005; Tavara, 2006). Each survivor's experience will be individual however, considerable evidence displays the short- and long-term effects. Survivors of sexual violence have an increased risk of anxiety, depression, PTSD, low self-esteem, substance misuse, suicide and self-harm than those who have not been victimised (Brooker & Durmaz, 2015; Campbell et al., 2009; Dworkin et al., 2017). These are not necessarily cause-effect relationships, other contextual factors may influence the psychological impact such as gender and racial disparities (Catabay et al., 2019; Dworkin & Terri, 2021; Fontes & Plumber, 2010).

Feelings of shame are prevalent following sexual violence and can be detrimental to psychological wellbeing (Muris et al., 2015). Contextual factors such as constructions

of womanhood can influence experiences of shame (Skjelsbæk, 2006). Research suggests that self-compassion can reduce shame in survivors (Bhuptani & Messman, 2021; Close, 2013; McLean, 2020). A clear sense of self is also suggested to protect survivors from identity disruption that can follow trauma (Hayward et al., 2020).

Professional support following sexual violence can be protective (Hegarty et al., 2016). Black women are subject to gender and race-related barriers when considering and accessing mental health support (Balsam et al., 2010; Campbell, 2005; Campbell et al., 2001; Tillman et al., 2010).

Literature suggests that the sociopolitical and cultural context in which Black women exist may create a unique intrapsychic and systemic experience of sexual violence. This may impact their mental health, identity, feelings of shame and help-seeking experiences, which are important to be explored.

1.11. Literature Review

The following literature review will explore research pertaining to the psychological impacts of sexual violence and help-seeking experiences of Black women survivors.

Scoping reviews are useful in their ability to observe the range and nature of available literature within a certain topic (Arksey & O'Malley, 2005; Cacchione, 2015). Due to the lack of research solely exploring the experiences of Black women, a scoping review was deemed most appropriate. This method facilitated observation of the range of available research and research gaps within this area.

Two scoping reviews were conducted in line with the steps outlined by Arksey and O'Malley (2005), see Appendix A.

Databases Academic Search Ultimate, APA PsycArticles, APA PsyInfo and CINAHL were used via EBSCO to find relevant literature for both reviews. Additional literature was sourced via Google Scholar and the open-source University of East London repository. Reference lists of relevant literature were also searched.

1.11.1. Scoping Review One: Black Women and the Impacts of Sexual Violence

The first review of interest pertained to the impact of sexual violence on Black women, particularly the psychological consequences.

The scope of this review was defined using Booth et al. (2016) framework:

1. Who = Black women
2. What = sexual violence, psychological wellbeing, psychological distress, identity, self-compassion, and shame
3. How (will the study impact on the who) = situate and justify current research investigating Black women's psychological wellbeing and experiences of self-concept, self-compassion and shame following sexual violence

The search included terms such as "sexual violence", "non-consensual sex", "Black", "women", "self-concept", "identity", and "psychological distress". A full list of search terms, inclusion and exclusion criteria, and a flowchart depiction of the scoping review process are available in Appendix B.

Studies included in the review measured aspects of psychological wellbeing and/or distress, focused on Black women and explored sexual violence that occurred during adulthood.

The papers below were identified as meeting the scoping review inclusion criteria:

1. Catabay et al. (2019) investigated the association between perceived stress and mental health outcomes (depression and PTSD symptoms) in American Black women that had and had not experienced sexual violence in adulthood. The second objective was to understand the mediating roles of resilience and social support.
    - N= 310 (18-44 years old)

2. Sigurvinsdottir et al. (2020) explored the relationship between self-blame, psychological distress (depression and PTSD symptoms), suicidal ideation and suicide attempts within American Black survivors over three years.
    - N= 473 (18-71 years old)

1.11.2. Psychological Outcomes

Catabay et al. (2019) conceptualised psychological distress as the presence of stress, PTSD symptoms and depressive symptoms. They utilised a screening measure to explore the women's experience and severity of PTSD- related symptoms in the previous month, depressive symptoms within the previous week and perceived level of stress. Participants who were exposed to sexual violence were significantly more likely to experience severe levels of PTSD and depression than those who had not experienced sexual violence. They also reported significantly higher levels of perceived stress, which was found to be highly correlated to poorer mental health outcomes. Similar findings were presented in Sigurvinsdottir et al.'s (2020) longitudinal study. On average, survivors of sexual assault experienced elevated levels of PTSD and depression symptoms that fell within the moderate to severe range. These levels of symptoms persisted throughout the three-year study.

The consequences of psychological distress were also observed in the studies. The prevalence of suicidality within Sigurvinsdottir et al.'s (2020) sample was elevated, with 45.3% reporting suicidal ideation and 32.3% reporting suicide attempts within their lifetime.

1.11.3. Summary, Critical Evaluation and Implications

The studies suggest that the psychological wellbeing of Black women is impacted following sexual violence. Specifically, Black women are vulnerable to high levels of stress, PTSD and depressive symptomology. The studies' quantitative design highlighted relationships between variables which can have utility in the clinical decision-making process. However, exploration of the wider context is limited due to this approach, and the participants' voices go unheard. Catabay et al. (2019) emphasised the sexist and racist context when considering their findings, particularly in their exploration of stress levels. They argued for provisions that acknowledge the chronic stressors that arise from gender and racial discrimination. Further research is needed to understand the relationships between the social context and psychological phenomena experienced following sexual violence. Through qualitative research, survivors could share expansive accounts of their lived experience which could facilitate exploration of relevant social context. Furthermore, the participants' voices would be active in the work and construct the narrative.

Sigurvinsdottir et al. (2020) was able to highlight the longitudinal impact of sexual violence on Black women's mental health. Such findings justify the need for the development and implementation of long-term intervention pathways for Black women.

The studies' generalisability was limited by their samples. The majority of Catabay et al.'s (2019) sample were aged 18-34 and were of lower socioeconomic status. Although Sigurvinsdottir et al.'s (2020) study had more diversity in terms of age, sexuality, socioeconomic status and education, the study had high attrition which limited the generalisability of the findings that were included in the final analysis. Additionally, both studies took place in America therefore the findings may not apply to other Black women in the global diaspora.

The studies explored a limited number of psychological outcomes. The focus on psychological distress conceptualised as PTSD, depression and stress limited the understanding of other psychological impacts. Furthermore, the studies did not explore shame, self-compassion or identity despite these being relevant to the topic of sexual violence. As a result, there is a limited understanding of the variables that may moderate or be associated with the psychological consequences of sexual violence. Further quantitative investigation including a wider range of variables could provide a more comprehensive insight into the relationships.

1.11.4. Scoping Review Two: Black Women and Help-Seeking

The second scoping review focused on Black women's experience of help-seeking following sexual violence. Search terms included "sexual violence", "non-consensual sex", "Black", "services" and "help-seeking". The full list of search terms and a flowchart illustrating the scoping review process can be found in Appendix C.

The review's scope was defined using Booth et al.'s (2016) framework:

1. Who = Black women
2. What = sexual violence, help-seeking
3. How (will the study impact on the who) = situate and justify current research investigating Black women's experience of seeking and engaging in mental health support following sexual violence

The papers below were identified as meeting the scoping review inclusion criteria:

1. Mintah (2022): a qualitative study exploring the factors influencing Black British women's decision to seek help following sexual violence and their experience of professional support.
    - N= 12 (early 20's to mid 30's)

2. Ullman & Lorenz (2020): a mixed methods study investigating African American women's relationship to seeking mental health support following sexual assault. The qualitative component of the study was the focus of this review.
    - N=32 (21- 59 years old)

1.11.5. Experiences of Help-Seeking

Both studies identified key themes pertaining to Black women's relationship to help, such as the strong Black woman and relevant cultural narratives, distrust of services and the importance of having a Black therapist.

The themes further highlighted the unique social positioning of Black women that serves as a backdrop during help-seeking journeys. The findings corroborated the notion that Black women navigate both specific cultural barriers and systemic barriers that relate to all women.

1.11.5.1. Relationship to help: Within Mintah's (2022) findings, participants shared the reasons they delayed or did not seek support from services. Their stories drew parallels to the 'strong Black woman' narrative. The women both explicitly and implicitly highlighted that the narrative places an expectation on them to be self-sufficient and endure violence without professional support. Therefore, the want or need for support would contradict the perception of strength they may hold, generating a sense of weakness or vulnerability which could be held with discomfort. One survivor described the embodiment of strength as a "double-edged sword". It delayed help-seeking but also helped them to cope with their experiences.

Ullman and Lorenz (2020) did not find evidence of the strong Black woman stereotype. However, similarly to Mintah (2022), they found other cultural factors that influenced the participants' relationship to help. In both studies participants were cognisant of the detrimental impact of not seeking help but recognised that help-seeking comes with interpersonal risks. The women explained how narratives within

their community shaped their decision-making. They acknowledged that non-adherence to the cultural expectation to not publicly discuss private matters could negatively impact familial relationships.

Ullman and Lorenz (2020) contextualised the cultural stigma and placed a spotlight on a possible precipitating factor. They found a theme of mistrust towards services. Participants spoke of the past mistreatment of Black communities by professional services. Participants in both studies alluded to a process of destigmatisation within their communities however understood that the legacy of stigma continued to influence the perception of help-seeking.

1.11.5.2. Experiences of mental health services: The investigations highlighted factors specific to Black women. Both studies supported the utility of mental health services in the recovery of survivors. Participants referred to the positive interactions they had with professionals. Women in Ullman and Lorenz's (2020) study appreciated validation from their therapists. Ullman and Lorenz (2020) acknowledged that this validation could be particularly helpful in mitigating shame and blame felt by survivors.

A key theme in both studies pertained to the racial composition of staff within mental health settings. The importance of having a therapist from the same racial background was salient within the findings. Mintah (2022) found that participants felt a sense of shared experience with their therapist which created psychological safety and allowed them to speak freely in sessions. The women felt that Black therapists have a cultural understanding that was absent when they worked with a White therapist. Therefore, the participants did not need to explain aspects of their culture which can be an additional burden for minoritised individuals when accessing therapy (Mintah, 2022; Ullman & Lorenz, 2020). Several survivors commented on how they would not have engaged with services if they did not have the choice of working with a Black therapist, emphasising the extent to which a shared identity is impactful and meaningful.

Some participants in Mintah's (2022) study had differing views. They appreciated a sense of anonymity when working with a White therapist (Mintah, 2022). Thus, the want for a therapist of the same racial background cannot be extended to all. Despite the benefits, there can be a sense of shame or perceived stigma when speaking to a

person that visibly represents a culture that can hold shaming narratives around sexual violence and help-seeking.

1.11.6. Summary, Critical Evaluation and Implications

These findings suggest that broader sociocultural context can configure the decision-making process for Black women as well as their experiences within professional services.

Although both studies are unique in their focus on Black women, one cannot assume their generalisability. As Ullman and Lorenz (2020) focused on African American women, findings should be tentatively applied to Black women in the UK. Mintah (2022) provided an insight into Black women's experiences within a British context. However, the diversity within the sample was limited regarding age and socioeconomic background. It is important to not homogenise Black women. There are intersects of identity that neither of the studies captured. In addition, both studies had small samples, further limiting their generalisability.

Nevertheless, these qualitative studies allowed for the voices of Black women to be captured and allowed them to create their narrative which is not possible in quantitative studies. Building upon this type of research focusing on Black women within the UK could be beneficial given the current lack of generalisability.

1.12. Research Gap and Relevance to Clinical Psychology

Sexual violence research has been limited by the variables explored and the samples involved. The definitions of psychological distress have been limited and hedonic and eudemonic variables have not been included. Most of the available literature derives from an American context and limited research conducted within Britain exists. UK studies that do include Black women also involve other racially minoritised women whose cultural and historical context may not be applicable (Imkaan, 2018; Imkaan 2020).

This study focused on Black women's experiences of psychological wellbeing, psychological distress, shame, self-compassion, self-concept and help-seeking following sexual violence. These variables are understood to be relevant to sexual violence but have not been investigated together with a sample of Black women. The

current study utilised a mixed methods design. The quantitative component aimed to investigate the correlating, moderating and predictive relationships between a larger range of variables than previously studied. Whilst the qualitative aspect allowed for the survivors' stories to be heard and social context to be explored thus adding to the UK-based literature.

This research can further the understanding of intersectional issues faced by Black survivors and enhance therapeutic considerations. Findings from this study could also go beyond individual level intervention. Within their leadership competencies, clinical psychologists could support policy and service development relevant to women of African and Caribbean heritage.

1.13. Research Aims and Questions

Through a mixed methods design, this study aimed to:

1. Quantitatively explore shame (internal and external), self-concept, self-compassion, psychological distress, and psychological wellbeing in Black women who have experienced sexual violence within the UK.
2. Qualitatively explore help-seeking, including the hindering and facilitating factors, in Black women who have experienced sexual violence. Semi-structured interviews allowed for identity to be openly explored as opposed to a top-down approach that would derive from quantitative measures.

The current study was guided by the following research questions.

1.13.1. Research Questions

Quantitative:

1. Is psychological wellbeing significantly associated with:
- Shame: a) external b) internal
- Self-concept clarity
- Self-compassion
2. Is psychological distress significantly associated with:
- Shame: a) external b) internal
- Self-concept clarity
- Self-compassion

3. Is psychological wellbeing predicted by:
- Shame: a) external b) internal
- Self-concept clarity
- Self-compassion
4. Is psychological distress predicted by:
- Shame: a) external b) internal
- Self-concept clarity
- Self-compassion
5. Does self-compassion moderate the relationship between shame and psychological distress?

Qualitative:

6. How do Black women understand their identity in relation to their experience of sexual violence?
7. What hinders and encourages Black women to seek mental health support following sexual violence?

2. METHOD

2.1. Overview

This chapter will outline the research's epistemological stance and discuss the ethical foundations of the study. This chapter will also detail the research design and methodology. Lastly, the analytic strategies and researcher reflexivity will be described.

2.2. Epistemology and Ontology

Epistemology refers to "the nature of knowledge and the methods of obtaining it" (Burr, 2003, p. 92). Epistemological positions are rooted in their corresponding

ontology, which is concerned with the knowledge of reality (Al-Ababneh, 2020). The realist epistemological position is situated within ontological realism, which proposes there to be an independently existing reality which can be examined (Haigh et al., 2019).

Realism as an epistemology is broad, ranging on a continuum from naïve realism to critical realism. On the naïve end of the spectrum, knowledge is suggested to be a universal truth that is directly measurable via empirical investigation. However, critics of this position argue that the observer of the information influences what is perceived. Empirical observations can be theory-laden and thus cannot be considered unbiased due to the impact of theoretical assumptions (Godfrey-Smith, 2000). These criticisms gave rise to critical realism.

Critical realism is situated between realist and social constructionist epistemologies. This stance recognises there to be independent, measurable processes existing separate from the researcher. However, it also recognises that investigation of these processes alone does not indicate reality as it is influenced by a relevant social, political, cultural, and historical context (McEvoy & Richards, 2006). For example, Black women have been pathologised within healthcare, with health disparities deemed a result of biological differences (Scott & Davis, 2022). However, consideration of social context such as discrimination has informed contemporary understandings (Chinn et al., 2021). Critical realism attempts to explore reality with a cautious and critical lens. This epistemological stance encourages attempts to uncover the mechanisms that produce scientific phenomena (Alvesson & Skoldberg, 2009) whilst also influencing human liberation (Bhaskar, 1998). As such it is deemed a stance appropriate in informing research exploring issues of social justice (Hoddy, 2019) such as sexual violence.

In regard to the relevant methodology, it is deemed appropriate to combine quantitative and qualitative methodologies whilst adopting a critical realist approach (McEvoy & Richards, 2006). Some have argued for the segregation of quantitative and qualitative methodologies due to supposed irreconcilable ontological differences (Petter et al., 2004), whilst others suggest a combination of the two can be effective from a critical realist perspective (Hoddy, 2019). Quantitative methods are strong in their ability to identify patterns and underlying mechanisms, an important component

of the critical realist stance. Conversely, qualitative methods can highlight complex concepts and themes that are not readily accessible via standardised measures, which facilitates the critical and reflexive approach endorsed by critical realism (Hoddy, 2019).

The current study was conducted in accordance with a critical realist position. The study aimed to observe and quantify independently existing phenomena (e.g., shame) whilst acknowledging the reality of the participants' experiences and how this interacts with a relevant cultural, historical and social context. A mixed-methods approach was adopted following consideration of the research's utility (Morgan, 2014). The quantitative analysis allowed for relationships between psychological wellbeing, psychological distress, self-compassion, shame and self-concept to be explored (Hussein, 2009). The qualitative approach enabled the survivors to engage in topic matters salient to them and their context as opposed to being contoured by the researcher's aims (Hoover et al., 2018). As the qualitative data was led by the survivors' discourse, the implications can inform clinical practice and service development that benefits Black women survivors rather than being devoid of value (Lyons et al., 2013). This approach displayed how research can be situated within critical realism and work for positive social change and the dismantlement of power structures within academia (Botha, 2021; Hoddy, 2019).

2.3. Design

A cross-sectional mixed methods design utilising quantitative and qualitative methodology was employed.

Participants could take part in either or both components of the study. Those that participated in the quantitative component completed a battery of online questionnaires at one time point. The relationships between shame, self-compassion, psychological distress, psychological wellbeing and self-concept clarity were explored. Open questions were included in the online survey. These questions were designed to collect qualitative data regarding help-seeking.

The qualitative component of the study explored identity in relation to sexual violence as well as barriers and facilitators of help-seeking via semi-structured individual

interviews. Due to the sensitivity of the research topic, interviews were chosen over focus groups to offer a one-to-one safe space for participants to share their experiences. Interviews were also selected to give voice to the stories of the survivors, which is common practice within sexual violence research (Campbell et al., 2009). Black women are frequently misrepresented within empirical research, which contributes to the pathologisation of their distress (Few et al., 2003). Therefore, providing a platform for their stories to be heard was of the utmost importance in this research.

2.4. Ethical Considerations

2.4.1. Ethical Approval

The University of East London Ethics Committee granted ethical approval for this study (Appendix D). No further ethical approval was required as participants were not recruited via NHS services.

2.4.2. Informed Consent

Upon logging onto the online survey, all participants were presented with a Participant Information Sheet (PIS; Appendix E). Participants that opted to take part in an interview were emailed the PIS, which summarised the nature of the study, what was expected of the participants, the right to withdraw and how data would be managed during and after the course of the research. Participants were provided with the contact details of the researcher and were able to ask any questions before consenting to their participation.

In the online survey, the participants provided consent by ticking a series of statements (Appendix F) and could not proceed unless they had ticked all the boxes to indicate their agreeance with the statements. For the interviews, participants returned a signed electronic copy of the consent form (Appendix G) to the researcher via email. The interviewees also provided verbal consent to take part at the beginning of the recorded interview.

All participants were informed that they were able to withdraw their consent to use their data without any consequence. The survey participants were informed that they could exit the survey at any point prior to submitting their data or email the researcher within 3 weeks of completing the survey to withdraw their consent.

Interviewees were informed they could withdraw consent at any point during the interview or email the research within 3 weeks of completion.

2.4.3. Confidentiality and Anonymity

2.4.3.1. Survey participants: To maintain the confidentiality and anonymity of survey participants, IP addresses were unknown. No identifiable information was collected in the survey. The participants created a unique code that they could use to identify their data if they wanted to withdraw consent following completion. Any emails received were permanently deleted to ensure email addresses were not stored.

2.4.3.2. Interview participants: Interview data was managed in accordance with the Data Protection Act 2018. Consent forms were stored on the researcher's University of East London's OneDrive for Business account which was password protected. Consent forms and interview data were kept separate on OneDrive. The visual and audio recordings generated by Microsoft Teams following the interviews were stored on the researcher's OneDrive account on a password-protected laptop. The autogenerated transcripts were kept in a separate folder. Participants were informed that the transcripts were only accessible by the researcher and anonymised versions may be discussed within supervision. All interviewees were given a pseudonym in their transcript. Any other identifying information was modified or redacted from the final transcripts. Any email correspondence from the interviewees was permanently deleted to ensure no email addresses were stored.

2.4.4. Managing Potential Distress

Careful consideration was given to the design of the study, given the potentially distressing nature and emotional consequences of sexual violence research (Burke Draucker, 1999).

2.4.4.1. Survey participants: In line with the British Psychological Society (2021) ethical guidelines for internet-mediated research, the procedures for consent and withdrawal were clearly presented on the PIS and debrief sheet (Appendix H. Participants were informed of the potentially distressing language used in the study, allowing them to make an informed decision regarding their participation. They were also provided with a list of support services on both the PIS and debrief sheet. Participants that did not meet the survey eligibility criteria were redirected to a debrief form with an explanation of their ineligibility and the information discussed (appendix I).

There was careful consideration of the measures used and the potential distress their content could raise. The measures were ordered to allow participants to start and end the survey with less emotive content.

2.4.4.2. Interview participants: Interview participants were also provided with information of support services in the PIS and debrief sheet. The interviewees were reminded before and during the interview that they could decline to answer any questions without repercussion and that they could choose the amount of information they disclosed. They were also reminded before, during and after the interview that they could withdraw parts of or the entirety of their data anytime within 3 weeks of the data collection.

During interviews, there was careful attention paid to the participant's demeanour as an indicator of their emotional wellbeing in the moment. All interviews were conducted in a validating and warm manner as recommended when conducting research with sexual violence survivors (Campbell et al., 2010).

2.4.5. Debrief

Survey participants were provided with the debrief sheet following the completion of the measures. Interview participants were provided with a verbal debrief at the end of the interview. They were also reminded of their right to withdraw and emailed a debrief sheet following the interview.

2.5. Materials

The measures (Appendix J) utilised were chosen by the researcher and research supervisor, with careful consideration of their length, psychometric properties, content/language, and face validity. The measures had been previously implemented in research and were thus deemed appropriate for use.

2.5.1. Survey Materials

2.5.1.1. The Warwick Edinburgh mental health wellbeing scale (WEMWBS): The WEMWBS (Tennant et al., 2007) measures general psychological wellbeing and is available for public access. It is a 14-item scale that asks respondents to rate how often they had experienced certain feelings or thoughts outlined in the item statements over the previous two weeks on a 5-point scale. The items measure positive affect (e.g.*, 'I've been feeling optimistic about the future'*), positive functioning (e.g., *'I've been dealing with problems well'*) and fulfilling interpersonal

relationships (e.g., *'I've been feeling close to other people'*). To score, all items are summed with possible total scores ranging between 14 and 70 with higher scores indicating better psychological wellbeing.

The WEMWBS has demonstrated high levels of internal consistency (Cronbach's α= 0.91) when with the general population. Normed scores fell between 45 and 56. The scale also has shown a moderate sized negative correlation with mental distress (r = -0.53, $p<0.01$) thus supporting its criterion validity (Tennant et al., 2007). The scale has been utilised in research exploring the psychological wellbeing of sexual violence survivors (Khaliq et al., 2021).

2.5.1.2. The short self-compassion scale (SSCS): The SSCS (Raes et al., 2010) is a 12-item tool measuring self-compassion. Respondents are asked to rank statements indicating how they typically act towards themselves during difficult times (e.g., '*I try to be understanding and patient towards those aspects of my personality I don't like'*). The statements are ranked from 1 (almost never) to 5 (almost always). Higher self-compassion is indicated by higher summed total scores. The measure has displayed good internal consistency (Cronbach's α= 0.86) and high correlation with the long form Self-Compassion scale ($r \geq 0.96$; Raes et al., 2010).

The scale has been implemented in mixed methods research exploring compassion in survivors of sexual abuse (McLean, 2021).

2.5.1.3. The depression, anxiety and stress scale (DASS-21): The DASS-21 (Lovibond & Lovibond, 1995) is a 21-item tool designed to measure psychological distress. The measure consists of three subscales (depression, anxiety and stress). Respondents are required to rate the extent to which the item applies to their experiences over the past week. Participants utilise a 4-point Likert scale (0-3) to rate statements such as *'I couldn't seem to experience any positive feeling at all'.* The total score and subscale scores are totalled and multiplied by 2. Higher scores represent greater levels of distress.

The measure has displayed good internal consistency for the total score and depression, anxiety and stress subscales (Cronbach's α= 0.93, 0.97, 0.92 and 0.95 respectively) and good construct validity when used on non-clinical samples (Henry & Crawford, 2005). The DASS-21 has been widely used in sexual violence research (Caravaca-Sanchez et al., 2019; Dye, 2020; Fekih-Romdhane et al., 2019).

2.5.1.4. The social comparison scale (SCS): The SCS (Allan & Gilbert, 1995) is an 11-item instrument that measures internal shame. The measure uses 11 pairs of antonyms (e.g., *'inferior and superior'*) on either side of a 10-point scale and asks the participant to indicate which side of the scale describes them in comparison to others. The total score is obtained by summing the items with possible scores ranging from 11 to 110. Higher scores indicate lower levels of internal shame. The SCCS has a high level of internal consistency (Cronbach's α= 0.89; Gilbert & Miles, 2000).

2.5.1.5. The other as shamer scale-2 (OAS): The OAS (Allan, Gilbert, & Goss, 1994) is an 18-item questionnaire that measures external shame. The items include beliefs of how others view the self (e.g., *'other people put me down a lot'*) and self-evaluations (e.g., *'I feel other people see me as not good enough'*) which respondents rate on a 5-point scale from 0 (never) to 4 (almost always). Total scores are the sum of all items with higher scores indicating greater levels of external shame. The OAS has displayed high internal consistency (Cronbach's α= 0.93).

2.5.1.6. The self-concept clarity scale (SCCS): The SCCS (Campbell et al., 1996), is a 12-item instrument measuring the stability, clarity, and consistency of self-concept. Respondents rate the extent that they agree with item statements such as, '*I seldom experience conflict between the different aspects of my personality'*, on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). Ten items are reversed scored and then all items are summed to obtain the total score. The scale has been shown to have good internal consistency (Cronbach's α= 0.86). The SCCS has been implemented in sexual violence research (Lassri et al., 2022).

2.5.1.7. Open-ended questions: To allow the participants to share their experiences of help-seeking without having to take part in the interview, open-ended questions were included. The questions were designed to capture the participants' experience of formal and informal help-seeking following sexual violence (e.g., *'What was helpful about the support you received?*').

2.5.1.8. Demographic information: Some demographic information was collected to assess how representative the data was to the wider population of Black women in the UK. Questions within the survey captured the age range and ethnicity of the participants. The participants were provided with ten age brackets, ranging from 18

to 65+. To capture ethnicity, participants were able to choose from, '*Black of African descent', 'Black of Caribbean descent'* or *'Black of other descent*'. Participants that chose *'Black of other descent'* were provided with a free text box to specify how they identify. A question was also included to capture the type of sexual violence the participant had experienced. The type of sexual violence categories (non-contact unwanted sexual experiences, unwanted sexual contact, sexual coercion, being made to penetrate someone else and rape) were based on the categories outlined by the National Centre for Injury Prevention and Control, which have been used in research (Black et al., 2010).

2.5.2. Interview Schedule

The individual interviews were guided by a semi-structured interview schedule developed by the researcher (Appendix K). To support the development of the interview schedule two women of Black Caribbean descent were consulted and a pilot interview was conducted with one woman of Black Caribbean descent. This process allowed for feedback and direction on the language, appropriateness and order/structure of the questions.

The schedule explored the impact of sexual violence on identity, and the potential emotional experiences following sexual violence such as shame and self-compassion. The questions also captured experiences of help-seeking and suggestions for services and lay people wishing to support. Probes and follow-up questions were used where appropriate. The participants were given the opportunity to add other details they felt relevant at the end of the interview.

2.6. Participants

2.6.1. Recruitment

Convenience sampling was used to recruit participants on social media platforms, Instagram, Twitter and LinkedIn. Social media accounts solely dedicated to the research were created for each platform. No personal accounts were used for recruitment purposes. Advertisements (Appendix L) promoting the study were posted on the social media platforms. To gain more interest in the study and increase the potential for participants, infographics sharing information relating to the research

topic were also posted on social media (Appendix M). An amendment was made to the ethics application to gain approval for the use of infographics (Appendix N)

A specialist organisation also promoted the study in their bimonthly newsletter. Their agreement to support recruitment can be seen in Appendix O. The name of the organisation has been redacted in the interest of confidentiality.

2.6.2. Inclusion Criteria

The inclusion criteria for the survey and interview were women that self-identify as Black, aged 18 years or above who had experienced sexual violence within adulthood. Adulthood was defined as aged 18 and above in line with legal definitions of adulthood within the UK (Centre for Aging and Demography, 2019).

There was no limitation put on how long ago the participants had experienced sexual violence as there was no available literature warranting this.

2.6.3. Exclusion Criteria

Individuals that did not have a level of English to read and understand the PIS were unable to participate in either component of the study. Those that would require the support of an interpreter to engage in a conversation were also unable to participate due to the restrictions of the interview process. It is important to highlight that this exclusion criterion limits the generalisability of the findings to English speakers.

2.7. Procedure

2.7.1. Pilot Phase

There was a pilot phase of the study where the content and length of the questionnaires and interview schedule were reviewed. To allow for maximum participation from the target population during the study, the participants in the consultation phase were intentionally drawn from outside the study population.

2.7.1.1. Survey pilot: Two women aged 54 and 59, self-identifying as Black who had not experienced sexual violence were recruited via convenience sampling. The women reviewed the questionnaires and reported that the online survey was appropriate regarding content and length.

2.7.1.2. Interview pilot: The two women also provided feedback on the interview schedule. They felt that the interview questions were gentle and non-judgmental. However, they provided some guidance on the phasing of prompts during the interview as they felt the schedule could be more conversational in nature. As such prompts were added to the interview schedule, the piloted schedule can be found in Appendix P.

A pilot interview was conducted with one woman aged 59, identifying as Black who had not experienced sexual violence. The pilot interviewee felt the interview was empathic and well-paced and deemed the questions to be appropriate.

2.7.2. Online Survey

The survey was hosted on the platform Qualtrics and was accessible by an electronic link. The participants were presented with the PIS. To access the survey, the participants were required to indicate their informed consent. To ensure that all respondents met the inclusion criteria, they were asked whether they had experienced sexual violence. Any participants that indicated that they had not experienced sexual violence were redirected to a debrief sheet that explained the reason for their exclusion as well as details for support organisations. Participants were required to make a unique code that they could quote if they wished to withdraw their data from the study following completion. The completion time of the survey was between 15 – 30 minutes. Participants were able to take breaks or discontinue the survey at any point. Participants were able to return to partially completed surveys up to a week after starting them. Any incomplete entries were considered as a withdrawal following one week. Once the survey was completed, the participants were presented with the debrief sheet. All data were transferred to SPSS (v. 28) and NVivo (10) for the quantitative and content analyses.

2.7.3. Interviews

The women contacted the researcher via email to enquire about participation. Participants were emailed the PIS and consent form and given the opportunity to ask the researcher any questions. Once returned, the PIS and consent were stored on the researcher's University of East London OneDrive for Business account. The interviews were conducted via Microsoft Teams. All interviews were recorded and auto-transcribed by Microsoft Teams. Participants provided verbal consent at the beginning of the interview. Interviews lasted between 1 hour and 2 hours and 15

minutes. Participants were verbally debriefed at the end of the interview and sent the debrief sheet.

The researcher remained conscious of the inherent power imbalances between the participants and researcher during the interviews. Participants were reminded to only disclose as much information as they felt comfortable with and were encouraged to ask questions. Due to the sensitive nature of discussing sexual violence, the researcher took a compassionate approach to the interviews and gave the participants control over the degree to which they responded (Campbell et al., 2010).

2.8. Analytic Approach

2.8.1. Survey Data Analyses

The quantitative data from the survey were analysed in SPSS. Correlational analysis was utilised to explore relationships between the variables in research questions 1 and 2. G*Power sample size calculator predicted a sample size of 84 participants to observe a medium effect size of 0.5, an appropriate power level for correlational analysis (Sullivan & Feinn, 2012).

Multiple regression analysis was used to observe any predictive relationships between the variables in research questions 3 and 4. Moderation analysis address research question 5.

Content analysis was used to analyse the qualitative data derived from open questions in the survey. Each participant's data was coded and categorised using NVivo software.

2.8.2. Interview Data Analysis

2.8.2.1. Rationale: After carefully considering a range of qualitative analyses, Thematic Analysis (TA) was deemed most appropriate for the interview data. The researcher aimed to conduct 8-10 interviews as this has been suggested to be a suitable amount of data for TA before reaching data saturation at 12 interviews (Guest et al., 2006). TA can be applied flexibly as it is not tied to a specific theoretical or epistemological stance (Braun et al., 2018). There are several approaches to TA. Reflexive TA was chosen for this study. Reflexive TA recognises the researcher's social positioning and its influence on the interpretation of the data

(Braun et al., 2018). This is aligned with the study's critical realist approach that recognises reality is influenced by a social, political, cultural and historical context (McEvoy & Richards, 2006).

Grounded theory (GT; Glaser & Strauss, 1967) was considered, however, its focus on generating new theory from data did not align with the study's aims. Interpretative Phenomenological Analysis (IPA; Smith, 1996) was also considered. IPA encourages the researcher to focus on the individual's process of making sense of their lived experience. IPA usually is conducted with a smaller sample size due to the level of depth required in analysis (Eatough & Smith, 2017). However, TA allowed comparisons to be made across a larger dataset. Discourse Analysis (DA) was another consideration. DA focuses on how language constructs reality (Potter & Wetherell, 1987). Although language is important to be understood, this study was focused on the material implications of sexual violence. TA offers a nuanced understanding of data without the focus being on the use of language (Braun & Clarke, 2006). In summary, due to the aims of the study, TA was selected as the most appropriate analytic procedure.

2.8.2.2. Analytic process: Through TA the researcher was able to identify the patterns of meaning from the participant's experiences shared in the interview (Braun & Clarke, 2006). The analysis followed the six-phase approach to TA (Braun & Clarke, 2012) to ensure consistency throughout the analytic process.

1. Familiarisation with the data

Conducting and transcribing the interviews was the beginning of the immersion process. The transcripts were then read and re-read as an entire dataset to understand the meanings and patterns (Appendix Q).

2. Generating initial codes

NVivo software was used to code the dataset. Data were coded for as many codes as possible that retained the significant contextual content. This process meant extracts were coded under multiple relevant themes (Appendix R).

3. Searching for themes

The approach to identifying themes was flexible. Notes, tables and visual mind maps were used to organise the initial codes into overarching themes and subthemes.

4. Reviewing themes

The dataset was revised to ensure any missed data was coded and the identified themes held validity. The coded excerpts under each theme were reconsidered for refinement and consistency.

5. Defining and naming themes

Hierarchies of subthemes were created and organised to create a narrative of the data aligned with the central story of the data.

6. Producing the Report

The narrative of the data was captured through writing the final report. Extracts from the data were included to express the essence of the themes.

2.8.3. Reflexivity

It is crucial for researchers to understand how their interests, social location, values and beliefs interact with and shape the research (Berger, 2013). The researcher exists within the social world they are investigating, thus a constant process of recognising and examining their own positioning in relation to the research via reflexivity is necessary (Palaganas et al., 2017).

Researchers have different positions in relation to the participants. The researcher can hold an 'insider' position, where they have similar experiences and characteristics as the participants or an 'outsider' position where their experiences are dissimilar (Dwyer & Buckle, 2009). Others take a non-binary approach to positioning, arguing that intersecting identities coincide to form each step of the research journey (Maxwell et al., 2016). I adopted an intersectional approach to my reflective considerations. Throughout the research journey, I kept a journal to support my reflective process (Appendix S). I reflected on my own responses to the material and below have summarised my experiences that I feel were influential in the development of the research.

My grandparents' Jamaican upbringing was salient throughout my own. Although I was raised in the UK, the British nationality does not particularly resonate with me,

especially because the prominent media representations of British people during my childhood did not include people that looked like me. As I grew up, the complexity of racial and ethnic identity became increasingly present as I navigated living as a global majority but being deemed as a minority within the UK. My upbringing was economically privileged, I had access to resources and opportunities that were statistically uncommon for Black people in the UK due to systemic oppression. However, I simultaneously experienced marginalisation. This influenced the way I experienced the literature describing the social positioning of Black women. Most of the literature reviewed explored the experiences of Black women from differing socioeconomic backgrounds to my own. The experiences of marginalisation described resonated with me, yet I was conscious of how my access to resources may have influenced my understanding of help-seeking and the way I would experience the consequences of sexual violence.

Black Feminism has influenced my clinical work and research. Knowledge of Black women's oppression has heightened my sensitivity to sociopolitical factors that reinforce their subjugation. However, I was aware of how my inherent power as a researcher could perpetuate the oppression the participants experienced. This reflection motivated me to limit power dynamics in the research process. For example, when developing the interview schedule, I made a meaningful effort to reduce power hierarchy within the interviews by assuring the survivors that they were the experts of their experience.

As a woman the threat of sexual violence is something I identify with. I was conscious of managing the emotional impact of the work through journaling and seeking support from my professional and personal network.

3. RESULTS

3.1. Overview

This chapter outlines and explores the study findings. The sample characteristics and sexual violence experiences will be detailed before the research questions are addressed. Bivariate correlation analysis explores research question 1 and 2. Multiple regression analysis investigates questions 3 and 4. Moderation analysis explores question 5. TA investigates questions 6 and 7. Content analysis also explores question 7.

3.2. Quantitative Analysis of Survey Data

3.2.1. Sample Characteristics

3.2.1.1. Respondents: Eighty-six individuals accessed the online survey. However, following examination of the data, it was identified that 49 (56.9%) did not complete the survey. There was no missing data from those that completed the survey. From an ethical standpoint and based on the guidance provided in the PIS, non-completion was viewed as a withdrawal from the study and these individuals were not included in the final study sample. As such, N=37 for the quantitative analyses.

3.2.1.2. Respondent characteristics: Demographic information of the survey respondents is outlined in Table 1. Regarding age, most participants were aged 28-32 (37.8%). Most were of African descent (56.8%), some were of Caribbean descent (29.7%) and a minority self-identified as Black of other descent (4%). Within the latter category, participants shared their preferred cultural identity as Black Caribbean and Black American, Black of African and Caribbean descent, Pan African and Mixed Black with White Hispanic.

Table 1

Characteristics of the Sample

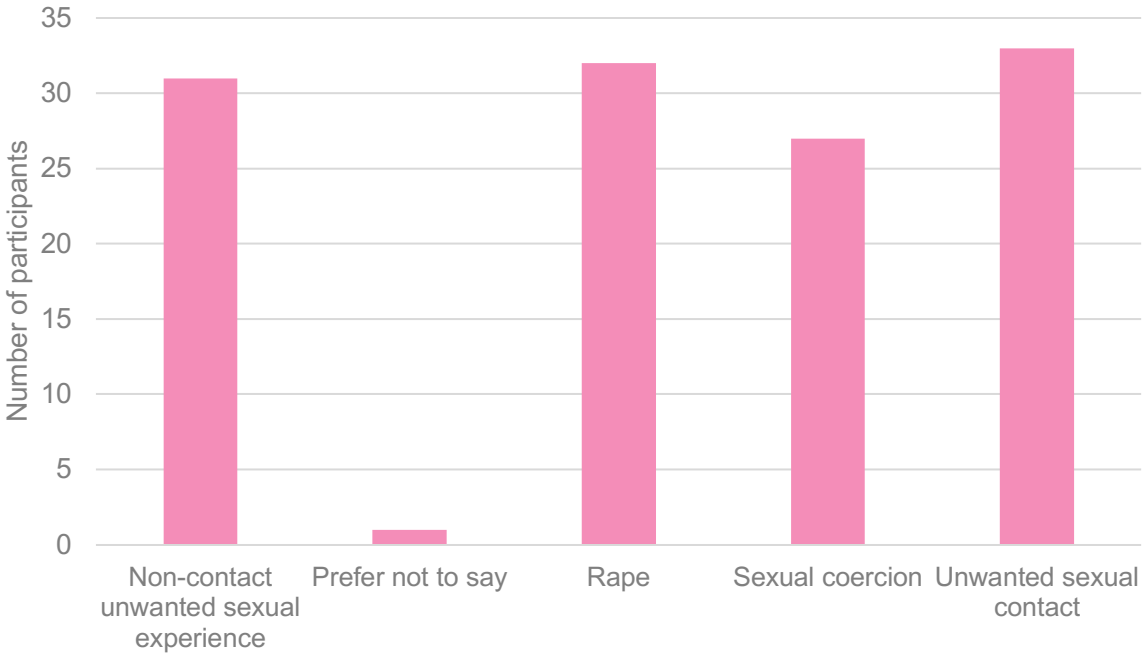
Characteristics	N	%
Age		
18-22	4	10.8
23-27	11	29.7
28-32	14	37.8
33-37	3	8.1
38-42	3	8.1
43-47	1	2.7
53-57	1	2.7
Cultural Background		
Black of African descent	21	56.8
Black of Caribbean descent	11	29.7
Black of other descent	4	10.8

3.2.1.3. Non-completers: Demographic information of non-completers (Appendix T) was examined to minimise any possible biased conclusions related to the completed data (Graham, 2009). The age of 18 'non-completers' was available. Participants within the completed group were marginally older than this in the non-completer group (37.8% age 28-32 compared to 11.1%). The cultural background of 14 'non-completers' was available. Within the non-completers group, 64.3% self-identified as Black of Caribbean descent, whereas 56.8% of the completed group were Black of African descent. Most 'non-completers' withdrew from the survey upon completing the consent form (Appendix U).

3.2.1.4. Experiences of sexual violence and help-seeking: The types of sexual violence that participants experienced were examined. The proportion of participants that had experienced each type of sexual violence is displayed in Figure 1. High proportions of the participants experienced unwanted sexual contact (89.2%), sexual coercion (73%), rape (86.5%) and non-contact violence (83.8%).

Figure 1

Types of Sexual Violence Experienced

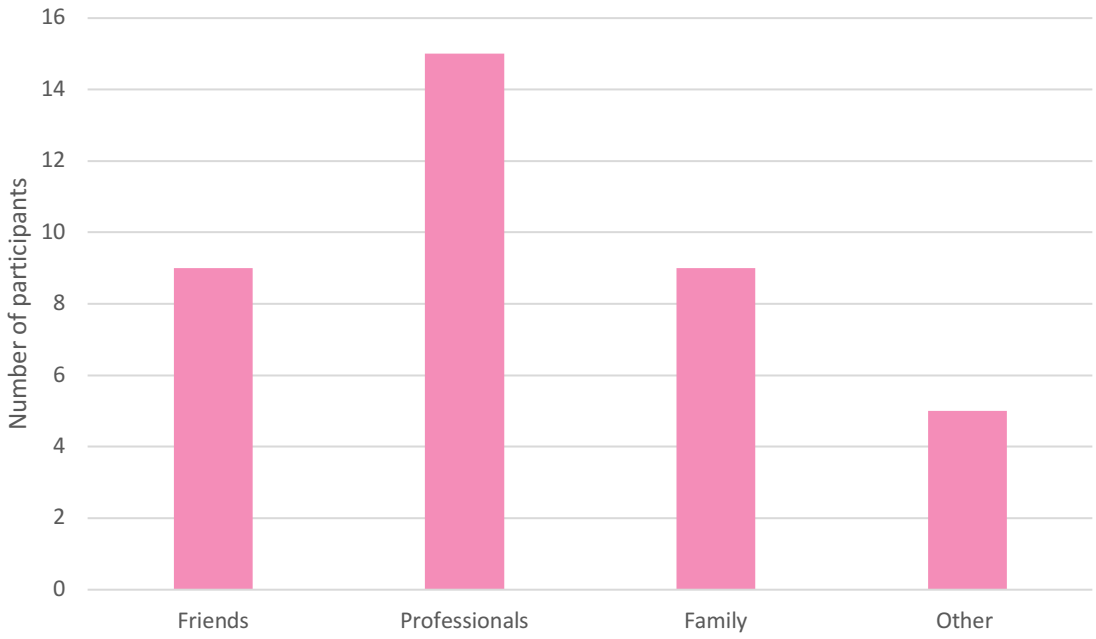


The number of survey participants that sought support following sexual violence was examined. There was a small difference observed in the participants' choices. Twenty (54.1%) participants did seek support whereas 17 (45.9%) did not seek support.

Of those that sought support, the sources of support were examined and are displayed in Figure 2. The majority sought support from professionals (75%), an equal proportion sought support from friends or family (45%) and 25% sought support from other sources. Of those other sources, 3 participants disclosed the source of their support, this included support from the Police and a workplace manager.

Figure 2

Type of Support Sought



3.2.1.5. Time after sexual violence: Some participants (48.6%) shared the period between their experience of sexual violence and the point at which help was sought. Two-thirds of these participants began the help-seeking process within one year of their experience. The remaining participants sought help over a year after their experience (Table 2).

Table 2

Time Period in which Survivors Sought Help

Time period	N	%
Within 1 month	6	33.3
Within 6 months	4	22.2
Up to 1 year	2	11.1
1-5 years	4	22.2
Over 5 years	2	11.1

3.2.2. Data Distribution

3.2.2.1. Reliability of measures: To assess the internal reliability of each measure Cronbach's alpha (α) was employed, as outlined in table 3. All measures were shown to have high internal consistency (>.80; Field, 2013) within this study.

Table 3

Internal Consistency of Measures

Measure	Cronbach's α
WE Mental Wellbeing Scale	.92
Short Self-Compassion Scale	.85
Depression, Anxiety and Stress Scale- Total	.95
Depression, Anxiety and Stress Scale- Stress Total	.83
Depression, Anxiety and Stress Scale- Anxiety Total	.83
Depression, Anxiety and Stress Scale- Depression Total	.92
Self-Comparison Scale	.84
Other as Shamer Scale	.95
Self-Concept Clarity Scale	.85

3.2.2.2. Parametric assumptions: To assess the data normality, exploratory analyses were employed. Histograms, P-P Plots and Q-Q plots were generated and visually inspected (Appendix V). In addition, statistics for Skewness, Kurtosis, and Kolmogorov- Smirnov were conducted. The Means (M), Standard Deviations (SD), Skewness (SK), Kurtosis (Rku) and Kolmogorov- Smirnov (K-S) are displayed in Table 4 for all measures including the three subscales of the DASS-21.

Table 4

Descriptive Statistics and Distribution Parameters

Measure	M	SD	SK	Rku	K-S
WE Mental Wellbeing Scale	43.35	9.13	-.30	-.42	.20*
Short Self-Compassion Scale	2.75	.72	.72	-.16	.15
DASS-21 Total	44.27	28.41	.65	-.40	.13
DASS-21 Stress	17.68	9.21	.42	-.49	.01
DASS-21 Anxiety	11.19	9.88	1.01	.39	.01
DASS-21 Depression	15.41	11.89	.52	-1.09	<.00
Self- Comparison	56.2	15.4	.01	-.31	.20*
Other as Shamer Scale	30.76	16.44	.10	-.48	.20*
Self-Concept Clarity Scale	30.35	11.77	-.62	.66	.20*

**Lower bound true significance*

The analyses indicated that all variables except the DASS-21 Stress, DASS-21 Anxiety and DASS-21 Depression subscales were normally distributed (K-S significance level >.05). As recommended by Tabachnick and Fidell, (2013) the univariate outliners were assessed for skewness. The DASS-21 Stress, DASS-21

Anxiety and DASS-21 Depression scores were converted into Z-scores. Z-scores greater than 3.29 ($p<.001$) are considered outliers (Tabachnick & Fidell, 2013). No significant outliers were identified following this process (Appendix W). In support, the relevant histograms showed skewness from a range of scores as opposed to extreme scores.

Skewed variables can cause standard error values to be inflated and thus inaccurate. Transformation of skewed variables can prevent this (Trafimow et al., 2019), however, it can make it more challenging to interpret analyses (Feng et al., 2014). Therefore, non-parametric tests were not used as they have less sensitivity than parametric tests and most variables were normally distributed (Field, 2013).

Bootstrapping techniques were utilised (based on 1000 bootstrap samples and 95% confidence intervals) for all analyses. The impact of skewed variables can be managed via bootstrapping as it calculates standard errors and confidence intervals (Boos, 2003).

3.2.3. Correlational Analyses

Pearson's correlation coefficients (*r*) were conducted to inform research questions 1 and 2. The association, strength, significance and direction of variables were explored. The correlations are displayed in Table 5. To reduce the likelihood of Type I errors, Bonferroni corrections were implemented (Field, 2013). As such, .05 p values were divided by the number of tests. As a result, coefficients were significant if $p < .01$.

Cohen's (1988) parameters were used to determine the strength of relationships. Weak (*r* = +/-.10- to +/- 2.9), moderate (*r* =+/- .3 to +/- 4.9) and strong (*r* = +/- .50 to +/- 1.0) correlations (Brydges, 2019).

Table 5

Pearson's Correlation Coefficients

Variables	WEMWBS	SSCS	DASS-21 Stress	DASS-21 Anx	DASS-21 Dep	DASS-21 Total	SCS	OAS	SCCS
WEMWBS	1.00								
SSCS	.50**	1.00							
DASS-21 Stress	-.48**	-.55**	1.00						
DASS-21 Anxiety	-.31	-.38*	.80**	1.00					
DASS-21 Depression	-.62**	-.56**	.77**	.72**	1.00				
DASS-21 Total	-.53**	-.54**	.93**	.91**	.92**	1.00			
SCS	.57**	.44**	-.22	-.17	-.39*	-.30	1.00		
OAS	-.52**	-.35*	.48**	.53**	.62*	.60**	-.44**	1.00	
SCCS	.04	.14	-.33*	-.35*	-.24	-.33*	.13	-.23	1.00

**Correlation is significant at the 0.01 level

*Correlation is significant at the 0.05 level

3.2.3.1. Research question 1- Is psychological wellbeing significantly associated with shame (external/internal), self-concept clarity or self-compassion: The bivariate correlation analyses suggested that psychological wellbeing was significantly associated with shame (internal and external) and self-compassion:

- Internal Shame (SCS)
  A strong positive relationship was found between SCS and WEMWBS (*r* = .57, CI= .35- .73), suggesting higher internal shame is correlated with lower psychological wellbeing.

- External Shame (OAS)
  A strong negative relationship was identified between OAS and WEMWBS (*r* = -.52, CI= -.71- -.29), suggesting higher external shame is associated with lower psychological wellbeing.

- Self-Compassion (SSCS)
  A strong positive relationship was detected between SSCS and WEMWBS (*r* = .50, CI= .27- .68) indicating higher levels of self-compassion are associated with higher levels of psychological wellbeing.

3.2.3.2. Research question 2- Is psychological distress significantly associated with shame (external/internal), self-concept clarity or self-compassion: The bivariate correlations indicated a significant relationship between psychological distress and self-compassion, external shame and self-concept variables:

- Internal Shame (SCS)
  No significant relationship was indicated between SCS and the DASS-21 Total (*r* = -.30, CI= -.55 to .01), DASS- 21 Depression (*r* = -.39, CI= -.63 to -.08)., Anxiety (*r* = .17, CI= -.47 to .14) or Stress (*r* = -.22, CI= -.49 to .08), suggesting internal shame is not associated with overall levels of distress, depression, anxiety or stress.

- External Shame (OAS)
  Strong positive relationships were detected between OAS and DASS-21 Total (*r* = .60, CI= .34 to .79) and Anxiety (*r* = .53, CI= .23 to .74). A moderate positive relationship was identified between OAS and DASS-21 Stress (*r* = .48, CI= .18 to .71). No significant relationship was found between OAS and DASS-21 Depression (*r* = .62, CI= .41 to .79, p >

.01). These findings suggest that higher external shame is related to higher levels of psychological distress, anxiety and stress. However no significant relationship between external shame and experiences of depression.

- Self-Compassion (SSCS)
  Strong negative relationships were found between SSCS and DASS-21 Total (*r* = -.54, CI= -.76 to -.26), Depression (*r* = -.56, CI= -.75 to -.31) and Stress (*r* = -.55, CI= -.73 to -.29). There was no significant relationship detected between SSCS and DASS-21 Anxiety (*r* = -.38, CI= -.62 to -.07, p > .01). This suggests that higher levels of self-compassion are significantly correlated to lower levels of psychological distress, depression and stress.
- Self-concept (SCCS)
  There were significant associations found between SCCS and DASS-21 Total (*r* = -.33, CI= -.63 to .05), DASS- 21 Depression (*r* = -.24, CI= -.58 to .14), Anxiety (*r* = -.35, CI= -.64 to .05) and Stress (*r* = -.33, CI= -.61 to .02) at the p > .01 level. This suggests that within this sample levels of SCC are not significantly associated with psychological distress, anxiety, stress or depression.

3.2.4. Multiple Regressions

A multiple regression model (Appendix X) was employed to address the research questions:

3. Is psychological wellbeing predicted by shame: (external/internal), self-concept clarity or self-compassion?
4. Is psychological distress predicted by shame (external/internal), self-concept clarity or self-compassion?

3.2.4.1. Assumptions: Multiple regression analysis requires several assumptions to be met (Field, 2013).

- Ratio of cases to predictor variables: For all regression models, the sample size recommendation is a minimum of 10 cases of data per

predictor (Nunez et al., 2011). As the current sample size did not allow for a model including all four predictor variables (internal shame, external shame, self-compassion and SCC) adjustments were made based on the correlational analysis.

SCC was not included as a predictor for psychological wellbeing as the two variables were not significantly correlated. Internal shame was not included as a predictor for psychological distress as these variables did not have a significant relationship.

- Homoscedasticity, linearity and normal distribution of errors: Multiple regression analysis requires the variance of errors to be equal across variables and for the independent and dependent variables to be linear (Bolin, 2022). The data plot of predicted values and standardised residuals demonstrated even distribution and most values fell between -2 and 2 (Tabachnick & Fidell, 2012; Appendix Y).
- Multicollinearity: Multicollinearity occurs when two or more predictor variables are correlated to one another, increasing the chance of error (Daoud, 2017). The VIF statistics were inspected to assess multicollinearity. The scores were above 0.2 and below 10 (cut-offs based on Menard, 1995), therefore there was no multicollinearity between the variables.

3.2.4.2. Regression model- wellbeing: The regression model including self-compassion, internal shame and external shame explained 46% of the variance in psychological wellbeing scores (F (3,33) = 9.35, p= <.00). Self-compassion and internal shame were individual predictors of psychological wellbeing. Specifically, participants with higher self-compassion (β = .26, p = .09) and lower levels of internal shame (β = .33, p = .03) were more likely to have higher levels of psychological wellbeing.

Table 6

Bootstrapped Multiple Regression Analysis

Variable	p	β	Bias	95% CI	SE beta
Self-compassion	.09	.26	.08	.17- 6.52	1.60
Internal shame	.03	.33	.01	.04- .38	.09
External shame	.06	-.16	.01	-.31 -.05	.09

3.2.4.3. Regression model- distress: The regression model including self-compassion, external shame and SCC explained 51% of the variance in psychological distress scores (F (3,33)= 11.50, p= <.00). Self-compassion and external shame were found to be individual predictors of psychological distress. Participants with lower levels of self-compassion were more likely to have higher levels of psychological distress (β= -.37, p = .03). Participants that experienced higher levels of external shame were more likely to have higher levels of psychological distress (β= .43, p = .01).

Table 7

Bootstrapped Multiple Regression Analysis

Variable	p	β	Bias	95% CI	SE beta
Self-compassion	.03	-.37	-1.33	-28.50 - -5.46	-.37
External shame	.01	.43	-.05	.13 – 1.19	.43
Self-Concept	.21	-.18	.03	-1.04 - .27	-.18

3.2.5. Moderation Analysis

Bivariate correlations found external shame and self-compassion to be significantly associated with psychological distress and the multiple regression suggested these variables significantly predict levels of psychological distress. The current findings and previous literature (Close, 2013) informed the following moderation analysis to explore research question 5*: Does self-compassion moderate the relationship between shame and psychological distress?*

3.2.5.1. Assumptions: Moderation analysis (Appendix Z) shares the same homoscedasticity, multicollinearity, independent errors and normality as regression tests (Fein et al., 2022) discussed above.

- Homoscedasticity, linearity and normal distribution of errors: The data plot of predicted values and standardised residuals demonstrated even distribution and the majority of values fell between -2 and 2 (Tabachnick & Fidell, 2012; Appendix AA).
- Multicollinearity: The VIF statistics were inspected to assess multicollinearity. The scores were above 0.2 and below 10 (cut-offs based on Menard, 1995), therefore there was no multicollinearity between the variables.

3.2.5.2. Moderation model: The interaction between self-compassion and external shame was not accountable for a significant proportion of the variance in psychological distress R^2= .53, F (3,33)= 12.18, p = .18. This suggests that self-compassion did not act as a moderator in the relationship between external shame and psychological distress.

3.2.6. Survey Content Analysis

Participants' responses to the open-ended survey questions were analysed using Content Analysis. Initial labels for responses were identified and then collapsed into content related categories (Elo & Kyngäs, 2008). An inductive and deductive framework guided the analysis to address research question 7: *What hinders and encourages black women to seek support following sexual violence?*

The categories and the amount related content appeared in the responses are detailed in Table 8. Focus on barriers and facilitators to help-seeking can be binary and limit the opportunity to understand interacting multisystemic factors (Zinzow et al., 2021). To exceed the limits of a binary perspective, the categories were formulated on different contextual levels to describe factors that influence help-seeking.

Table 8

Content Analysis

Category	Frequency
Safe spaces	14
Validation	9
Victim blaming	5
Lack of protection	5
Silencing survivors	5
Shame	5
Advocacy	4
Service inaccessibility	4
Access to psychological therapy	3
Understanding Black women's needs	2
Doubt in systems	2

3.2.6.1. Relational factors: Participants particularly valued validation (9 times) from mental health professionals. This was highlighted as a key factor in positive experiences of help-seeking.

3.2.6.2. Service-related factors: Participants suggested that service inaccessibility (4 times) was particularly tiresome and for others, it contributed to them not seeking support at all. This suggests that services need to be accessible, for example regarding location and points of contact, to allow maximum engagement. Services facilitating safe spaces (14 times) which allow for full emotional expression was valued by the participants and encouraged the use of services. The perceived absence of safe spaces hindered help-seeking. The opportunity for advocacy (4 times) and access to psychological therapy (3 times) via services contributed to a positive experience for survivors.

3.2.6.3. Interacting factors: The widespread phenomenon of victim blaming (5 times) was apparent to the participants. Whilst some had explicit experiences of victim blaming, others were concerned about the potential of being blamed. Victim blaming led to feelings of shame (5 times) among the participants. Victim blaming could also lead to the systematic lack of protection (5 times) faced by women. The apparent lack of understanding of Black women's needs (2 times) that permeates society made participants feel isolated. This may intersect with the lack of protection, leading survivors to express doubt in systems (2 times) thus inhibiting help-seeking.

3.3. Thematic Analysis

TA was used to analyse data from interviews, using guidance outlined by Braun and Clarke (2012). Both deductive and inductive approaches were used to develop themes. Multiple thematic maps were created and refined to produce the final thematic map. A 'top-down' and 'bottom-up' approach was employed, guided by the research questions:

6. How do black women understand their identity in relation to their experience of sexual violence?
7. What hinders and encourages black women to seek support following sexual violence?

3.3.1. Interview Sample Demographics

All participants were given the opportunity to self-define their demographics, to move away from identity categories that can be limiting and homogenising (Fakin & Macaulay, 2020). Five women were interviewed in total. All participants were able to stop or reschedule their interviews, however, none did. None of the participants withdrew their data or made contact for additional support following the interview. All data relating to the participants will be discussed under their given pseudonyms.

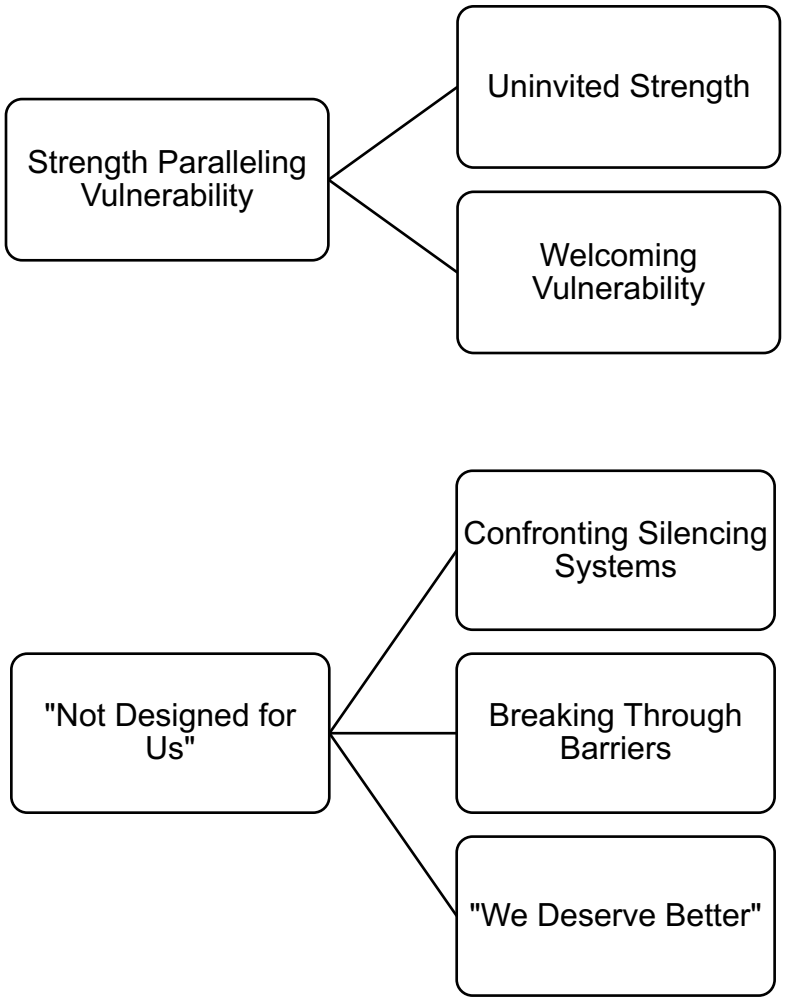
- Lisa, late 20's, Black Caribbean
- Fiona, early 30's, Mixed Black
- Yvette, mid 20's, Black African
- Hanna, late 20's, Black British
- Melanie, late 20's Black Caribbean

3.3.2. Theme Development

The codes were organised into an initial thematic map which was then refined by a process of induction and deduction (Appendix AB), to generate internal homogenous and external heterogenic themes (Patton, 1990). The final thematic map can be seen in Figure 3.

Figure 3

Final Thematic Map



3.4. Theme One: Strength Paralleling Vulnerability

This theme describes the complexity of strength following sexual violence. The two subthemes (*Uninvited Strength* and *Welcoming Vulnerability)* explore the perceived need to be strong. Participants discussed the systems that place an expectation of unwavering strength on Black women. In response to this expectation, Black women may lean into strength and value its ability to support them through the aftermath of sexual violence. However, participants reflected on the double-edged sword that is strength and discussed how they still seek space for vulnerability.

3.4.1. Uninvited Strength

Participants discussed the perceived need to uphold strength following sexual violence. For example, Melanie explained:

> *"[M]y mental health was really, really impacted. So, I had like… I had depression, I had PTSD, I was having panic attacks… to the point that I couldn't work. Umm. But after it happened, I felt like I had to just keep going. I had to be strong. I had to be resilient. I couldn't stop".*
>
> Melanie

Earlier in the statement, Melanie recognised the impact of sexual violence was detrimental to her psychological wellbeing and consequently, her career. However, she *"had to be strong"*. Melanie's repetition of the phrase *"I had to"*, indicates that being strong was the only option she felt she had. This suggests that even in times of turmoil there was no opportunity for recuperation, as would be recommended by mental health professionals. She only had the option "*to be strong*". Melanie went on to state *"I feel like as a black woman, I feel like I have to be strong. I can't like be down and out".* This suggests that Melanie's perceived need to endure the impact of sexual violence is unquestionably linked to her identity as a Black woman.

Fiona further discussed the need for perpetual strength:

> **"***But the thing was, there was no time or opportunity to even really be on the floor. I suppose internally I was, but you know, externally I had to continue*

> *earning. I had to deal with all the legal situation. I had to, you know, there were all these things that I had to do. There was no rest."*
>
> Fiona

Fiona too recognised there was no opportunity for vulnerability following her experience despite describing herself as internally *"on the floor".* This phrase suggests that Fiona was experiencing severe levels of psychological distress. It is noteworthy that Fiona referenced what was happening *"externally"*. When she expressed a need to *"continue earning"* and to *"deal with all the legal situation"* she was clearly speaking to societal systems in which she and other women must navigate following sexual violence. From this narrative, it is evident that the need to be strong is a response to a system that offers no other options, opposed to originating from an intrinsic source of unwavering strength.

Participants reflected on the origins of strength. Hanna spoke about her experience of cultural *"narratives"* within the Black community and stated, *"I feel like there's a lot of encouragement to sort of . . . be tough"*. Hanna recognised there to be an explicit community endorsement of enduring hardship. However, she and other participants considered this within the context of a wider sociopolitical and historical system. Melanie explored this at a service level.

Melanie described her experience with White professionals within services:

> **"***I felt like they had no empathy for me. I kind of wondered if it was because I was Black, because if it was a White woman sitting in front of them, would their empathy levels be different? Because I know people tend to view black women as strong."*
>
> Melanie

Even within a system designed to help, Melanie found that professionals robbed her of empathy due to unspoken expectations for Black women to be *"strong".* This speaks to how the expectation of strength is silently communicated in relational dynamics. Fiona recognised that services do not exist within a vacuum when she stated, *"colonial hierarchies that are implicit in the design of everything".* Hanna and Fiona discussed the wider context that silently and insidiously pressurises Black women to be 'strong'.

> "*They don't expect us to feel pain and I think that comes from colonialism. I think that comes from slavery, that comes from a lot of historical oppression. But like, we feel pain just as much as anyone else, if not more, sometimes and, because of what we go through and yeah, we're supposed to just shoulder it and not talk out, not speak up."*
>
> Hanna

> "*As a society, right, which is misogynistic. But of course, we're talking about Bailey's misogynoir. Yeah. Paternalistic. Misogynistic. Racist. You know, all intersecting in this sort of minimizing of the humanity, or the validity or the deservedness or the softness and vulnerability."*
>
> Fiona

Hanna spoke to the legacy of slavery and colonialism. She recognised that this historical context continues to oppress Black women and Fiona used Moya Bailey's (2010) misogynoir to name the oppression specifically relating to Black women. Both Hanna and Fiona recognised that Black women experience *"softness", "vulnerability"* and *"pain",* with Hanna arguing this to be even more so than other women due to what they *"go through"*. This is the acknowledgement of how oppression makes Black women particularly vulnerable in comparison to their counterparts. Hanna recognised that despite their vulnerability, Black women are expected to remain resilient. Considering this, it is understandable that Black women may lean into the notion of strength as a necessity to endure the hostility of their context and benefit where they can. Melanie spoke to this, stating "*I've started a career . . . done like 3 degrees. And I've been able to do that because of that strength and that resilience"*.

For Fiona, strength offered an opportunity for a spiritual experience. She spoke of being "*able to access levels of power"* that resided *"very, very deep . . . on that sort of more spiritual level*" which helped her to endure *"some of the darkest moments"* following sexual violence. Fiona explained that she believed this *"connect[ed] [her] to the women before [her] and the women before them".* Fiona's connectedness to her ancestors may speak to the longstanding existence of oppression. Just as Black women within Fiona's lineage would have had to conjure strength and power to survive oppression, Black women within the current society must do the same. As society continues to mirror history, and literature outlines how this comes at the price

of human lives, one may question how and if society is capable of allowing space for Black women's vulnerability that is crucial to their survival.

3.4.2. Welcoming Vulnerability

Participants reflected on the consequences that come along with expectations to be strong. Hanna expressed that the continued pressure for Black women to be strong is nonsensical when considered in context. Hanna explained Black people are "*still being told that [they are] really strong",* but there is an *"overrepresentation of Black people in the mental health system"* which to Hanna was *"a contradiction".* Within this discourse, Hanna acknowledged that Black people are in high need of caring spaces for their psychological wellbeing. However, society continues to communicate that Black people are the embodiment of strength, which excludes them from such spaces putting them at risk of severe difficulties.

Participants spoke about how the strength placed on Black women impacts their wellbeing. Hanna spoke about this in relation to loved ones, *"I've seen that in my family. I've seen that in my friend circles and it's not healthy . . . we need to be able, to talk about our feelings".* Melanie also explored this concerning her wellbeing. After discussing the benefits of being *"strong"*, Melanie discussed the other side of strength. *"You might push yourself too much to the point that you're burning out, or you don't feel like you can rest or relax or feel your emotions because you have to keep going*". She later stated that this *"impacted [her] mental health over the years".* Melanie acknowledged that pursuing relentless strength can be hurtful in the long term, as women may be at risk of *"burning out".*

From the discourse, it is evident that the survivors had spent time considering and witnessing the impact of 'being strong'. They expressed their desire to relinquish this expectation to allow space for vulnerability. Yvette spoke about how she welcomes "*humanity"* as she believes that *"we can have expectations of people. . .but not at the detriment of their health or their mental wellbeing".* Melanie also shared this sentiment stating, *"I don't have to keep on being strong or pretend like I'm fine, but I can feel my emotions and then rebuild".* This suggests that Melanie gave herself permission to be vulnerable to her emotions before proceeding with action. These statements are indicative of how the survivors wish to challenge the expectation placed on them as Black women. Within context, their desire for vulnerability can be

perceived as an act of resistance against the systems that communicate that Black women's vulnerability is not welcome.

3.5. Theme Two: "Not Designed for Us"

This theme captures participants' nuanced experiences and perceptions of professionals and mental health services. The three subthemes: *Confronting Silencing Systems, Breaking Through Barriers* and *"We Deserve Better"* describe the journey of seeking support, the welcomed and disappointing aspects of support once accessed as well as the systemic changes the survivors wish to see.

3.5.1. Confronting Silencing Systems

Participants explained they had reached a point of crisis, that had some "*fearful"* (Fiona) for their mental health before considering support. Participants discussed the cultural and structural barriers they met when considering help-seeking.

Hanna and Yvette recognised the familial and cultural responses to help-seeking:

> **"***I feel like there's a lot of encouragement to sort of keep things in the family or keep things close to your heart and be tough and not necessarily, umm… talk about your problems so, I think that stereotypical or that cultural sort of narrative can be difficult when you're trying to open up or when you're trying to seek help."*
>
> Hanna

> *"Black families, the idea of getting seeking help is frowned upon. Like shouldn't God be enough to just heal you? Like you should pray, pray more. You know, like if you pray more then it would all go away."*
>
> Yvette

Hanna highlighted that families could encourage the concealment of distress. This promotion of silence within cultures can be difficult to navigate when attempting to find support. Yvette added to this notion, highlighting that not only is there a "narrative" that indirectly discourages help-seeking, but it is actively "*frowned upon*" as there are other methods of support, such as prayer, that are favoured. Hanna also

recognised certain types of support are excluded from the range of options when she said, "*There's a perception that therapy is not for us, as Black women, sometimes in the Black community".* Hanna and Yvette learned to not openly share their distress outside of the family. The message conveys a cultural expectation of how one goes about recovery. Extrafamilial support, particularly therapy, is viewed as fundamentally not suitable for Black women.

Fiona further explains the ideas behind this deterrence:

> ***"****I was brought up by a mom who, since I was as young as I could remember, made it very clear, like not to trust white people about a lot of things. Don't tell people your business, beyond anything else, don't tell white people your business was the rule."*
>
> Fiona

Fiona learned to keep her "*business*" private as White people are not to be trusted. Fiona described this to be a "*rule*", suggesting there to be a rigid cultural expectation to not speak openly about distress, similarly to Hanna and Yvette. One could infer that breaking such a "*rule*" could come with ramifications.

Yvette explained the perceived consequences of going against the cultural expectation of silence. She spoke of how "*not making the family proud and not living up to what one is meant to"* can be difficult. There is a pressure to not share hardships as the community "*may look down*" on a person and be seen as though "*they betrayed their family…or that they betrayed their community*". Understandably, feeling as if they have betrayed their community could be paralysing for survivors in the pursuit of support, as this could risk ostracisation during a time that can be extremely challenging.

Participants explained that those able to reconcile the cultural expectation of not seeking support are faced with service procedures that act as structural barriers to help-seeking. At the first stage, participants communicated a lack of clarity around what services were available to them and how to access them. Yvette, who at the time was contemplating support, questioned "*where would they be? I'm not sure where to find them"*. Fiona shared this sentiment when she explained her initial process of reaching out:

> "*You know like different charities, and they have a line, and they say just call. And I thought 'Oh OK, I'll call them. They'll be able to signpost me. They'll be able to because I'm just not OK right now and I don't understand what's out there'".*

Fiona

From Fiona's experience, it appeared that third-sector organisations acted as a middleman between her and mental health services. Raising questions about the visibility of services and clarity of their processes, especially for those in need. Participants explained that their "*mental health got really bad*" (Lisa) and they were "*just not OK*" (Fiona) however their accounts suggest that the onus is on the individual to act as their "*own trauma administrator"* (Fiona). This could be arduous as *"trying to look for a suitable [service]. . . [is] so triggering it's so heavy"* (Fiona). Fiona explained the emotional impact of seeking services:

> "*And that's sort of bewildering when you're traumatised and you've found a way to try and explain, so someone gets it so they can answer your question. You know, you're just shot then like it would take me like couple weeks or, you know, whatever before I even build the energy to do it again."*

Fiona

Fiona described the "*bewildering*" process of speaking to professionals to get support and then needing time to "*build energy*" following this. This suggests that services' lack of visibility makes help-seeking exhausting to the point where women may feel unable to speak openly. Fiona explained that she needed weeks to feel able to continue with the help-seeking process. However, this may not be the experience for all. Some may require longer or decide to not continue with the process at all. Services exist within a sociopolitical context, in which some women may face additional oppressive systems that impact their ability to start and/or maintain a search for services. As such, it could be suggested that the perceived invisibility of services could silence women. The search for allusive service entry points may be too arduous for women with limited resources, discouraging them from help-seeking and silencing them in the process.

Participants described the difficulties they faced once they found a service. Waiting times were particularly frustrating for Lisa, Fiona and Hanna. They described the wait time for support as "*really long"* (Hanna) with the wait time "*over a year long"* for Fiona. Lisa shared that by the time she was at the top of the waiting list, "*therapy was not anything to with…[her] sexual trauma".* Lisa went on to discuss that she was offered a "*finite amount of sessions"* and explained the consequences of this:

> "*How do I decide out of everything that I'm going through, everything I've experienced that this one thing I have experienced should be the priority? Maybe it's this other problem that I wanna talk about. I think it's like hard to really prioritise that way. Who has the power to be like actually, we can let people get support from us for as long as they want. You know, I don't think that's the reality of the NHS right now, is it?"*
>
> Lisa

This suggests that between initially seeking support and being able to access therapy, enough time had elapsed where her trauma was no longer at the forefront of her difficulties or perhaps one could theorise that speaking about sexual violence within a limited time frame could feel insufficient. Lisa supported this sentiment when stating that there is "*pressure"* to talk about *"traumas in session one with someone [you] haven't even built rapport with yet"*. This may speak to an underlying power dynamic that implies that survivors should be ready to speak about their sexual violence experiences when and for how long professionals decide. For some, the perceived pressure to divulge all details of their experience within a finite timeframe could discourage them from engaging in services. Without the opportunity to establish a substantive therapeutic relationship, women may prefer not to speak about their experiences to protect themselves from being left disappointed or unfulfilled by an offer of limited support. Therefore, limited packages of care could be deemed as silencing those in need.

In attempts to bypass lengthy wait times, some participants were willing to explore private support. Fiona, Yvette and Hanna spoke about the financial cost of this. The expense of therapy can impede survivors from getting substantial support if any at all. In support, Yvette expressed that cost has limited her options for professional help, stating, *"I don't feel like I have the money to keep going, to keep paying for it".*

This in conjunction with excessive waiting times, highlights the dilemma systems place on survivors. Survivors are faced with the option of managing the emotional impact of sexual violence alone for long periods before accessing support or *"spending money [they] do not have"* and deciding whether they can *"afford proper therapy or have [their] needs or bills met"* (Fiona). This could be particularly detrimental to the most marginalised women. If economically disadvantaged women are unable to access timely statutory services or pay for private services, they will be left without access to valuable professional resources and thus be silenced by the system process.

3.5.2. Breaking Through Barriers

Participants described the welcomed aspects of therapy. Some participants spoke from experiences of therapy whilst others shared their desires for therapy. Hanna and Yvette discussed the importance of a safe space. For Yvette, therapeutic safety could offer an "*environment that [her] body can feel also that it's safe, that [she could] share, then maybe would allow [her] to remembe*r". For Hanna a "*safe space for talking with a therapist [was] exactly what [she needed]".* This discussion suggests that a safe space can be both physically and psychologically necessary. Sexual violence violates psychological and physical boundaries, jeopardising the holistic health of the individual. Although therapy is considered to solely focus on psychological wellbeing, it is apparent that safe spaces offer the opportunity for survivors to restore both physical and psychological wellbeing.

Participants described the mechanisms through which safety can be achieved. Hanna explained that *"there shouldn't be a sense of judgement"*. Yvette supported this when she stated individuals should *"feel welcomed and accepted"*. They both later went on to explain how a therapist can display a non-judgmental and welcoming space when *"they just listen"* (Yvette). Hanna explained that her therapist *"will listen to what [she has] got to say and then reframe… and then put it back to [her]".* Hanna stated that this "*validates"* her feelings. Melanie further added to this when speaking about how questions are asked in a *"gentle way"* within therapy, which supported her in feeling able to speak openly about her experiences. These thoughts show the value of core therapeutic skills.

Participants also discussed what they felt was missing from their therapeutic experiences - particularly, support from a Black therapist. Hanna stated that she

“specifically wanted a black therapist… a black female therapist”. Hanna added to her comment by specifying the gender of the therapist she wished for. This suggests that Hanna had considered how the impact of race and gender were important to her when discussing sexual violence. She later divulged:

> “*[T]here's always an element of misogynoir, like sometimes there's a shaming of you as a woman, but then there's a racial lens as a black woman as well. And sometimes that's why you need a black therapist because you don't wanna feel like you’re being subjected to racism and or sexism in the space that you're trying to heal.”*
>
> Hanna

Hanna’s reference to misogynoir recognises the intersectional discrimination that Black women can be exposed to. She acknowledged that racism and sexism can be present in therapy despite it being intended as a space *“to heal”.* This is an interesting quote from Hanna as one would expect that a therapeutic space exists to be beneficial and non-judgemental - a refuge from subjugation. However, it is apparent that the oppression of Black women is so insidious it can infiltrate a space dedicated to wellbeing. Black women are so privy to how oppression operates they are tasked to stay aware of it even after sexual victimisation, as society fails to protect them. Staying valiant to discrimination is an emotional burden placed on Black survivors additional to the psychological consequences of sexual violence.

Fiona shared similar sentiments stating that she *“didn't know how much [she] understood that [she] would need culturally appropriate care”* before going on to explain experiences with White professionals:

> “*[T]hey wanted me to go to some charity that was not equipped because it was nice white people. And I was just like, I'm not going to put myself in a room with anymore nice white people who are not going to… because the damage of them only being able to discuss half the experience is like more trauma, more harmful, not more traumatising, but it's more harmful at this stage in my recovery than just making sense of it with support from [redacted] a mixed black woman training to be a therapist.”*
>
> Fiona

Fiona used the phrase *"nice white people"* suggesting that she recognised that the professionals were well-intentioned, but as she explained, good intentions do not exonerate professionals from enacting harm on Black women. The comment regarding White therapists *"only being able to discuss half of the experience"* is likely to reference *"the racial lens"* discussed by Hanna. This suggests that aspects of race are left taking up zero per cent of the therapeutic space despite it being perceived as at least fifty per cent of the experience at hand. It could be inferred that this was a repeated experience for Fiona as she did not want to speak with White professionals *"anymore",* suggesting that she had experienced a series of microaggressions from White professionals. As such, it is evident that the survivors' interest in having a Black therapist was not driven by preference but by a need to protect themselves from harm.

Alongside the potential harm that can arise from not having a Black therapist, participants discussed the impact this can have on the therapeutic experience and relationship. Hanna reflected on the relational consequences that could arise, explaining "*you have the risk of it being not as understanding a place as you'd want. Uh, so I tried to really [not] get that experience*". Being understood was also of importance to Yvette. She shared her wishes for a therapist *"who kind of understands the dynamic … of how families and cultures work, especially in Black families and Black cultures".* She also expressed her desire for the therapeutic experience to be *"like you're talking to a grandma".* This suggests that a level of understanding, relatability, and care, similar to that she may have with an older relative, would be an important element of the therapeutic relationship alongside conceptual knowledge of culture and family systems. Without this, one could suggest that the therapeutic relationship is limited. Hanna explained the importance of understanding within therapy. "*So that you feel that when, whilst you're trying to heal, you're not also putting up fences or trying to defend yourself or explain yourself in therapy".* This suggests that, without the element of a shared understanding, Black survivors may feel they need to enforce personal boundaries to mitigate the emotional impact of being misunderstood. This could have consequences:

> "*I think that's a lot of the reason why a lot of us don't go to get help is because we don't believe we're gonna be listened to or we're not believed that we're gonna be… We're not gonna feel that we can relate to our therapist."*
>
> Hanna

Here Hanna suggested that a lack of understanding from a therapist can impact the likelihood of Black survivors seeking therapeutic support.

3.5.3. "We deserve better"

The participants discussed the changes that need to occur to provide Black women survivors with the care they deserve. Participants spoke about multi-level, structural changes.

When asked for suggestions on how services could be improved, Yvette said "*the first that comes to mind is for Black women to be able to know that these professional services are there. They are available*". This suggests that services need to increase their visibility, speaking to inaccessibility previously discussed. Lisa also discussed changes in service availability, "*if there was a way that services ensured that people are not gonna be like discharged after a certain amount of sessions".* This statement displays how important having undetermined amounts of time is to Lisa and potentially to other survivors.

Some participants discussed the need for change in the education and training of service professionals. Fiona said, *"some little module in therapy training for every white therapist, [where they have] to learn about people of colour so they can be culturally responsive".* Hanna also agreed that issues of race should be incorporated into education. She also discussed how such training could manifest within the therapeutic space:

> "*I think questions such as ... 'Would you like a black therapist? Would you like a black female therapist? Do you feel that your experiences have taken on an element of racism in them? Do you feel that your experience is taken on an element of sexism?'"*
>
> Hanna

Hanna shared that explicit questions relating to race and gender issues are "*really important to ask".*

Despite these suggestions, Fiona also recognised that training White professionals may not be comprehensive enough of a measure when she stated "*they're still going to perpetuate more harm. Even with the best intentions*". This speaks to how training and education cannot compare to lived experience. The racialised and gendered oppression of Black women cannot just be learned via theory, it is an experience that *"nobody seems to understand apart from other black women"* (Fiona). The survivors acknowledged this when they made suggestions for the training and platforming of Black professionals. Hanna expressed the need for "*the NHS [to]. . . train and hire more . . . Black female psychologists".* Hanna specified the NHS, suggesting her desire for Black professionals to be accessible for free opposed to privately sought after being denied the option via the NHS.

Fiona discussed this further:

> "*I think we've been fixing it for ourselves or supporting each other for a very long time. And I think that support just needs to be recognised, valued, supported and by that, I mean funded and platformed. And have doors opened and stages yielded that mean that you know, those who are equipped and are becoming equipped can support our sisters with this f*****g problem."*
>
> Fiona

Fiona suggests that Black women are *"equipped"* to support each other and have been doing so for *"a very long time"* however her request for these women to be *"funded and platformed"* alludes to systemic failures that have not allowed Black professionals to be accessible. Fiona went on to recognise that the suggestion would require *"bigger cultural, societal, legal changes",* highlighting the macrolevel change that would need to occur to provide effective and inclusive support that Black survivors of sexual violence deserve.

4. DISCUSSION

4.1. Overview

This study aimed to contribute to and develop the current literature surrounding shame, psychological wellbeing, self-concept and self-compassion as it pertains to Black women survivors of sexual violence. This chapter will explore the sample characteristics and data within the relevant context and, research questions. The study's limitations, strengths and implications are outlined as well as an evaluation of the research's quality and suggestions for future research. Researcher reflexivity is revisited before concluding thoughts are shared.

4.2. Quantitative Findings

4.2.1. Survey Sample

The disparities between the survey 'completers' and 'non-completers' were assessed to understand the demographic information of the sample and situate the research within the wider context. There was an observable difference regarding the cultural background of the participant groups. The 'completers' were predominately of African heritage. Women of Caribbean heritage made up the next largest proportion of the 'completers' followed by those that identified as Black of other descent. Within the Black population that occupies the UK, 62% are of African descent, 26% are of Caribbean descent and 12% are of other descent (Garlick, 2022) as such the sample within this study can be considered representative of the wider population.

Most respondents were aged 23-32. This could reflect the user demographics of the online platforms used for recruitment. Fifty-nine per cent of Instagram users are under the age of 35 (Dixon, 2023) and the largest proportion of Twitter users are between the ages of 13 and 34 (Dixon, 2022). Due to the limited age range of participants, generalisation of the findings to younger or older women should be tentative.

4.2.2. Contextualisation of Findings

The mean scores for each variable will be compared to previous studies to contextualise the findings. Standard deviations, where possible, will also be presented given the limitations of the mean as a central tendency measure (Manikandan, 2011). Due to Black women's lack of representation within the literature, findings are compared to studies with differing populations, which will be specified. The participants' sexual violence experiences will also be explored in relation to previous research. All conclusions are to be considered tentative due to the study's small sample size.

It is the position of the researcher to not assume the organic presence or absence of the variables within the participants. To avoid further contributing to the pathologisation of Black women (Ussher, 2017) the participants' experiences of the concepts will be considered a response to a wider context.

4.2.2.1. Psychological wellbeing: The average WEMWBS score (M= 43.35, SD= 9.13) was higher than studies including non-black women survivors (M= 36.85, Grace et al, 2002) but lower than a general population of women (M= 50.3; Stewart-Brown & Janmohamed, 2008). Although these were the only studies available for comparison, this suggests that participants within the current study experienced higher levels of psychological wellbeing than other survivors. However, they had lower psychological wellbeing than those without disclosed experiences of sexual violence. Whilst it cannot be assumed those in the general population study had not experienced sexual violence, this sample's score speaks to the significant psychological impact of sexual violence (Jina & Thomas, 2013; Leserman, 2005; Tavara, 2006).

4.2.2.2. Self-compassion: The participants had a lower average score on the SSCS than women survivors of differing cultural backgrounds in other studies (M= 4.05, SD= 1.28, Cazeau, 2015) suggesting fewer experiences of self-compassion for these participants than in other studies. Cultural differences could account for the discrepancy observed (Montero-Marin et al., 2018). Alternatively, elevated experiences of shaming discrimination and stereotypes may limit self-compassion (Kanyeredzi, 2018).

4.2.2.3. Psychological distress: No available studies have measured the total DASS-21 score with Black women. In comparison to nationally normed scores, the mean total DASS-21 score of the current sample (M= 44.27, SD= 28.41) were significantly higher (M= 9.43, SD= 9.66; Henry & Crawford, 2005). These findings were consistent with other studies that suggest women of African and Caribbean descent experience elevated levels of psychological distress following sexual violence (Catabay et al, 2019; Sigurvinsdottir et al, 2020). Given this increased risk of psychological distress, care for Black women's psychological wellbeing should be a priority within clinical settings.

4.2.2.4. Internal shame: Mean SCS scores (M= 56.16, SD= 15.36) were notably lower than previous sexual violence studies with non-black women (M= 78.13, SD= 18.93; Berber Celik & Odaci, 2012) and women without disclosed experiences of sexual violence (M= 59.11, SD= 17.30; Gorry, 2021). This indicates that the survivors compared themselves less favourably to others and thus experience higher levels of internal shame.

Cultural context and temporal shifts have been suggested to influence levels of internal shame. For example, increased social media use is associated with elevated negative social comparisons (Lup et al, 2015). As the opportunity for social comparison increases via social media Black women may be at risk of elevated levels of internal shame (Verduyn et al, 2020). As Social Rank Theory (Gilbert, 2000) suggests, it is possible that as society places a 'lower' social status on Black women, they have an increased likelihood of internal shame experiences.

4.2.2.5. External shame: The average OAS score (M= 30.76, SD= 16.44) was lower than in studies with non-black women survivors (M= 37.04, SD= 14.65, McLean, 2021). Although the scores were more elevated in other studies, high levels of external shame were indicated within this study. This could indicate the participants experienced shaming from others and/or a perceived sense of inferiority. This aligns with the literature suggesting external shame may be amplified for Black women survivors due to sociocultural and political factors that subjugate and blame them for experiences of sexual violence (Dworkin & Terri, 2021; Fontes & Plumber, 2010).

4.2.2.6. Self-concept clarity: The mean SCCS score (30.35, SD= 11.77) was lower than sexual violence studies including non-black women (M= 42.79, SD= 10.24,

Lassri et al, 2022). This suggests the participants experienced lower levels of SCC than those in other studies. Research indicates cultural differences in SCC (Campbell et al, 1996) which could explain the observed difference. This would align with Intersectional Feminism that acknowledges identity differences between Black and non-black women. The historic invalidation of Black women's womanhood and identity (Crenshaw, 2006; Zounlome et al., 2019) could influence SCC. Additional research exploring Black women's experiences could further understanding of SCC differences.

4.2.2.7. Sexual violence experiences: The participants reported a wide range of experiences, which is noteworthy given the national low report rate to services (Stripe, 2021).

Participants in the current study experienced a wider range of sexual violence than non-black women in other studies (Black et al, 2010). The current findings display the experiences of a small cohort of Black women. Nevertheless, they suggest Black women are at risk of a wide range of violence, as supported by National statistics showing their disproportionate likelihood of victimisation within the UK (Stripe, 2021).

Within this study sample, more survivors sought support (54%) than the estimated amount that disclose within the national context (17%; Stripe, 2021); indicating that survivors of African and Caribbean heritage are open to support, despite the literature suggesting them to be a 'hard-to-reach' population (Kovandžić et al, 2011).

4.3. Discussing Research Questions

To address the research questions, the data is discussed and considered in relation to the relevant research and theoretical context.

4.3.1. Research Question 1: Is Psychological Wellbeing Significantly Associated with Shame (External/ Internal), Self-Concept Clarity or Self-Compassion?

The strong relationships found between psychological wellbeing and both internal and external shame indicate that those that experience higher levels of shame, whether internally or externally, may be prone to lower levels of psychological wellbeing. This is consistent with the Biopsychosocial model of shame (Gilbert, 2006) as experiences of shame elevate the individual's threat responses

consequently comprising psychological wellbeing. As discussed, Black women's experiences of shame may be heightened due to their societal subjugation. Considering this, it is apparent that the psychological wellbeing of all Black women may be compromised due to systemic shaming however, this may be exacerbated by sexual violence experiences. This has been discussed within the literature as Black women face double- victimisation from sexual violence as well as systemic oppression (Collins, 2000).

The strong positive relationship found between self-compassion and psychological wellbeing indicated that elevated levels of self-compassion are related to better psychological wellbeing. According to the CFT model, this relationship is to be expected as self-compassion is suggested to disable the threat response triggered by shame. The current findings support the model and tentatively add to the literature suggesting self-compassion is positively associated with psychological wellbeing (Close, 2013; Craig et al., 2020).

There was no significant relationship found between SCC and psychological wellbeing. This is a surprising result as previous studies have suggested SCC to be positively associated with psychological wellbeing (Ritchie et al, 2011). However, this is the first study to explore this relationship with Black survivors. There is a complex sociocultural and political landscape surrounding Black women's identity formation and maintenance (Nnawulezi & West, 2018; Oyserman et al., 2012; Showers & Zeigler-Hill, 2012). The experiences of migration and systemic invalidation may impact self-concept (Ryan & Deci, 2012; Zou et al., 2007). Therefore, further investigation, with a larger sample, may be warranted.

4.3.2. Research Question 2- Is Psychological Distress Significantly Associated with Shame (External/ Internal), Self-Concept Clarity or Self-Compassion?

Interestingly, no significant relationship was found between internal shame and overall psychological distress. This result was surprising considering that the participants displayed elevated levels of internal shame and previous research suggests shame to be related to psychological distress, especially for survivors of sexual violence (DeCou et al., 2017; Sarkar & Sarkar, 2005; Timblin & Hassija, 2022; Vidal et al., 2007). However, significant associations were found between external shame and overall psychological distress. The relationship found between external shame, which was not present for internal shame, may speak to how shame is

experienced within Black women. Within this sample, shame from others was particularly distressing. This could be acutely relevant to Black women whose femininity and sensuality have been shamed by external narratives and power structures for decades (Donovan & Williams, 2002; Hill Collins, 2000; Kanyeredzi, 2018).

The associations found between self-compassion and psychological distress indicated that increased levels of self-compassion are related to decreased psychological distress. Again, these findings are consistent with the CFT model and indicate that self-compassion could be useful in reducing psychological distress among Black women. Nevertheless, as shame experiences and how they relate to psychological distress could be different for Black women is it important that these findings are considered tentatively, and further research is conducted to explore these relationships.

The relationship found between SCC and overall psychological distress suggested that higher levels of SCC are associated with lower levels of psychological distress. This is in line with previous findings displaying the protective nature of a coherent and stable self-concept (Campbell et al., 2003; Cicero, 2017; Lassri et al., 2022; Ritchie et al., 2011; Schiller et al., 2016). This finding may be particularly important for women of African and Caribbean descent. Black women are continually marginalised, and their identity is questioned by contradicting Controlling Images (Hill Collins, 2000) that both glorify and diminish their womanhood (Ashley, 2013). As such, initiatives that promote a secure self-concept could be beneficial in reducing psychological distress in Black survivors of sexual violence.

4.3.3. Research Question 3: Is Psychological Wellbeing Predicted by Shame (External/ Internal), Self-Concept Clarity or Self-Compassion??

Due to sampling limitations and the results of the correlational analysis, only self-compassion, internal shame and external shame were included as predictor variables in the analysis.

Previous studies have not explored the predictive relationships between shame variables, self-compassion, and psychological wellbeing despite documented associations (Aakvaag et al., 2016; Bhuptani & Messman, 2021; Burmeister et al., 2018; Ritchie et al., 2011).

Self-compassion and internal shame were found to be predictors of psychological wellbeing. As previous studies have not explored the predictive relationships between these variables, comparisons cannot be made. Nonetheless, these findings were consistent with the postulates of CFT and the Biopsychosocial model of shame. As this study explored two types of shame, the findings contributed a more detailed understanding of the relationship between shame and psychological wellbeing in the literature. Professionals can tentatively consider decreasing the experience of internal shame and increasing self-compassion within Black women survivors to support their psychological wellbeing.

4.3.4. Research Question 4: Is Psychological Distress Predicted by Shame (External/ Internal), Self-Concept Clarity or Self-Compassion??

Due to sampling limitations and the outcome of the correlational analysis, only self-compassion, external shame and SCC were included as predictor variables in the analysis.

The analysis suggested that self-compassion and external shame are predictors of psychological distress. Specifically, the analysis indicated that higher levels of self-compassion predict lower levels of psychological distress. Additionally, higher levels of actual or perceived shame from others predict elevated psychological distress. Therefore, supporting Black women with self-compassion as well as interventions to destigmatise experiences of sexual violence could lessen the psychological distress of survivors. To support destigmatisation, services and wider contexts need to explore how they can cultivate compassion to avoid the responsibility being put onto Black women to do so. Marginalisation and discrimination faced by women of African and Caribbean heritage can be incredibly shaming (Bains, 2010). Therefore, systems should hold the responsibility to foster compassion alongside Black women. Interpersonal compassion could be achieved through individual working relationships or within service structures by adopting a Trauma Informed Care approach (Forkey et al., 2021).

4.3.5. Research Question 5: Does self-compassion moderate the relationship between shame and psychological distress?

As no significant association was found between internal shame and psychological distress, the moderating effect of self-compassion between external shame and psychological distress was investigated.

Self-compassion was not found to have a moderating impact on the relationship between external shame and psychological distress. This was a surprising finding given previous research displaying self-compassion's strong association and moderating impact on shame and subsequent psychological distress (Bhuptani & Messman, 2021; Close, 2013). As the literature reiterates the relationship between self-compassion and shame (Neff, 2003, Craig et al, 2020), further investigation with larger samples may be warranted. Conversely, this study displayed that external shame was particularly salient for the participants and this should be accounted for when considering self-compassion as an intervention for Black women. Black women face pervasive shaming discrimination (Collins, 2000; Kanyeredzi, 2018), which may not be sufficiently addressed by self-compassion alone. External sources of compassion, via clinical work and systemic change that prioritises Black women's care may be required.

4.4. Qualitative Findings

4.4.1. Interview Sample

Five women were interviewed. To move away from the limitations of identity categories, the participants self-defined their demographics.

Providing a voice to the participants was of the utmost importance, therefore the researcher heavily considered how to include quotes within the work. Some spoke more extensively than others, hence some quotes were longer as to not silence or misrepresent their contributions.

4.4.2. Research Question 6: How do Black Women Understand their Identity in Relation to Their Experience of Sexual Violence?

The Strength Paralleling Vulnerability theme highlighted the nuance of strength. External expectations of perpetual strength and the participants' desire to relinquish these expectations for vulnerability was explored through the subthemes.

The 'strong Black woman' narrative has been promoted for decades (Hill Collins, 1998). Literature suggests that for women of African and Caribbean descent this narrative is paradoxical by nature (Kanyeredzi, 2018; West et al., 2016) and this was the experience of the participants in the current study. The women spoke about how they drew upon strength to survive the aftermath of sexual violence. The 'Uninvited Strength' subtheme recognised how the narrative was created and perpetuated

through systems. Whilst some recognised the benefits of leaning into strength, they also recognised the emotional toil and shared their decision to abandon the notion of unwavering strength to welcome vulnerability. The discourse highlighted the need for structural and ideological reform that provides the opportunity for Black women to have the space for vulnerability and recovery from sexual violence.

The survivors spoke about how their psychological wellbeing was impacted following sexual violence. Despite clear indications of distress, the survivors explained that they leant into strength to navigate systems following their experiences. This implies that strength operated as a form of survival, which could be argued to be present for all women regardless of race (Sink & Saint-Arnault, 2020). Yet, the women's comments suggest that strength was inextricably linked to their identity as Black women. This is consistent with literature that has documented Black women's accounts of the 'strong Black woman' narrative and the perceived need to comply to embody a salient aspect of their identity (Beauboeuf-Lafontant, 2007; Kanyeredzi, 2018; West et al., 2016). It is apparent that this identity script was significant following sexual violence.

The 'strong Black women' narrative can produce a complex dissonance. Whilst the narrative can create opportunities for personal development and empowerment, it also dehumanises leaving little space for vulnerability (Kanyeredzi, 2018). This was apparent for the women in the current study. For some participants, leaning into strength allowed them to pursue career aspirations or cultivate an enhanced spiritual connection to women in their lineage. However, the women also acknowledged that long-term endurance impacted their wellbeing to the verge of burnout. Some participants did not discuss their own experiences but shared how they had noticed that perpetual strength impacted loved ones and other Black people within society. This shows that the women were aware of the paradoxical nature of the strong Black women narrative which has been documented by participants in other studies (Beauboeuf-Lafontant, 2007; Kanyeredzi, 2018; Mintah, 2022). Understandably, the juxtaposition of the narrative was at the forefront of the discussions. Black women are unable to escape the systems that underpin their lived experience (Crenshaw, 1989). One could suggest that these considerations did not begin following sexual violence but were perhaps exacerbated by the experience, as the survivors had to

grapple with the realities of upholding expectations of strength whilst creating space to care for their psychological wellbeing.

Discussion within the 'Uninvited Strength' subtheme related to the legacy of the 'Mammy' and 'Matriarch' controlling images that are well-documented in the literature (Donovan & Williams, 2002; Hill Collins, 1998). For one participant the insidious expectation of strength led to a help-seeking experience void of empathy. Unfortunately, this participant's experience was consistent with previous studies that exposed the inequitable care experienced by service users due to racially charged stereotypes (Gran-Ruaz et al, 2022). This highlights how the wider context manifests within all facets of society (Bryant-Davis et al., 2010) and the participants named this when speaking to misogynoir and the "*colonial hierarchies that are implicit in the design of everything"*. The discourse surrounding the wider context showed that the notion of strength was placed upon the participants rather than being an organic part of the Black experience (Kanyeredzi, 2018). It is important to recognise that systems situate this notion of strength within Black women. Black women are often problematised and depicted as hyper-independent without consideration of the systemic factors at play (Lueng & Williams, 2019). Societal and organisational acknowledgement of this may be key to developing inclusive and effective services. Black women value vulnerability as observed in the "Welcoming Vulnerability" subtheme but are not often afforded the space for it, as has been illustrated in the literature (Kanyerdezi, 2018; Mintah, 2022). Care providers should be conscious to not explicitly or implicitly communicate strength as a disposition within Black women, as this can contribute to the silencing and damaging impact of racism within UK-based services (Papadopoulos et al, 2004) which can hinder the use of services (Sue, 2001).

4.4.3. Research Question 7: What Hinders and Encourages Black Women to Seek Support Following Sexual Violence?

The survey and interview participants discussed their experiences of help-seeking, providing insight into the hindering and facilitating factors.

4.4.3.1. Content analysis: The survey participants shared multiple relational, service-related and interacting systemic factors when considering the facilitating and hindering aspects of help-seeking.

On a service level, inaccessibility and inconsistency within services hindered utilisation. This is consistent with reviews on the accessibility of services for women following gendered violence (McCathy & Birchall, 2022). For the participants, the opportunity for advocacy and psychological therapy was of value. Thus, service inaccessibility and inconsistency may prevent women from accessing valuable resources. Therefore, services should evaluate their service pathways and modify areas of inaccessibility to facilitate help-seeking.

The need for safe spaces was referenced most frequently, displaying an appreciation and desire for psychological safety within help-seeking experiences. For Black women who navigate multiple levels of systemic injustice, the threat of racism and sexism is ever present, even within spaces designated for wellbeing (Papadopoulos et al, 2004; Rennison, 2014). Therefore, creating a validating space is vital, as subtle forms of misogynoir can infiltrate safe spaces and impede help-seeking.

Participants' expressed doubt in helping systems may be in response to systemic neglect and lack of understanding of Black women's needs. The survivors have lived experience of intersecting forms of societal oppression (Crenshaw, 1989) which serves as a backdrop to sexual violence experiences (Dworkin & Terri, 2021; Fontes & Plumber, 2010). The oppressive context permeates service structures and results in damaging institutional racism (Papadopoulos et al, 2004). Additionally, the oppression underpins cultural narratives and controlling images that place the responsibility of sexual violence on Black women (Hill Collins, 1998). The possibility of victim blaming was salient for the participants and may have interacted with feelings of shame thus hindering motivation to seek support. Participants may have experienced high levels of distress following sexual violence, however, the risk of experiencing a lack of protection from services may have been perceived as more detrimental. Justifiably, some could avoid help-seeking to protect themselves from this risk.

4.4.3.2. "Not designed for us": The findings within this theme suggest that services with substantial resources, knowledge and skills are crucial in catering to the experiences of Black women, as there can be cultural and structural barriers to help-seeking.

In support of Ullman and Lorenz's (2020) study, some participants explained there was a cultural expectation to not seek support from extrafamilial sources, which is important to contextualise. The participants' quotes implied the expectation was underpinned by a mistrust rooted in historical oppression. This is consistent with research displaying Black people's awareness of harmful institutionalised racism within UK-based services (Lacobucci, 2022; Keating, 2002; Papadopoulos et al., 2004). Whilst racist ideologies continue to run rife within systems, cultural narratives cannot be seen as the sole reason Black women may not seek support. Therefore, the responsibility for changing this narrative should not be solely held by Black people. Systems must change their practices to ensure the safety and unprejudiced care of Black people. Until this happens, the cultural expectation of silence may continue, and Black women will understandably not help-seek as a way of enforcing psychological boundaries to protect themselves from systemic harm.

Participants that did go through the process of help-seeking were faced with structural hindrances in the form of service invisibility, long wait times and finite sessions. Literature has outlined the potential lifelong impact of sexual violence, with survivors being at risk of chronic psychological distress (Brooker & Durmaz, 2015; Campbell et al, 2009; Dworkin et al, 2017). Hence, limited therapeutic input can be viewed as an insufficient intervention in the face of long-term consequences. The participants expressed dissatisfaction with the number of sessions offered indicating that they would value more leniency which is consistent with findings from Thira and Roy (2020) who found participants appreciated long-term and flexible support following sexual violence. To enable substantive care provisions, commissioners should take a longitudinal perspective and consider the possible chronic impact of sexual violence when funding services, as without the opportunity for long-term support survivors may not seek help.

Although participants valued a validating and welcoming space once in therapeutic services, the lack of available Black therapists was apparent for the survivors. Their expressed desire and active search for a Black woman therapist are consistent with findings from Mintah (2022) and Ullman and Lorenz (2020). The survivors were vocal about the misogynoir that could emerge in therapeutic spaces if the professional was not privy to the social, political, cultural and historical context that creates intersecting oppression for Black women; a concern that has been also well-

documented (Tillman et al, 2010; Washington, 2001). As such, the participants were cautious of the psychological harm they could be subjected to with a White therapist, even with the best intentions. Accordingly, Black survivors may be reluctant to seek support from non-black professionals, perhaps as a psychological and social boundary to protect themselves from further traumatisation (Tyagi, 2001). These reflections are in line with those from Mintah's (2022) study, where survivors also stated that having a therapist that "*looked like them*" (p, 82) was of great importance.

The arduous search for a Black therapist was exhausting for the survivors and resulted in them having to make a potentially financially damaging albeit understandable decision to seek private therapy. One cannot assume that all Black women would prioritise having a therapist with shared lived experience (Mintah, 2022), however, it not being a readily available option is concerning and for some participants deterred them from services. When considering the needs of women who are perpetually marginalised, organisational leaders must acknowledge that Black women may be priced out of safely healing, left alone to manage the detrimental impact of the sexual violence enacted on them.

The participants' experiences and perceptions of help-seeking informed the multi-level structural change ideas they shared. People of African and Caribbean descent are often positioned as a 'hard to reach' population (Kovandžić et al, 2011) situating the problem within them. Diversity and inclusion initiatives often problematise populations and suggest that they do not help-seek (Cortis, 2011). However, the participants' request for increased visibility of services suggests that they are open to the right types of support if services are clearly advertised. Therefore, it should be for services to ensure that their pathways are easily accessible, perhaps by bringing the service to the community opposed to putting responsibility on Black women to seek help (Bess et al., 2009).

Participants discussed the need for the training and platforming of Black-ran services and therapists within the NHS. For some participants upskilling the workforce with the relevant sociocultural knowledge would result in care that explicitly considers race (i.e., through questioning that opens discussion for race issues). Although some participants noted the benefit of non-black professionals having relevant cultural knowledge, they also expressed that this would be insufficient. This speaks to the

indescribable power of lived experience which the survivors acknowledged when suggesting macrolevel changes to support the employment of Black therapists in the NHS. These suggestions are not new, previous literature has made similar recommendations (e.g., Mintah, 2022; Papadopoulos et al, 2004; Thira & Roy, 2020; Ullman & Lorenz, 2020) however the survivors' discourse casts a further spotlight on the need for change.

4.5. Implications and Recommendations

The current findings highlight the importance of addressing Black women's experiences of sexual violence. Their experience is situated within a sociocultural and political context that has an insidious impact on psychological wellbeing and help-seeking experiences. The implications of these findings are discussed at different systemic levels.

4.5.1. Clinical Practice

The data suggests that experiences of psychological distress, internal and external shame may be significant for women of African and Caribbean heritage following sexual violence. Self-compassion was significantly associated with psychological wellbeing and distress, suggesting that cultivating self-compassion could be beneficial for psychological wellbeing. Thus, interventions geared towards improving self-compassion, such as CFT, could be of some utility. CFT and its benefits have been well researched (Leaviss & Uttley, 2015; Millard et al, 2023). However, Black women are underrepresented within the literature thus knowledge of CFT within their relevant sociocultural context is limited.

Within this study, self-compassion was not a significant moderator between external shame and psychological distress. This may be relevant to the sociocultural context that has not been extensively explored within the literature. Black women experience elevated levels of external shame via damaging stereotypes (Dworkin & Terri, 2021; Fontes & Plumber, 2010; Hill Collins, 2000) which may not be significantly moderated by self-compassion. Consequently, the effectiveness of individual interventions for those who experience system levels of discrimination may be limited, particularly for individuals who experience intersecting oppressions (Purdie-Vaughns & Eibach, 2008). Therefore, clinicians need to be conscious of not

problematising those who have difficulty with self-compassion. It is crucial to not situate the problem within survivors and acknowledge the impact of continuing systemic failings.

From the survivors' discourse, it was apparent that Black women value safe spaces where they can feel a sense of connectedness to other Black women. As such, group interventions, facilitated by Black professionals, may offer a meaningful and validating space where interpersonal compassion can challenge shame and bolster wellbeing (Gilbert & Irons, 2009).

Within the survey sample, there were differences in the time taken to seek support. However, as reflected in the survivor's interviews, the help-seeking process is nuanced and may only happen at the point of crisis. The survivors discussed the complex cultural and social factors that promote strength and endurance and limit help-seeking. Therefore, professionals should be considerate of the significance of Black women's choice to seek support. The women should be met with empathy and a welcoming space that validates their journey. The women should be afforded the time to speak or communicate in a method best suited to them, given the potential of retraumatisation and revictimisation within services (Ahrens, 2002; Balsam et al, 2010; Campbell, 2005; Campbell et al, 2001).

The survivors shared the desire to welcome vulnerability opposed to tirelessly adhering to the strong Black woman narrative. As reflected in the current discourse and literature, professionals can be influenced by controlling images that perpetuate stereotypes (Kanyeredzi, 2018; Nash, 2009). It is for psychologists and other professionals to be aware of, interrogate and address any gendered racial bias they may hold when working with Black women. This can be supported within supervision or anti-racist reflective practices facilitated by certified practitioners.

Participants across both aspects of the study shared their concerns about being misunderstood and their needs being unmet. The women expressed their desire for a Black therapist due to assumed shared understanding. Currently, clinical psychology is a predominately White, middle-class profession. Whilst the funding, education and platforming of Black therapists are required those already within the profession can make changes within their current capacity of continuous professional development (CPD). Psychologists should participate in training and pursue personal

research opportunities to understand Black women's experiences (Hawkins, 2011). It is crucial that the psychologists then incorporate their learning with existing skills of individualised formulation ensuring they do not homogenise the Black women they work with. Within the study, cultural factors were highlighted by the participants. The researcher is of the position that the cultural experiences shared in relation to help-seeking were in response to systemic oppression. As such, it is recommended that psychologists who learn about the relevant context work to acknowledge the cultural factors within a similar framework as to not problematise culture and perpetuate harmful systemic oppression.

4.5.2. Service Policy

The findings suggest that the accessibility of services is crucial for women seeking support following sexual violence. Organisational leaders need to acknowledge that Black women may be left alone to manage the detrimental impact of sexual violence if unable to access services. Whilst the use of the word 'services' suggests this discussion solely applies to statutory agencies; it is hoped that there is utility for a variety of organisations.

Long waiting times and ambiguous pathways were of concern for the survivors and can exacerbate distress (Imkaan, 2018). Services can review their current policies and procedures for their visibility, inclusivity and effectiveness in providing specialised support for Black women. As highlighted by the survivors and literature, colonial legacies permeate service structures (Papadopoulos et al, 2004). An anti-oppressive, intersectional framework that captures, addresses and regularly reviews the needs of Black women, should be incorporated into the design of services. The remodel of services should be operationalised in conjunction with paid survivors and professionals of African and Caribbean descent.

To support the CPD of staff, services can provide mandatory and protected time for learning informed by anti-racist practices and delivered by specialist practitioners (Thiara & Roy, 2020). Training sessions can target and address the prevailing stereotypes which can cause harm within therapeutic spaces.

4.5.3. Local and National Policy

The threat of sexual violence is pervasive and scaffolded by the sociopolitical landscape. Preventative measures to address these factors are crucial. The government have recognised the need for primordial intervention in the Violence

Against Women and Girls (VAWG) 2021 to 2024 strategy (Home Office, 2021). It is vital that the mentioned preventive measures, such as campaigns to raise awareness, are used alongside the other suggested interventions. As discussed, colonial legacies are rampant and the potential for them to emerge in new initiatives is an ongoing risk. Thus, preventative strategies should be developed with a specialist working group of Black women survivors and professionals to assess their efficiency in addressing the relevant sociocultural factors that impact Black women's experience of sexual violence.

Policy leaders should also ensure the incorporation of intersectionality and Critical Race Theory in the education programmes of clinical psychology and other professions. Integrating this learning in the early stages of career development could support the creation of a critically minded and inclusive workforce.

4.6. Future Research

This study contributed to the limited literature exploring Black women's experiences of sexual violence within the UK. As discussed, there is an underrepresentation of African and Caribbean heritage women within research. Further research is required to offer a fuller understanding of Black women's experiences of psychological wellbeing, psychological distress, self-compassion, shame, identity, and help-seeking in relation to sexual violence. Furthermore, these concepts must be explored with consideration of the relevant sociocultural and political context.

The current research suggested relationships between shame, self-compassion, self-concept, psychological wellbeing and psychological distress. A larger sample size would allow for these relationships to be further understood. For example, the moderating effects of self-compassion between shame and psychological distress could be explored.

African and Caribbean women are often homogenised within research; however, their identity formation and experiences are nuanced. To understand and contextualise their needs in more depth, future research could divide the population into smaller groups, for example by migration generation, sexuality or culture.

Black women are often misrepresented within the research and thus may be reluctant to participate (Few et al, 2003). This study highlighted the concerns that

survivors can have when speaking to a non-black person. Where possible, Black researchers, academics and/or organisations should be funded to lead or consult on each step of the research. However, this may not completely eradicate recruitment difficulties, as observed in the current study. Although this study's researcher was a Black woman, there were challenges with recruiting a large sample, perhaps due to the sensitivity of the topic. Therefore, it could be useful to create psychological safety and protection within the design of the study, which may allow women to feel safe enough to participate. Participatory action research approaches and working in partnership with community organisations could support future studies in creating non-problematising methodologies and encourage participation.

4.7. Critical Review

Quantitative research should be evaluated on its ability to reach study objectives and provide generalisability (Coughlan et al., 2007). Exploration of the appropriateness of statistical tests employed, questionnaire reliability and validity, and evaluation of the constructs investigated can help ascertain generalisability.

The statistical tests used were appropriate for the sample size and addressed the research questions (i.e., met the study aims). The chosen measures demonstrated validity and reliability within the study and in previous research. As discussed, the study variables have been investigated individually but not collectively within a sample of Black women. Thus, exploration of the constructs from a non-diagnostic lens was a strength of the study, offering a nuanced understanding of how they are experienced by Black women.

Yardley's (2015) principles were used to evaluate the qualitative component's sensitivity to context, commitment and rigour, coherence and transparency and impact and importance. See Appendix AC a for a fuller evaluation of the study's quantitative and qualitative components.

4.8. Limitations and Strengths

4.8.1. Sample and Diversity Issues

The small sample size within both strands of the study limited the generalisability of the findings. In regard to the quantitative analysis, the power of the statistical analyses was limited, which increased the possibility of Type II errors (Banerjee et al, 2009). Much of the survey sample was aged 23-32 years old. The five survivors interviewed were predominantly in their late twenties, with one being in their early thirties. The limited range of ages means that the experiences of younger or older women were not qualitatively captured and underrepresented quantitatively. Generational differences can be significant due to temporal changes in the sociocultural context that influence experiences (Stern, 2002). Generational differences are both closing and widening with the development of social media (Bolin & Skogerbø, 2013), meaning it is as important as ever to capture insights across age groups.

The study focused on sexual violence within a heteronormative context. Although one participant explicitly identified as bisexual, other participants described sexual experiences with men only. Furthermore, the inclusion criteria specified individuals that self-identified as Black women. Although it cannot be assumed that all participants were cisgendered women, due to the study's focus, the experiences of Black LGBTQ+ people have not been represented within this research, meaning the findings cannot be extrapolated to this population.

All participants were recruited online, which made the research accessible to a wide range of participants. However, the recruitment strategy also limited participation to those who use social media or have access to relevant technology. Consequently, the voices of those that do not use technology were excluded.

4.8.2. Online Interviews

Conducting interviews via video chat opened the study to a wide geographical area and to those who could have been disadvantaged by travelling to a physical location (i.e., by travel costs or health conditions). Online interviews can simulate similar experiences as face-to-face interviews (deVilliers et al, 2022). For example, it was possible to establish a rapport and observe aspects of non-verbal communication. Nonetheless, technical difficulties arose during some interviews. Whilst participants

were asked to repeat sentences that were disrupted, one cannot be certain that they felt comfortable speaking at length once again as technical disruptions may have been unsettling, especially given the sensitivity of the topic.

4.8.3 Mixed Methods Approach

The study's mixed methods design was a strength as it offered the participants an element of choice. The participants were able to choose whether they took part anonymously via the survey with the opportunity to speak at length in response to the open-ended questions. Those that wanted to share their thoughts verbally were able to do so via the interviews. The choice could have been particularly important for survivors whose right to autonomy has been violated by sexual violence. Allowing the survivors to speak about their experiences how and if they wanted to, could have been a source of empowerment (Ross, 2017).

Furthermore, the quantitative and qualitative aspects of the study complemented each other. Whilst the quantitative data highlighted relationships between variables the qualitative aspect offered context to these findings. For example, the levels of external shame indicated in the quantitative analysis were contextualised by the interview participants' accounts of shaming societal narratives and expectations.

4.9. Revisiting Researcher Reflexivity

The importance of examining the social positioning of a researcher was discussed in the method chapter. Here I share my reflections on how aspects of my identity shaped various stages of the research.

Recruiting participants online felt exposing. The increased public awareness of race issues has received great encouragement as well as pushback (Nguyen et al, 2021). I was aware of how my focus on Black women could receive backlash from those resistant to the liberation of racialised communities. As a Black woman, I felt vulnerable to online racism because of my study. I was conscious of how this could have limited my recruitment drive. However, despite a small number of disparaging comments, the overwhelming positive engagement highlighted that many valued the research. This was a motivating experience that solidified my desire to produce a piece of work that centred Black women and had utility.

Immersing myself in literature about the oppression of Black women was emotionally tumultuous. Racialised and gendered oppression is a part of my lived experience. I am heightened to the subjugation of Black women and the risk of sexual violence. Therefore, at times, reading about intersectional oppression and sexual violence exacerbated my sensitivity to these issues. Regular breaks and discussions with my supervisor helped the emotional exhaustion that periodically accompanied the research.

Engaging with the interview transcripts was difficult. The possibility of vicarious trauma via research is well documented (Elmir et al, 2010). Reviewing the content of the survivors' experiences reiterated the ever-present threat of misogyny and sexual violence. I was conscious of the potential of vicarious trauma and found refuge in speaking to other women. My community were vital during this part of my research.

A conversation with a survivor highlighted the importance of language to me. She spoke about how terms used to describe survivors can infer that the crime was a passive act and minimise the perpetrator's role. Although I positioned myself as an ally, I was conscious of how as the researcher, I was in a position of power and could perpetuate harmful narratives in the language used. I was continuously conscious of maintaining the integrity of what was said when presenting the survivors' quotes. I wanted the survivors' voices to shape the study as opposed to me contorting the discourse to fit the research aims. I was clear with my intentions for the study with the participants with the hopes of diminishing power dynamics. However, I remained conscious that the power dynamics could not be completely eradicated.

Overall, the work allowed me to engage with and channel my core values. I was able to critically engage in and present material that I believe has great potential for social change. For me, the process has emphasised psychology's critical role in liberation, policy change and service development.

4.10. Conclusion

This study was the first to explore the psychological wellbeing, psychological distress, identity, and help-seeking experiences of Black women survivors within the UK.

The quantitative findings suggest that Black women's psychological wellbeing is particularly compromised following sexual violence. Black women may experience elevated levels of psychological distress associated with high levels of internal and external shame and lower levels of self-compassion. The qualitative themes and subthemes illustrated how societal narratives influence Black women's perception of strength and vulnerability. Help-seeking experiences were shown to be complex, silencing and influenced by sociocultural and political factors.

Acceptance, care and understanding of Black women's needs are impactful. These sentiments need to extend beyond individual clinical practice to the policy, education, and service development on a local and national scale. Future researchers and policymakers can work with survivors, professionals and academics of African and Caribbean heritage to centre their voices and address the needs of Black women across different system levels. It is a collective effort and moral obligation to dismantle oppressive structures and build services that survivors of African and Caribbean descent deserve.

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6. APPENDICES

Appendix A: Arksey and O'Malley's (2005) Steps to Scoping Reviews

1. Identify the aim of the search
2. Identify the relevant studies, including grey literature
3. Review the selected studies
4. Record the characteristics of the studies
5. Summarise and report the study findings

Appendix B: Literature Search Terms and Flow Chart (Review One: Black Women and the Impacts of Sexual violence)

The literature search to identify relevant papers included the following search terms:

- "sexual violence" OR "sexual assault" OR "rape" OR "forced sex" OR "unlawful sex" OR "sexual coercion" OR "non-consensual sex" OR "non consensual sex" OR "sexual harassment"

AND

- "women" OR "woman" OR "female"

AND

- "black" OR "black British" OR "African American" OR "African" OR "Caribbean" OR "black American" OR "Black English" OR "Black African" OR "Black Caribbean"

AND

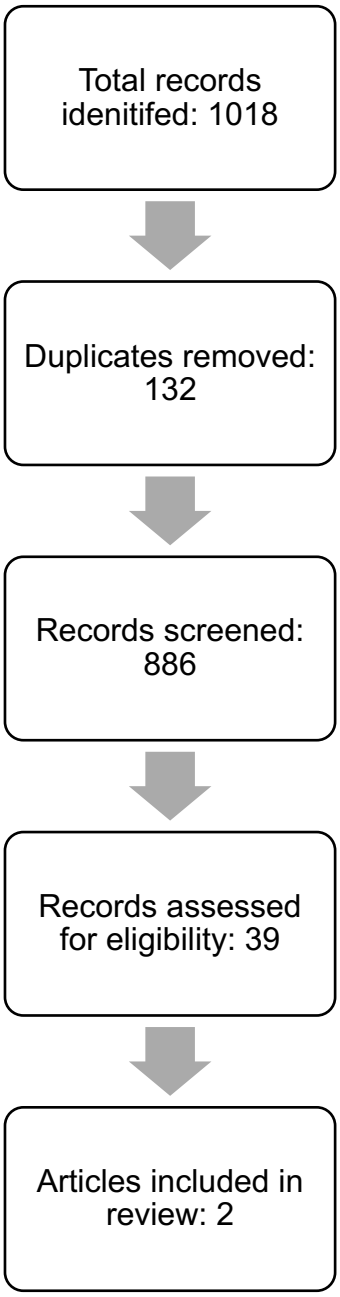
- "compassion" OR "self-compassion" OR "mental health" OR "psychological wellbeing" OR "psychological distress" OR "identity" OR "self-concept" OR "shame" OR "self" OR "wellbeing" OR "distress"

Inclusion criteria:

- Studies that include a measure of psychological wellbeing and/or distress
- Studies that focus on black women aged 18+
- Studies that explored sexual violence experienced in adulthood

Excluded criteria:

- Not including black women in study
- Not written in English
- Not conducted within the UK or USA


Total records idenitifed: 1018
Duplicates removed: 132
Records screened: 886
Records assessed for eligibility: 39
Articles included in review: 2

Appendix C: Literature Search Terms and Flow Chart (Review Two: Black women and help seeking)

The literature search to identify relevant papers included the following search terms:

- "sexual violence" OR "sexual assault" OR "rape" OR "forced sex" OR "unlawful sex" OR "sexual coercion" OR "non-consensual sex" OR "non consensual sex" OR "sexual harassment"

AND

- "women" OR "woman" OR "female"

AND

- "black" OR "black British" OR "African American" OR "African" OR "Caribbean" OR "black American" OR "ethnic minority" OR "BAME" OR "BME" OR "minority ethnic"

AND

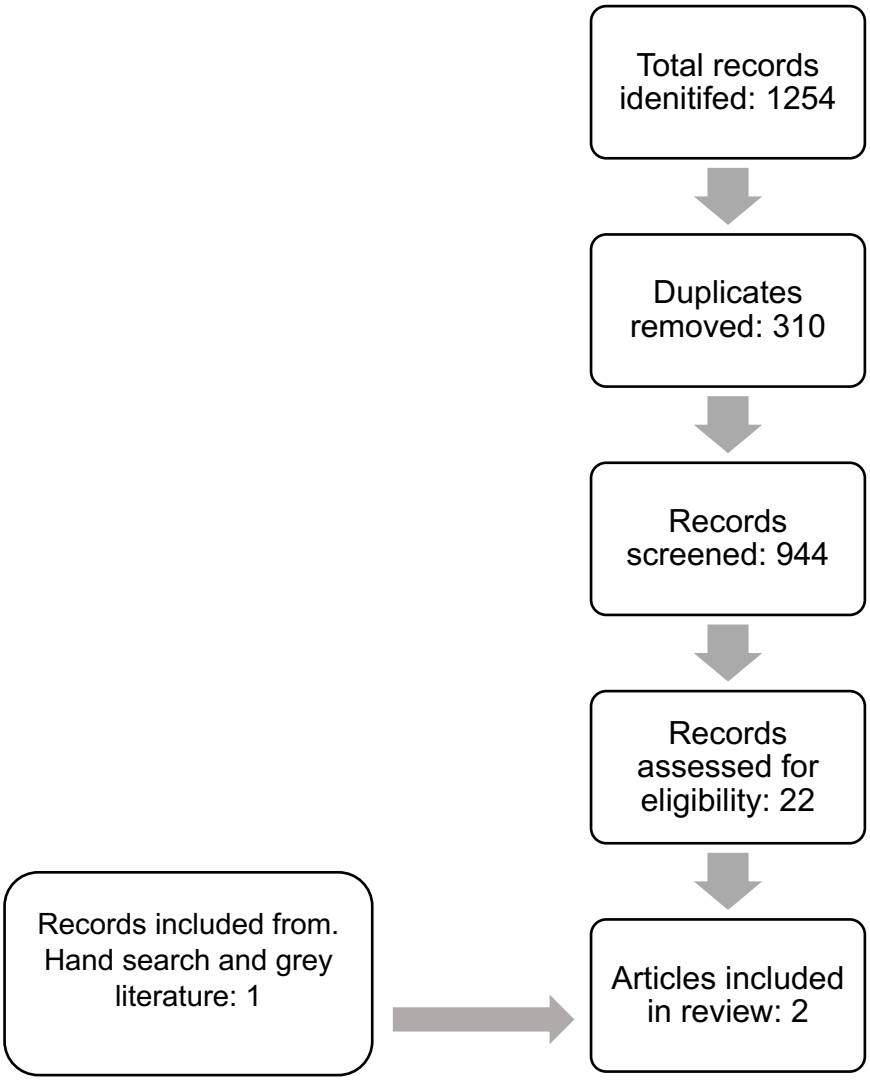
- "help seeking" OR "help-seeking" OR "support" OR "help" OR "social support" OR "services" OR "barriers" OR "report" OR "disclosure"

Inclusion criteria:

- Studies that include explore help-seeking experiences
- Studies that focus on black women aged 18+
- Studies that explored sexual violence experienced in adulthood

Excluded criteria:

- Not including black women in study
- Not written in English
- Not conducted within the UK or USA


Total records idenitifed: 1254
Duplicates removed: 310
Records screened: 944
Records assessed for eligibility: 22
Records included from. Hand search and grey literature: 1
Articles included in review: 2

Appendix D: UEL Ethical Approval

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details	
Reviewer:	Kenneth Gannon
Supervisor:	Trishna Patel
Student:	Amani Milligan
Course:	Prof Doc in Clinical Psychology
Title of proposed study:	Exploring shame, mental health, compassion, identity, and help-seeking in Black women who have experienced sexual violence

Checklist (Optional)			
	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☒	☐
Detailed account of participants, including inclusion and exclusion criteria	☒	☐	☐

Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☒	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☒	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	X☐	☐	☐
Clear and detailed outline of data collection	☒	☐	☐
Data collection appropriate for target sample	X☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☒
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☒
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☒	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☒	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☒	☐
If required, General Risk Assessment form attached	☐X	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	X☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☒	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☒
If required, a DBS or equivalent certificate number/information provided	☐	☐	☒
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☒	☐	☐
All relevant information included in the participant information sheet (PIS)	☒	☐	☐
Information in the PIS is study specific	☒	☐	☐
Language used in the PIS is appropriate for the target audience	☒	☐	☐
All issues specific to the study are covered in the consent form	☒	☐	☐
Language used in the consent form is appropriate for the target audience	☒	☐	☐

All necessary information included in the participant debrief sheet	☒	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☒	☐	☐
Study advertisement included	☒	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☒	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study	
Please indicate the decision:	**APPROVED**

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	Kenneth Gannon
Date:	07/04/2022
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee	
RESEARCHER PLEASE NOTE For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place. For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.	

Appendix E: Participant Information Sheet- Survey and Interview

Exploring shame, mental health, compassion, identity and help -seeking in Black women that have experienced sexual violence

Contact person: Amani Milligan
Email: u2075218@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Amani. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and I am studying for a Professional Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into understanding the impact sexual violence has on Black women's mental health and identity. I would like to also understand Black women's experiences of seeking help after sexual violence. The aim of the study is to inform and improve the type of support available for Black women who have experienced sexual violence.

Why have I been invited to take part?

To address the study aims, I am inviting women who self-identify as Black to take part in my research. If you are a Black woman over the age of 18 who has experienced sexual violence (such as sexual harassment, sexual abuse and stalking), you are eligible to take part in the study. It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to either take part in an online survey made up of six questionnaires which should approximately 20 minutes to complete or an hour-long interview with me. The interview will be an informal chat and will take place on Mircosoft Teams. Our meeting will be video and audio recorded by Mircosoft Teams. You can also choose to participate in both the interview and online survey.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage

or consequence. If you would like to withdraw from the online survey, you can do so by exiting the survey at any point before submitting the information. If you would like to withdraw from the interview you can do so by telling me at any point during our meeting. If you withdraw, your data will not be used as part of the research. Separately, you can also request (via email) to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

At the start of the survey, you will be asked to create a memorable code, please make a note of this code as it will be requested should you wish to withdraw your survey data from the study.

Are there any disadvantages to taking part?

- It can be difficult to think or speak about experiences of sexual violence. Therefore, it is possible that taking part could be emotionally upsetting.
- It is possible that some of the language included in the survey may be upsetting. You can choose to take a break from or stop the survey at anytime
- There is a list of specialist organisations that can provide information on different types of support below.

How will the information I provide be kept secure and confidential?

The data from this survey will be stored on Qualtrics which adheres to EU Data Protection acts. The data will then be backed up to the researcher's UEL OneDrive. The data from Qualtrics will be deleted once analysis is complete. Electronic consent forms will be exported from Qualtrics and saved in a separate UEL OneDrive for Business folder to other research data.

After the study is completed, my supervisor (Dr Trishna Patel) will have a copy of the anonymised data for storage purposes. This will be kept in a secure file for 3 years before being permanently deleted from the UEL OneDrive. I will share the files with Dr Trishna Patel via the secure UEL email service.

Once the thesis is finalised and approved for publishing, I will permanently delete the information. For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository https://repository.uel.ac.uk. Findings will also

be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided. Anonymised research data will be securely stored by Dr Trishna Patel for a maximum of 3 years, following which all data will be deleted. Who has reviewed the research? My research has been approved by the School of Psychology Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me. Amani Milligan u2075218@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ, Email: t.patel@uel.ac.uk

Thank you for taking the time to read this information sheet

Sexual Violence support
Hersana
Phone: +44 7376 293 487
Email: info@hersana.org
Website: https://www.hersana.org/

Women's Aid
Email: helpline@womensaid.org.uk
Website: https://www.womensaid.org.uk/

Sistah Space
Website: https://www.sistahspace.org/contact-us

Eva's women aid
Phone: 07525591971
Website: https://evawomensaid.org.uk/
Email: info@eva.org.uk

Women's Trust
Email: office@womanstrust.org.uk
Phone: 020 7034 0303
Website: https://womanstrust.org.uk/

Mental Health Support

Mind
Phone: 0300 123 3393

Samaritans
Phone: 116 123
Website: https://www.samaritans.org/

NHS talking therapies
Website: https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service/

Appendix F: Participant Consent Form- Survey

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Exploring shame, mental health, compassion, identity and help- seeking in Black women that have experienced sexual violence

Contact person: Amani Milligan
Email: u2075218@uel.ac.uk

- ☐ I confirm that I have read the participant information sheet for the above study
- ☐ I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.
- ☐ I understand that if I withdraw during the study, my data will not be used.
- ☐ I understand that I have 3 weeks from the date of the survey to withdraw my data from the study.
- ☐ I understand that my personal information and data will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.
- ☐ It has been explained to me what will happen to the data once the research has been completed.
- ☐ I agree to take part in the above study.

Appendix G: Participant Consent Form- Interview

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Exploring shame, mental health, compassion, identity and help-seeking in Black women that have experienced sexual violence

Contact person: Amani Milligan

Email: u2075218@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated XX/XX/XXXX (version X) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview and/or survey to withdraw my data from the study.	
I understand that the interview will be recorded using Microsoft Teams	
I understand that my personal information and data, including video recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	

I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

……
……

Participant's Signature

……
……

Researcher's Name (BLOCK CAPITALS)

……
……

Researcher's Signature

……
……

Date

……..……
……

Appendix H: Participant Debrief Sheet for Survey and Interview Participants

PARTICIPANT DEBRIEF SHEET

Exploring shame, mental health, compassion, identity and help-seeking in Black women that have experienced sexual violence

Thank you for participating in my research study on sexual violence, shame, mental health, identity and help-seeking. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs and social media. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. Any personally identifying information will be removed from the thesis.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Trishna Patel or a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been

challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

Sexual Violence support

Hersana

Phone: +44 7376 293 487

Email: info@hersana.org

Website: https://www.hersana.org/

Women's Aid

Email: helpline@womensaid.org.uk

Website: https://www.womensaid.org.uk/

Sistah Space

Website: https://www.sistahspace.org/contact-us

Eva's women aid

Phone: 07525591971

Website: https://evawomensaid.org.uk/

Email: info@eva.org.uk

Women's Trust

Email: office@womanstrust.org.uk

Phone: 020 7034 0303

Website: https://womanstrust.org.uk/

Mental Health Support

Mind

Phone: 0300 123 3393

Samaritans

Phone: 116 123

Website: https://www.samaritans.org/

NHS talking therapies

Website: https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service/

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

u2075218@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: t.patel@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix I: Debrief Sheet for Participants that did not meet the Eligibility Criteria for Survey

PARTICIPANT DEBRIEF SHEET

Exploring shame, mental health, compassion, identity and help-seeking in Black women that have experienced sexual violence

Thank you for your interest in participating in my research study on sexual violence, shame, mental health, identity and help-seeking. It appears that you do not meet the full eligibility criteria for this study. If you feel as though you do meet the criteria (a self-identifying Black woman over the age of 18 who has experienced sexual violence (such as sexual harassment, sexual abuse and stalking), please feel free to restart the survey and indicate this. Otherwise please feel free to contact me on the details below.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs and social media. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. Any personally identifying information will be removed from the thesis.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Trishna Patel or a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

Sexual Violence support

Hersana

Phone: +44 7376 293 487

Email: info@hersana.org

Website: https://www.hersana.org/

Women's Aid

Email: helpline@womensaid.org.uk

Website: https://www.womensaid.org.uk/

Sistah Space

Website: https://www.sistahspace.org/contact-us

Eva's women aid

Phone: 07525591971

Website: https://evawomensaid.org.uk/

Email: info@eva.org.uk

Women's Trust

Email: office@womanstrust.org.uk

Phone: 020 7034 0303

Website: https://womanstrust.org.uk/

Mental Health Support

Mind

Phone: 0300 123 3393

Samaritans

Phone: 116 123

Website: https://www.samaritans.org/

NHS talking therapies

Website: https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service/

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Amani Milligan

u2075218@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: t.patel@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for your interest

Appendix J: Measures

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

SELF-COMPASSION SCALE–Short Form

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

_____1. When I fail at something important to me I become consumed by feelings of inadequacy.

_____2. I try to be understanding and patient towards those aspects of my personality I don't like.

_____3. When something painful happens I try to take a balanced view of the situation.

_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____5. I try to see my failings as part of the human condition.

_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____7. When something upsets me I try to keep my emotions in balance.

_____8. When I fail at something that's important to me, I tend to feel alone in my failure

_____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____11. I'm disapproving and judgmental about my own flaws and inadequacies.

_____12. I'm intolerant and impatient towards those aspects of my personality I don't like.

The Depression, Anxiety and Stress Scale

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0= Did not apply to me at all, 1= Applied to me to some degree, or some of the time, 2= Applied to me to a considerable degree or a good part of time, 3= Applied to me very much or most of the time

I found it hard to wind down	0 1 2 3
I was aware of dryness of my mouth	0 1 2 3
I couldn't seem to experience any positive feeling at all	0 1 2 3
I experienced breathing difficulty (e.g. excessively rapid breathing,	0 1 2 3
breathlessness in the absence of physical exertion)	0 1 2 3
I found it difficult to work up the initiative to do things	0 1 2 3
I tended to over-react to situations	0 1 2 3
I experienced trembling (e.g. in the hands)	0 1 2 3
I felt that I was using a lot of nervous energy	0 1 2 3
I was worried about situations in which I might panic and make a fool of myself	0 1 2 3
	0 1 2 3
I felt that I had nothing to look forward to	0 1 2 3
I found myself getting agitated	0 1 2 3
I found it difficult to relax	0 1 2 3
I felt down-hearted and blue	0 1 2 3
I was intolerant of anything that kept me from getting on with what I was doing	0 1 2 3
I felt I was close to panic	0 1 2 3
I was unable to become enthusiastic about anything	0 1 2 3

I felt I wasn't worth much as a person	0 1 2 3
I felt that I was rather touchy	0 1 2 3
I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0 1 2 3
I felt scared without any good reason	0 1 2 3
I felt that life was meaningless	0 1 2 3

Social Comparison Scale

Please circle a number at a point which best describes the way in which you see yourself in comparison to others.

For example:

Short 1 2 3 4 5 6 7 8 9 10 Tall

If you put a mark at 3 this means you see yourself as shorter than others; if you put a mark at 5 (middle) about average; and a mark at 7 somewhat taller. If you understand the above instructions, please proceed. Circle one number on each line according to how you see yourself in relationship to others.

In relationship to others I feel:

Inferior	1 2 3 4 5 6 7 8 9 10	Superior
Incompetent	1 2 3 4 5 6 7 8 9 10	More competent
Unlikeable	1 2 3 4 5 6 7 8 9 10	More likeable
Left out	1 2 3 4 5 6 7 8 9 10	Accepted
Different	1 2 3 4 5 6 7 8 9 10	Same
Untalented	1 2 3 4 5 6 7 8 9 10	More talented
Weaker	1 2 3 4 5 6 7 8 9 10	Stronger
Unconfident	1 2 3 4 5 6 7 8 9 10	More confident
Undesirable	1 2 3 4 5 6 7 8 9 10	More desirable
Unattractive	1 2 3 4 5 6 7 8 9 10	More attractive
An outsider	1 2 3 4 5 6 7 8 9 10	An insider

Other as Shamer Scale

Read each statement carefully and circle the number to the right of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement.

0 = Never 1= Seldom 2= Sometimes 3= Frequently 4= Almost always

1. I feel other people see me as not good enough.	0 1 2 3 4
2. I think that other people look down on me	0 1 2 3 4
3. Other people put me down a lot	0 1 2 3 4
4. I feel insecure about others opinions of me	0 1 2 3 4
5. Other people see me as not measuring up to them	0 1 2 3 4
6. Other people see me as small and insignificant	0 1 2 3 4
7. Other people see me as somehow defective as a person	0 1 2 3 4
8. People see me as unimportant compared to others	0 1 2 3 4
9. Other people look for my faults	0 1 2 3 4
10. People see me as striving for perfection but being unable to reach my own standards	0 1 2 3 4
11. I think others are able to see my defects	0 1 2 3 4
12. Others are critical or punishing when I make a mistake	0 1 2 3 4
13. People distance themselves from me when I make mistakes	0 1 2 3 4
14. Other people always remember my mistakes	0 1 2 3 4
15. Others see me as fragile	0 1 2 3 4
16. Others see me as empty and unfulfilled	0 1 2 3 4
17. Others think there is something missing in me	0 1 2 3 4

18. Other people think I have lost control over my body and feelings	0 1 2 3 4

Self-Concept Clarity Scale

Scale ranges from 1 (strongly disagree) to 5 (strongly agree)

1. My beliefs about myself often conflict with one another.*	1 2 3 4 5
2. On one day I might have one opinion of myself and on another day I might have a different opinion.*	1 2 3 4 5
3. I spend a lot of time wondering about what kind of person I really am.*	1 2 3 4 5
4. Sometimes I feel that I am not really the person that I appear to be.*	1 2 3 4 5
5. When I think about the kind of person I have been in the past, I'm not sure what I was really like.*	1 2 3 4 5
6. I seldom experience conflict between the different aspects of my personality.	1 2 3 4 5
7. Sometimes I think I know other people better than I know myself. *	1 2 3 4 5
8. My beliefs about myself seem to change very frequently.*	1 2 3 4 5
9. If I were asked to describe my personality, my description might end up being different from one day to another day.*	1 2 3 4 5

10. Even if I wanted to, I don't think I could tell someone what I'm really like.*	1 2 3 4 5
11. In general, I have a clear sense of who I am and what I am.	1 2 3 4 5

Qualitative Questions in Survey

1. Have you had an unwanted sexual experience?
    - Yes
    - No
2. How would you describe your unwanted sexual experience(s)?
    - Non-contact unwanted sexual experience
    - Unwanted sexual contact
    - Sexual coercion
    - Being made to penetrate someone else
    - Rape
    - Prefer not to say
3. Did you seek support following your experience?
    - Yes
    - No
4. [If yes to q3] How long after your experience did you seek support (open question)
5. [If yes to q3] Where did you seek support?
    - Friends
    - Family
    - Professionals
    - Faith organisations
    - Other (please specify)
6. [If yes to q3] What was helpful about the support you received? (if you received multiple types of support please specify which type of support you are commenting on)
7. [If yes to q3] What was unhelpful about the support you received? (if you received multiple types of support please specify which type of support you are commenting on)
8. [If no to q3] Was there anything in particular that led you to deciding not to seek support?

Demographic questions in survey

1. What is your age?

    18-22

    23-27

    28-32

    33-37

    38-42

    43-47

    48-52

    53-57

    58-62

    63+

2. Which of the following options do you identify with most?

    Black of African descent

    Black of Caribbean descent

    Black of other descent (please specify)

Appendix K: Interview Schedule

Thank you for your interest in my study. This research aims to understand the impact of sexual violence on Black women's mental health and identity. I would also like to also understand Black women's experiences of seeking- help after sexual violence.

As outlined in the information sheet you can change your mind about participating at any point, even during our conversation. You do not have to answer any questions that you do not want to. None of your personal information will be used during my analysis or write up.

This conversation could be up to an hour. Are you still happy to go ahead?

If there is anything you do not understand about the questions feel free to ask me to clarify.

1. Could you start by telling me your age and ethnicity?

2. Could you talk a bit about your experience(s) of sexual violence? Remember only to share what you feel comfortable with sharing.

3. *It is normal for a lot of different feelings to arise after an experience(s) like this*. Would you mind sharing the feelings you felt after your experience(s)?

    Possible prompts: name some feelings (ie: numbness, fear, shame, worry etc)

4. Do you think that your experience(s) impacted the way that you see yourself in any way?

    Follow up questions: In what ways do you think it impacted you?

    How would you describe yourself before/after your experience(s)?

    How did you view others before/after your experience(s)?

    Were you able to be kind to yourself following this and how?

5. Did you try to get some support following your experience(s)?

If sought help	***If didn't seek help***
• Would you mind sharing your experience of seeking support following your experience? • *Possible prompts:* • *Who did you seek support? from (family/friends and/or professional services?)* • *How long after your experience(s) did you seek support?* • *Why was it important for you to seek help from others? What were the main reasons you decided to seek help?* • *How did you feel when speaking about your experience with others?* • *What was helpful or unhelpful about the help?* • *[if engaged in professional services] what was helpful/unhelpful about the referral process? what did the service offer? what were your thoughts about what was offered?* • *[if reached out but decided not to engage] what about your experience of reaching out led to you to not continue?* • *Was there anything you were particularly concerned about that could have stopped you from seeking help?* • *Follow up questions: Have your feelings/ thoughts about this changed since?*	6. Did you think about reaching out to friends/family/services for support? • *Possible prompts:* • *Was there anything in particular that led you to deciding not to reach out?* • *Did you have particularly thoughts or feelings about the idea of seeking support?* • *Follow up questions: Have your feelings/ thoughts about this changed since?* •

6. What do you think professional services can do to make the process of reaching out more comfortable for people?
   - *Possible prompts: What do you think would be helpful for professionals to ask? What information do you think would be useful to know before engaging in with professional services?*

7. What do you think the people you know could do to make you feel more comfortable to share your experience?

8. Is there anything else that you think would be important for us to talk about that we haven't yet?

Appendix L: Recruitment Advertisement

ARE YOU A BLACK WOMAN?

HAVE YOU HAD AN UNWANTED SEXUAL EXPERIENCE?

WE WANT TO HEAR YOUR VOICE!

We are interested in understanding how sexual violence (such as sexual harassment, stalking, sexual assault, being exposed to unwanted sexual images) may effect black women's mental wellbeing and identity as well as their experiences of seeking support.

.....

Your participation will help us to understand the unique experience and needs of black women. This will help us to know what is working, what is not working and what services need to do to better support black women who have experienced sexual violence

There are two ways you can take part:

1. completing an online survey (which should take about 20mins to fill in)

and/or

2. having a 40-60 minute conversation with me online

.....

If you would like to take part or want more information please contact me

Amani Milligan
u2075218@uel.ac.uk

University of East London

Appendix M: Example of Infographics Created for Recruitment Strategy

Appendix N: UEL Ethics Amendment Approval

University of East London

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents	
A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES** ☒

Details	
Name of applicant:	**Amani Milligan**
Programme of study:	**Professional Doctorate in Clinical Psychology**
Title of research:	Exploring shame, mental health, compassion, identity and help-seeking in Black women who have experienced sexual violence
Name of supervisor:	**Dr Trishna Patel**

Proposed amendment(s)	
Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below	
Proposed amendment	**Rationale**
Additional route to recruitment	In order to increase the scope for recruitment, I will be posting infographics on a social media account dedicated to the research
Addition to the debrief form	Those that start to complete the online survey, but do not meet the eligibility criteria will be directed to an amended debrief form
Addition to demographic questions	In order to capture the ethnic background of the participants, there will be an additional demographic question in the online survey (see appendix H) This will allow me to observe any differences between participants of Caribbean, African or other descent
Proposed amendment	Rationale for proposed amendment

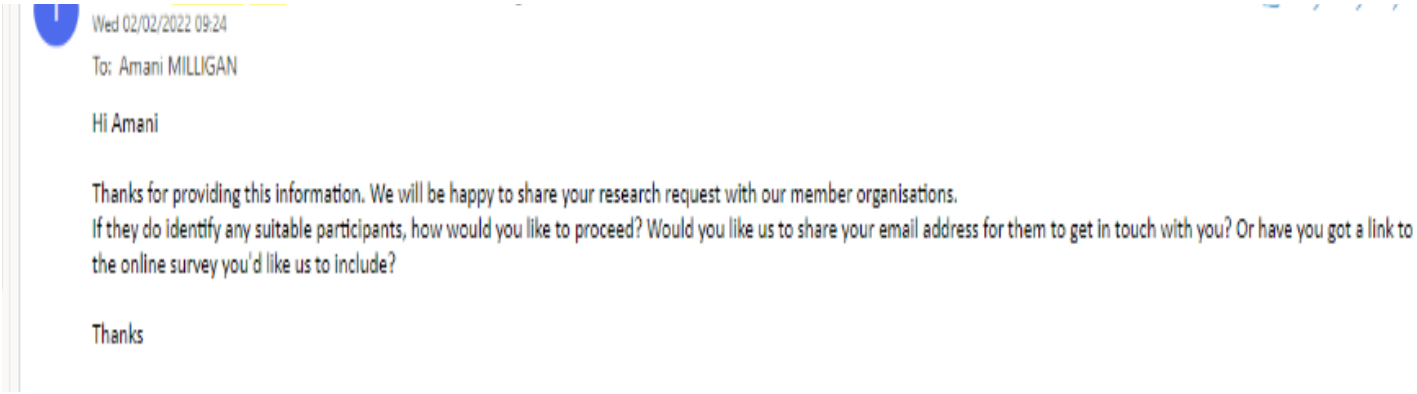
Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student's signature	
Student: (Typed name to act as signature)	**Amani Milligan**
Date:	**06/06/2022**

Reviewer's decision		
Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	**In the amended debrief sheet for those not eligible to take part, please consider removing sections relevant only to those who have participated in the study. I would encourage you to keep the contact information of supporting agencies.**	
Reviewer: (Typed name to act as signature)	**Trishna Patel**	
Date:	**08/06/2022**	

Appendix O: Specialist Organisation Agreement to Support with Recruitment



Wed 02/02/2022 09:24

To: Amani MILLIGAN

Hi Amani

Thanks for providing this information. We will be happy to share your research request with our member organisations.
If they do identify any suitable participants, how would you like to proceed? Would you like us to share your email address for them to get in touch with you? Or have you got a link to the online survey you'd like us to include?

Thanks

Appendix P: Pilot Interview Schedule

Would it be okay to talk a bit about your experience of sexual violence? Remember only to share what you feel comfortable with sharing

Do you think that your experience impacted the way that you related to yourself at all?

- *How would you describe yourself before/after your experience?*

Would you mind sharing the feelings you felt after your experience(s)?

[if sought help] Would you mind sharing your experience of seeking help following your experience?

- *Why was it important for you to seek help from others? What were the main reasons you decided to seek help?*
- *Did you feel any shame in discussing?*
- *Did you seek from family/friends and/or professional services?*
- *What was helpful or unhelpful about the help?*
- *[if engaged in professional services] what was helpful/unhelpful about the referral process? what did the service offer? what were your thoughts about what was offered?*
- *[if reached out but decided not to engage] what about your experience of reaching out led to you to not continue?*
- *Was there anything you were particularly concerned about that could have stopped you from seeking help?*

[if didn't seek help] Did you think about reaching out to friends/family/services for help?

- *Was there anything in particular that led you to deciding not to reach out?*

What do you think services can do to make the process of reaching out more comfortable for people?

- *What do you think would be helpful for professionals to ask?*

What do you think the people you know could do to make you feel more comfortable to share your experience?

Is there anything else that you think would be important for us to talk about that we haven't yet?

Appendix Q: Sample of Coded Extract

Thank you for sharing that. You were speaking about identity and intersectionality. How you view yourself outside of other people's exception. I really wanna get into that a little bit. Do you think that these experiences impacted the way that you see yourself or saw yourself in any way?

Umm. Yeah, in ways that are kind of nuanced and almost conflicting. Because I (…) Witnessed myself as more vulnerable than (…) any of us should be, and when I say should be like none of us (…) We deserve better. We deserve better than the level and lack of protection and safety and care and supportive systems and supportive outcomes that there are. And I understood that within those, you know. Very, very, very easily (…) spirits can be broken, bodies can be broken, and lives can be lost. You know they can. But there were points when I was suicidal, like after it. But you know I'm older than I was now and, somehow I came through and I say somehow because I don't think that you know women that go through this, black women that go through this, that do not make it out the other side. Don't they don't not make it out because of any lack of anything in them, there's no lack of virtue, there's no lack of strength, there's no lack of anything there. Everything you know, they are. They deserve to fight their way out of that kind of horror, just as much as anybody else. I believe that the way the you know, social or interpersonal or financial health, whatever factors in their circumstances have just intersected in a way that has made it too hard. Sorry, that's painful for me because you know I've really learned through this that (…) the ones that make out the other end, if there is another end, you know we don't get there because we're any better. We don't get that- Not that I want to feel better, but I grieve for the ones who don't, because I understand how (…) possible and in some ways probable it is that so many of us might not, because of how much is lacking in terms of (…) and I don't like this the word "victim". So I'm gonna say person centred care. Person centred support which is intersectionally informed and addresses all of the intersections.

Observing vulnerability

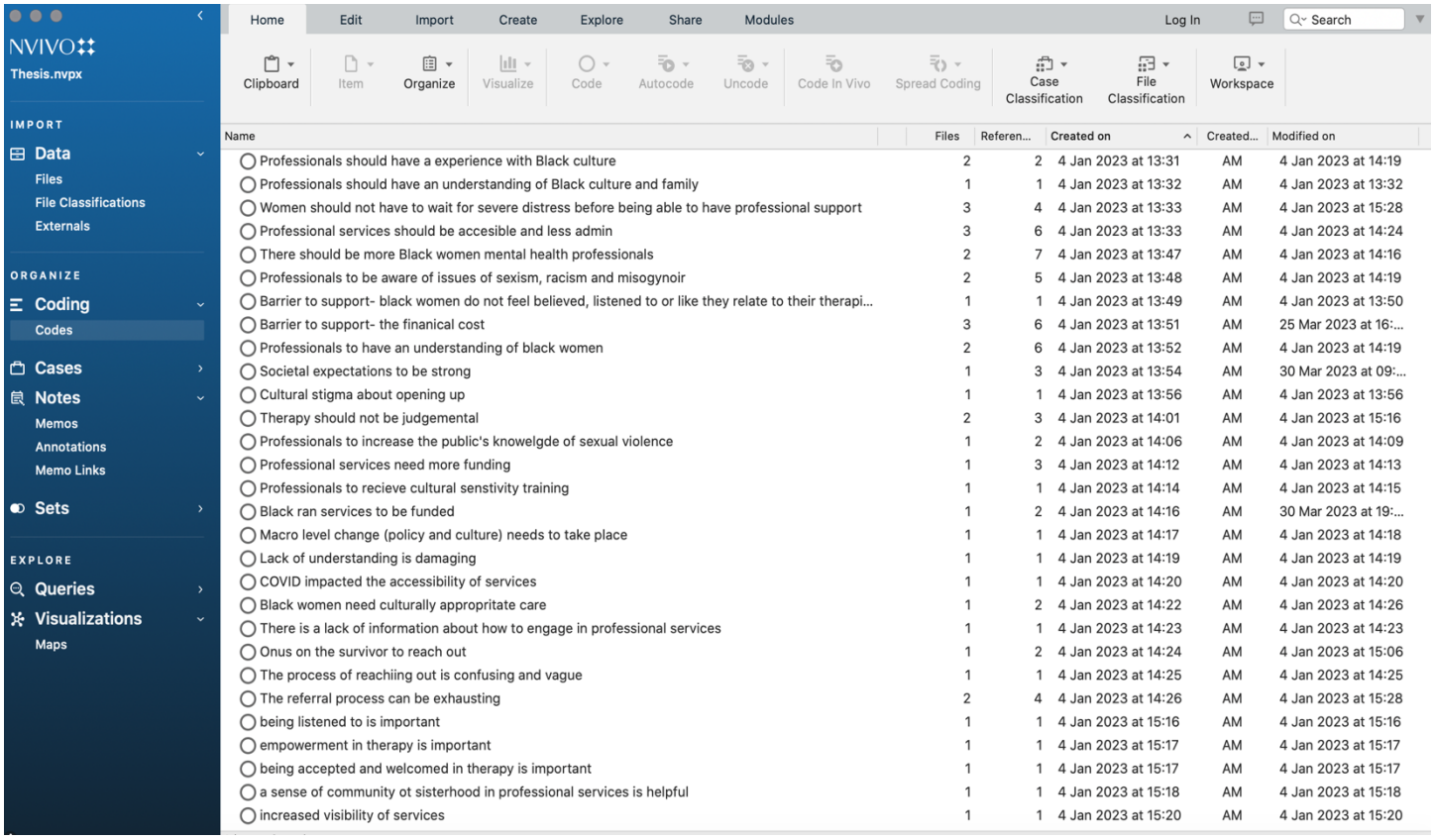
Challenging the strong Black women narrative- allow space for vulnerability

Black women deserve survival

A lack of person-centred care

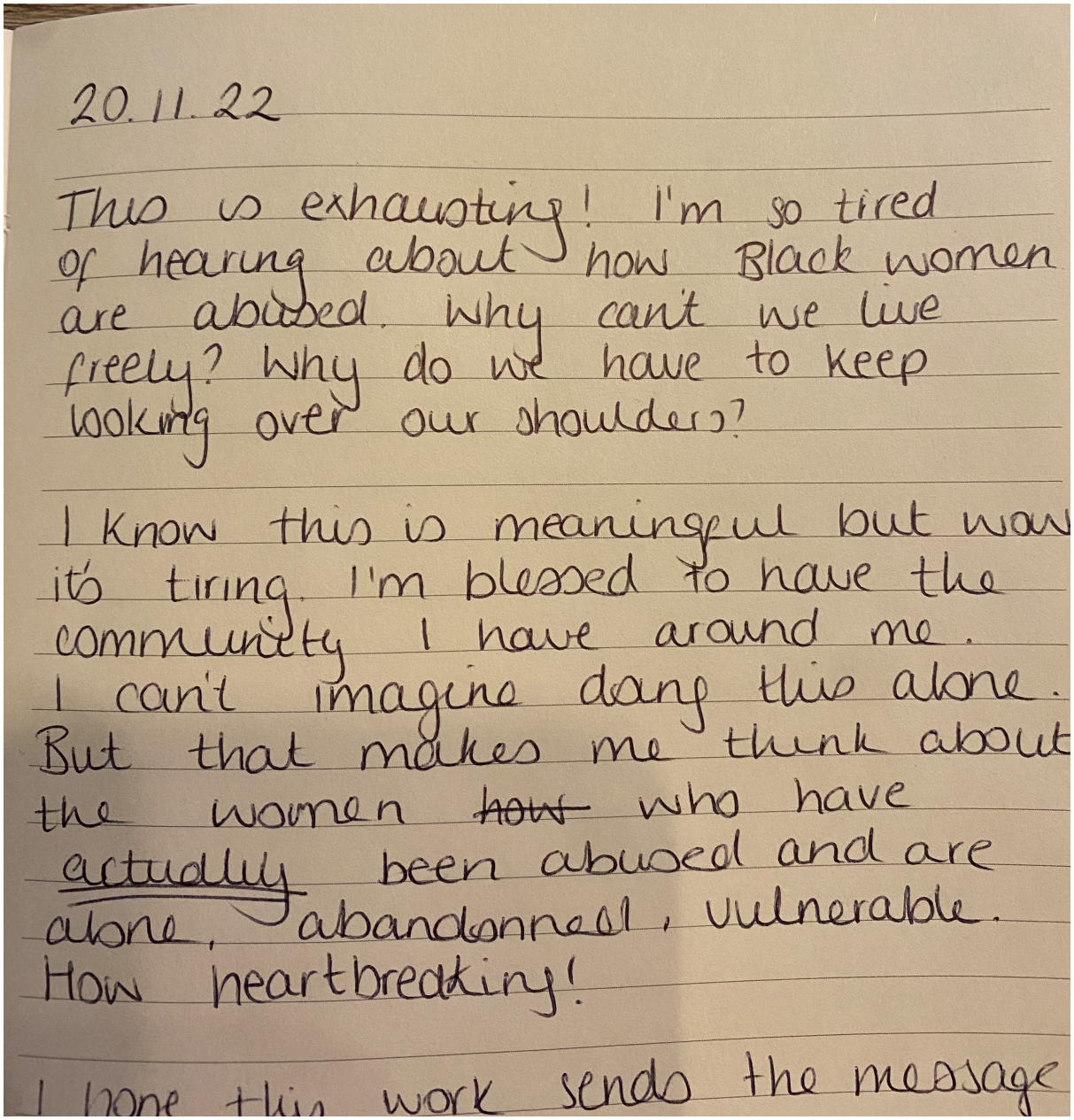
A lack of intersectionality

Appendix R: Sample of Initial Codes



Name	Files	Referen...	Created on	Created...	Modified on
Professionals should have a experience with Black culture	2	2	4 Jan 2023 at 13:31	AM	4 Jan 2023 at 14:19
Professionals should have an understanding of Black culture and family	1	1	4 Jan 2023 at 13:32	AM	4 Jan 2023 at 13:32
Women should not have to wait for severe distress before being able to have professional support	3	4	4 Jan 2023 at 13:33	AM	4 Jan 2023 at 15:28
Professional services should be accesible and less admin	3	6	4 Jan 2023 at 13:33	AM	4 Jan 2023 at 14:24
There should be more Black women mental health professionals	2	7	4 Jan 2023 at 13:47	AM	4 Jan 2023 at 14:16
Professionals to be aware of issues of sexism, racism and misogynoir	2	5	4 Jan 2023 at 13:48	AM	4 Jan 2023 at 14:19
Barrier to support- black women do not feel believed, listened to or like they relate to their therapi...	1	1	4 Jan 2023 at 13:49	AM	4 Jan 2023 at 13:50
Barrier to support- the finanical cost	3	6	4 Jan 2023 at 13:51	AM	25 Mar 2023 at 16:...
Professionals to have an understanding of black women	2	6	4 Jan 2023 at 13:52	AM	4 Jan 2023 at 14:19
Societal expectations to be strong	1	3	4 Jan 2023 at 13:54	AM	30 Mar 2023 at 09:...
Cultural stigma about opening up	1	1	4 Jan 2023 at 13:56	AM	4 Jan 2023 at 13:56
Therapy should not be judgemental	2	3	4 Jan 2023 at 14:01	AM	4 Jan 2023 at 15:16
Professionals to increase the public's knowelgde of sexual violence	1	2	4 Jan 2023 at 14:06	AM	4 Jan 2023 at 14:09
Professional services need more funding	1	3	4 Jan 2023 at 14:12	AM	4 Jan 2023 at 14:13
Professionals to recieve cultural senstivity training	1	1	4 Jan 2023 at 14:14	AM	4 Jan 2023 at 14:15
Black ran services to be funded	1	2	4 Jan 2023 at 14:16	AM	30 Mar 2023 at 19:...
Macro level change (policy and culture) needs to take place	1	1	4 Jan 2023 at 14:17	AM	4 Jan 2023 at 14:18
Lack of understanding is damaging	1	1	4 Jan 2023 at 14:19	AM	4 Jan 2023 at 14:19
COVID impacted the accessibility of services	1	1	4 Jan 2023 at 14:20	AM	4 Jan 2023 at 14:20
Black women need culturally appropritate care	1	2	4 Jan 2023 at 14:22	AM	4 Jan 2023 at 14:26
There is a lack of information about how to engage in professional services	1	1	4 Jan 2023 at 14:23	AM	4 Jan 2023 at 14:23
Onus on the survivor to reach out	1	2	4 Jan 2023 at 14:24	AM	4 Jan 2023 at 15:06
The process of reachiing out is confusing and vague	1	1	4 Jan 2023 at 14:25	AM	4 Jan 2023 at 14:25
The referral process can be exhausting	2	4	4 Jan 2023 at 14:26	AM	4 Jan 2023 at 15:28
being listened to is important	1	1	4 Jan 2023 at 15:16	AM	4 Jan 2023 at 15:16
empowerment in therapy is important	1	1	4 Jan 2023 at 15:17	AM	4 Jan 2023 at 15:17
being accepted and welcomed in therapy is important	1	1	4 Jan 2023 at 15:17	AM	4 Jan 2023 at 15:17
a sense of community ot sisterhood in professional services is helpful	1	1	4 Jan 2023 at 15:18	AM	4 Jan 2023 at 15:18
increased visibility of services	1	1	4 Jan 2023 at 15:20	AM	4 Jan 2023 at 15:20

Appendix S: Reflective Journal Extract



20.11.22

This is exhausting! I'm so tired of hearing about how Black women are abused. Why can't we live freely? Why do we have to keep looking over our shoulders?

I know this is meaningful but wow it's tiring. I'm blessed to have the community I have around me. I can't imagine doing this alone. But that makes me think about the women ~~how~~ who have actually been abused and are alone, abandonned, vulnerable. How heartbreaking!

I hope this work sends the message

Appendix T: 'Non-completers' Demographic Information

Table

Characteristics	N	%
Age		
18-22	2	11.1
23-27	5	27.8
28-32	2	11.1
33-37	3	16.7
38-42	3	16.7
43-47	2	11.1
53-57	1	5.6
Cultural Background		
Black of African descent	4	28.6
Black of Caribbean descent	9	64.3
Black of other descent	1	7.5

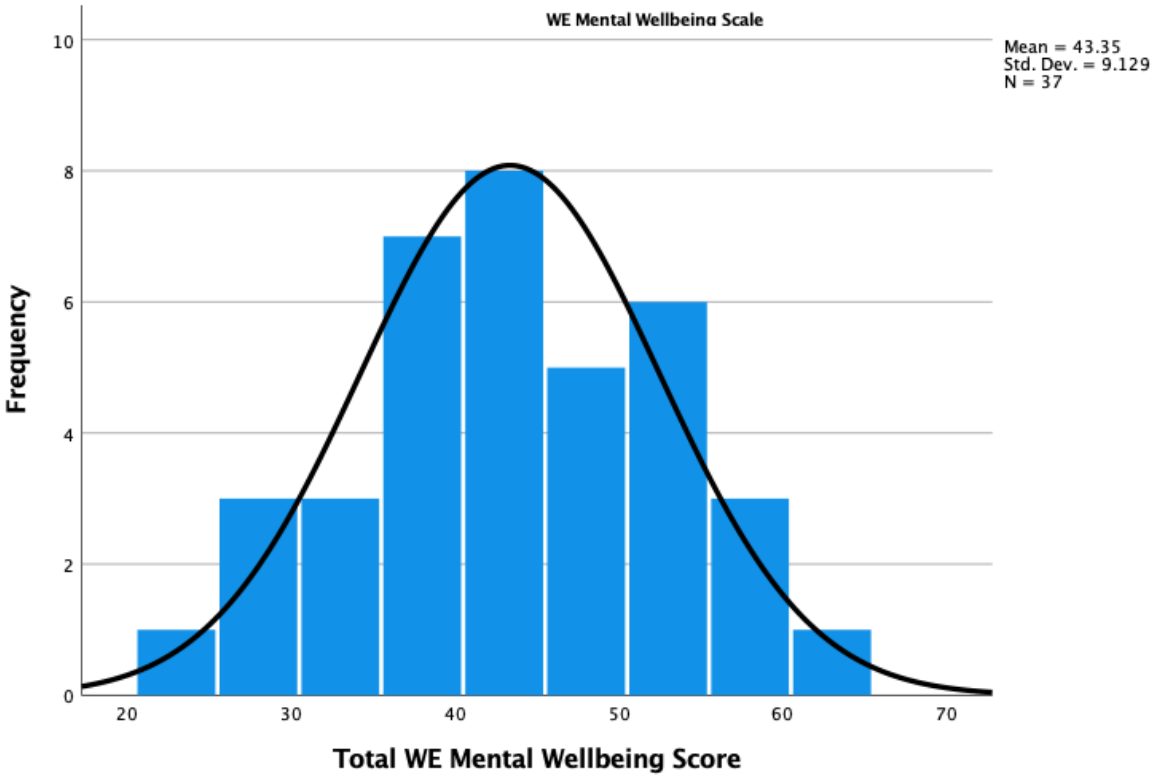
Appendix U: Stages of Study Withdrawal

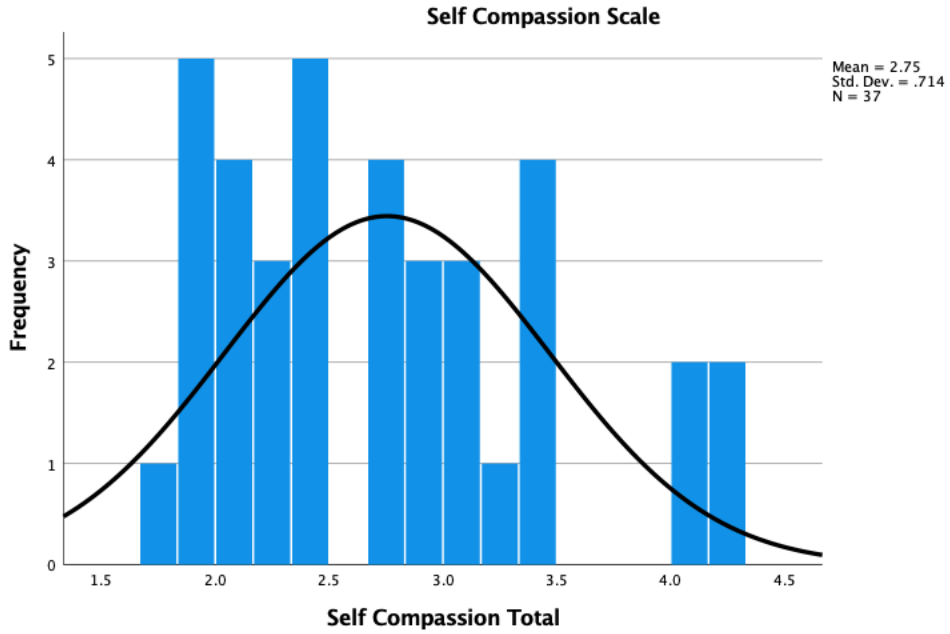
Table

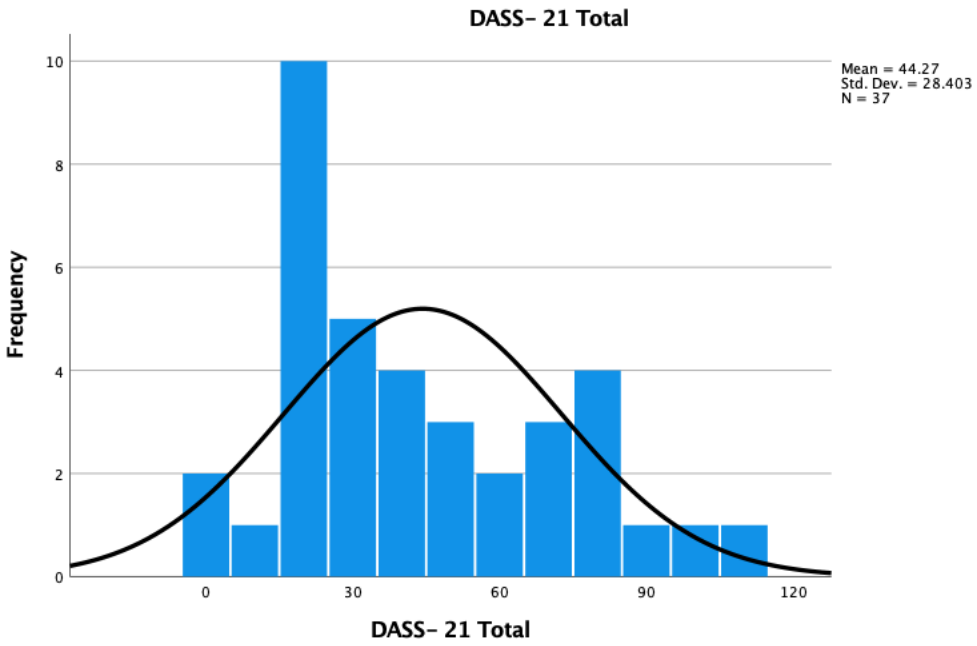
Stage of Survey Withdrawal	**N**	**%**
Completion of consent form	29	33.7
Completion of demographic questionnaire	7	8.1
Completion of sexual violence experiences	1	1.2
Completion of wellbeing measure	6	6.9
Completion of self-compassion measure	6	6.9
Total	49	56.9

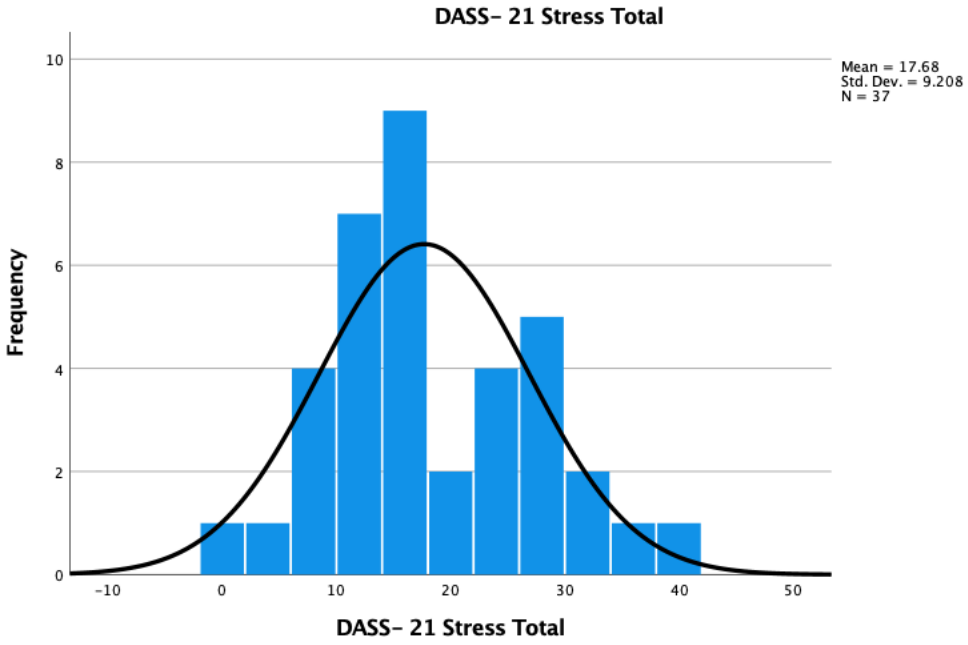
Appendix V: Distribution of Variables

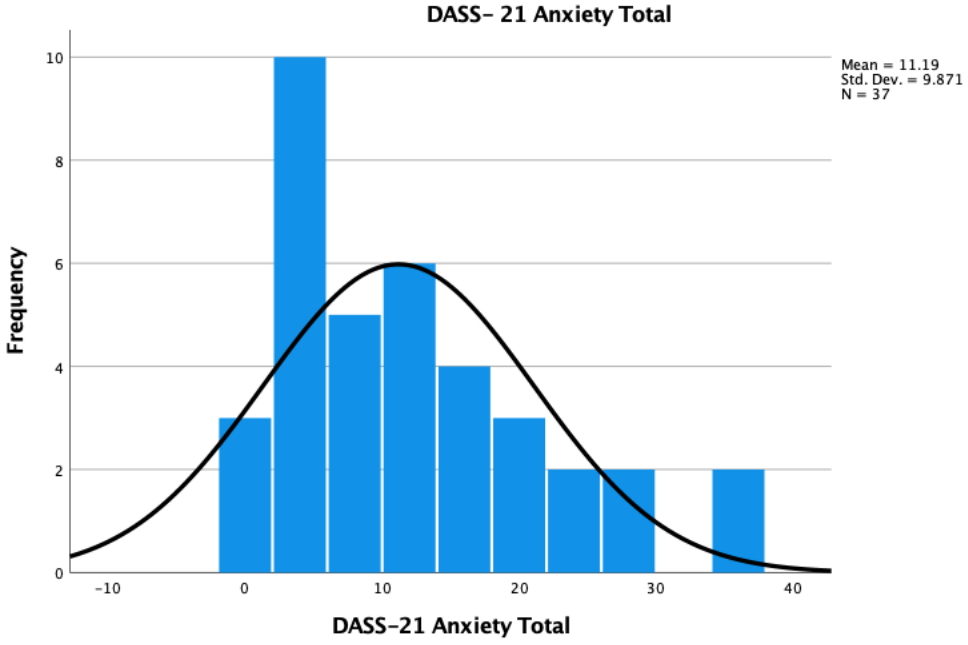
Histograms

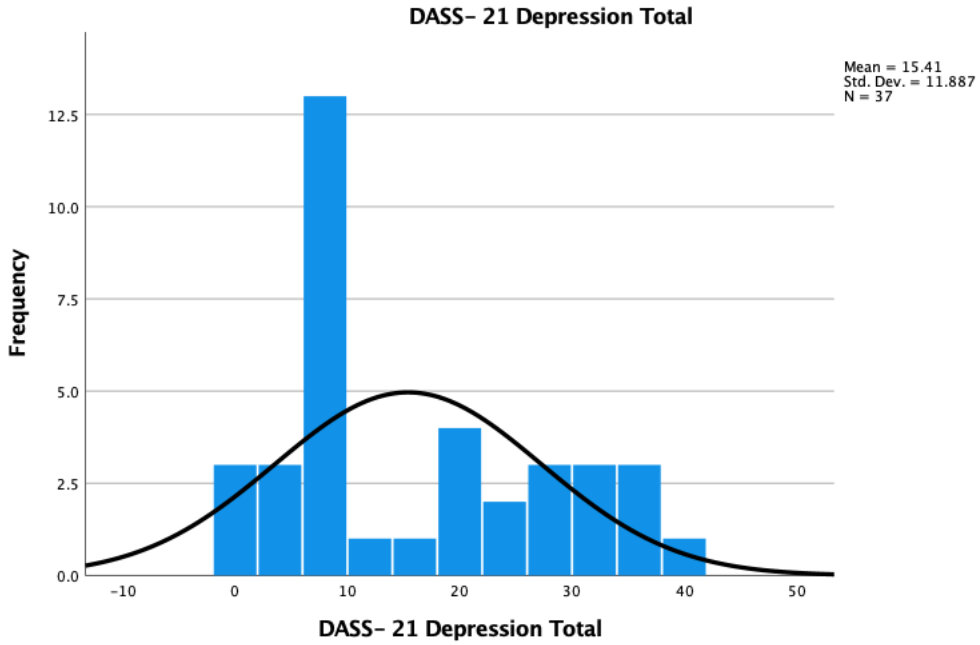




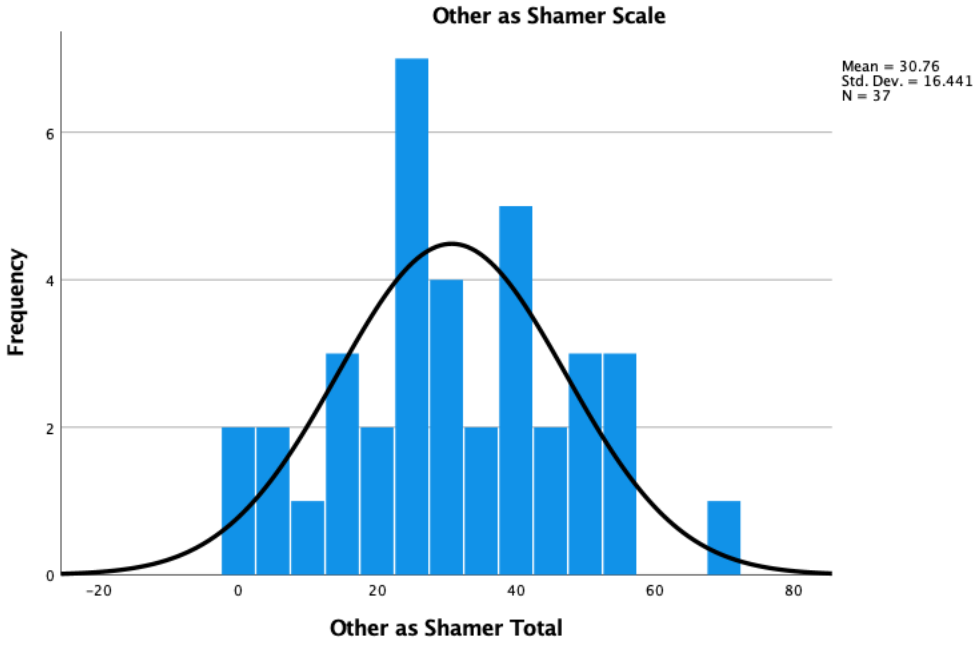

DASS- 21 Total
Mean = 44.27
Std. Dev. = 28.403
N = 37
Frequency
10
8
6
4
2
0
0
30
60
90
120
DASS- 21 Total

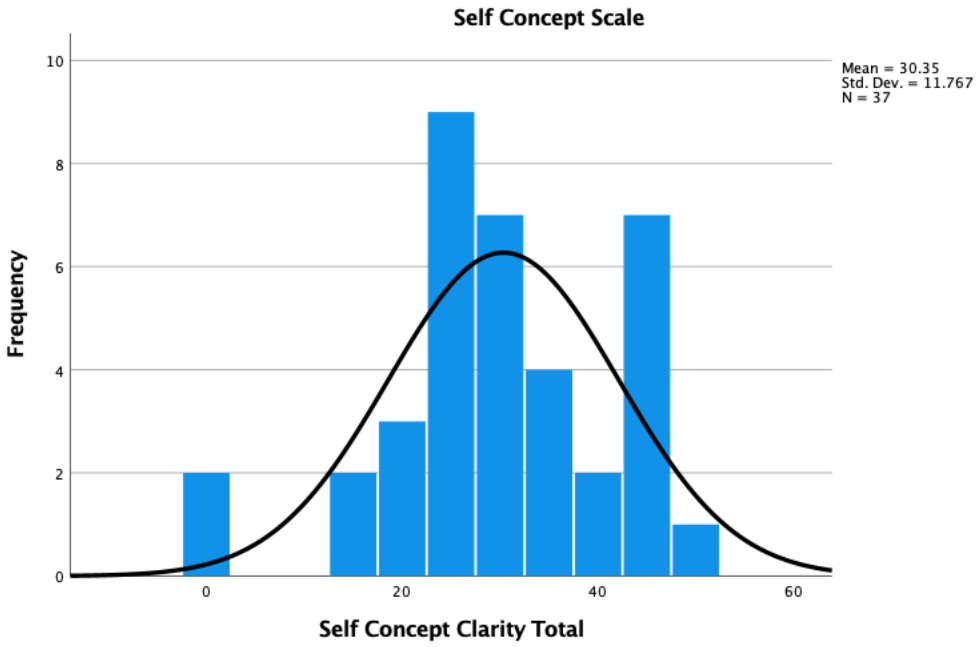

DASS- 21 Stress Total
Mean = 17.68
Std. Dev. = 9.208
N = 37
Frequency
DASS- 21 Stress Total


DASS- 21 Anxiety Total
Mean = 11.19
Std. Dev. = 9.871
N = 37
Frequency
DASS-21 Anxiety Total

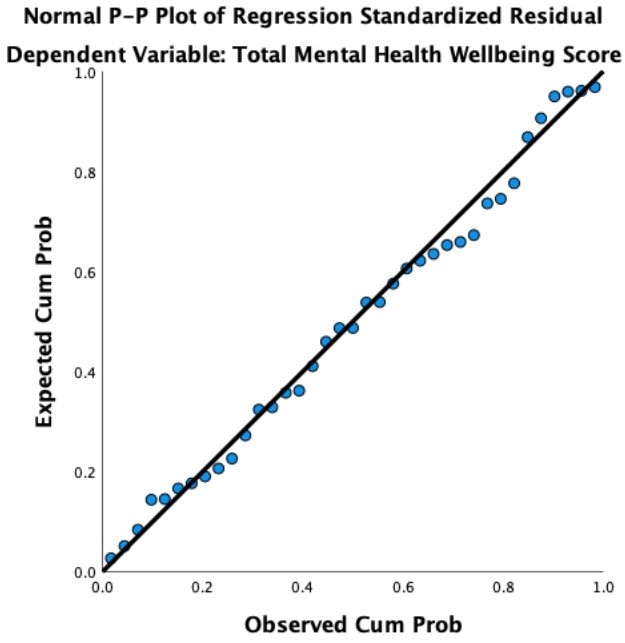

DASS- 21 Depression Total
Mean = 15.41
Std. Dev. = 11.887
N = 37
Frequency
12.5
10.0
7.5
5.0
2.5
0.0
-10
0
10
20
30
40
50
DASS- 21 Depression Total

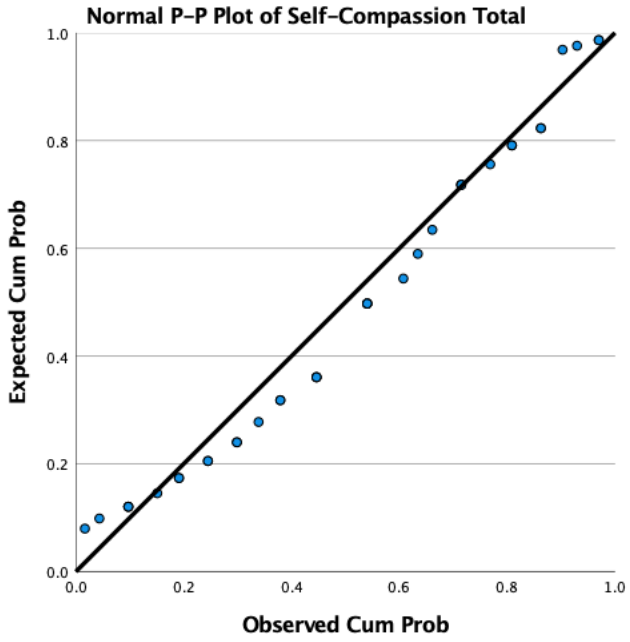

Self-Comparison Scale
Mean = 56.16
Std. Dev. = 15.358
N = 37
Frequency
Self Comparison Total

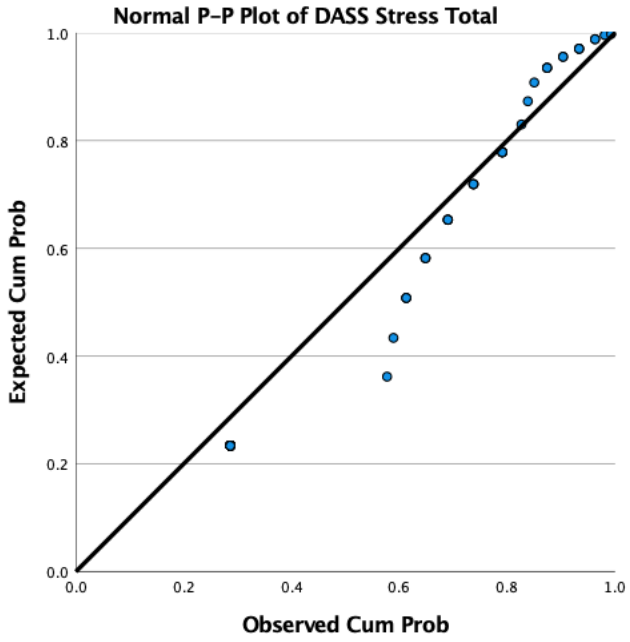

Other as Shamer Scale
Mean = 30.76
Std. Dev. = 16.441
N = 37
Frequency
Other as Shamer Total

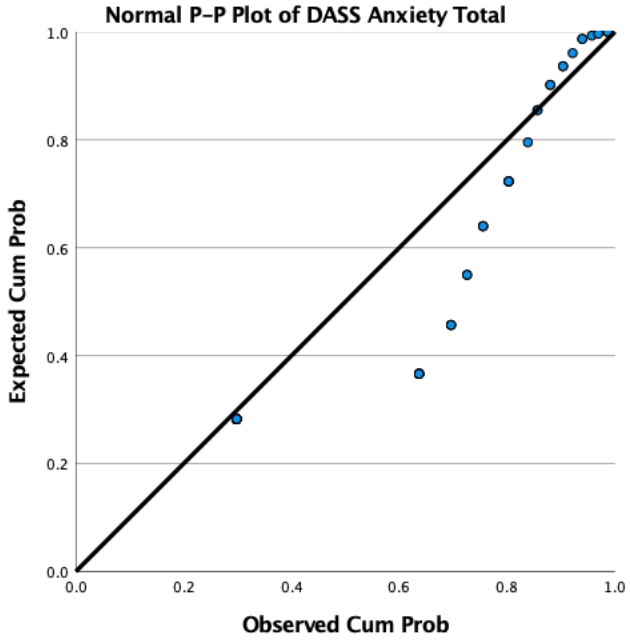

Self Concept Scale
Mean = 30.35
Std. Dev. = 11.767
N = 37
Frequency
Self Concept Clarity Total

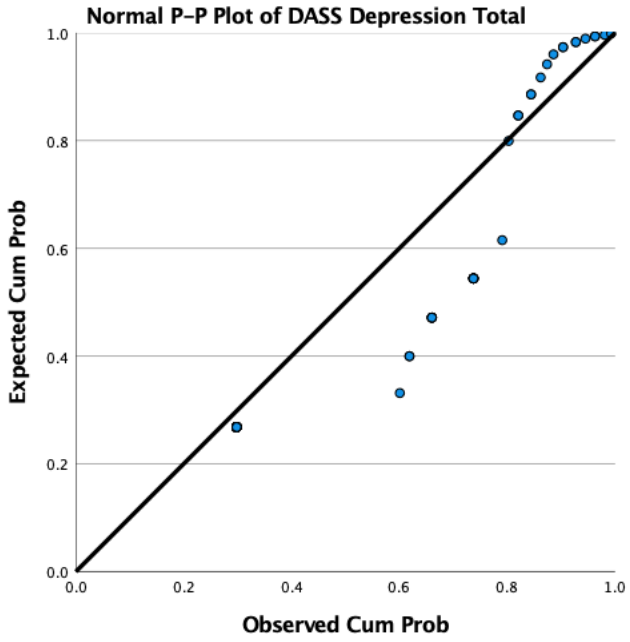
P-P Plots

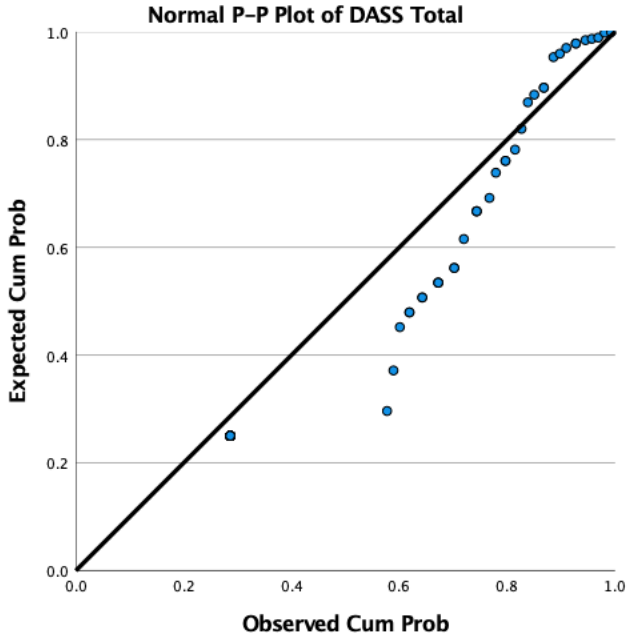

Normal P-P Plot of Regression Standardized Residual
Dependent Variable: Total Mental Health Wellbeing Score
Expected Cum Prob
Observed Cum Prob

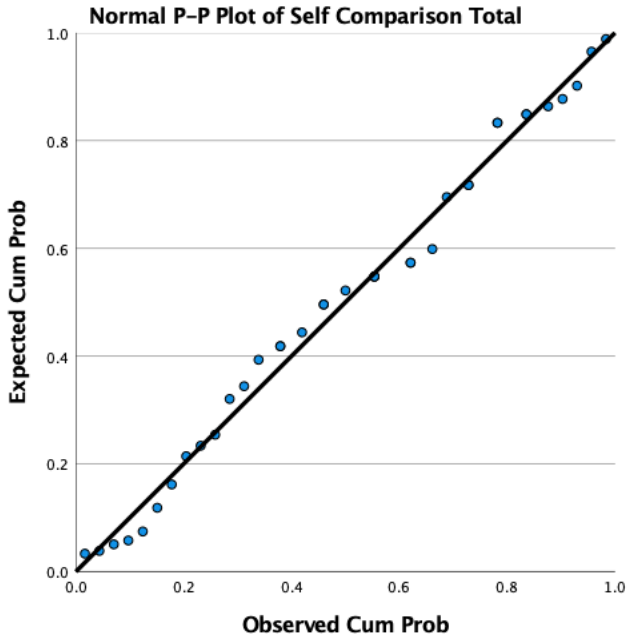

Normal P-P Plot of Self-Compassion Total
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

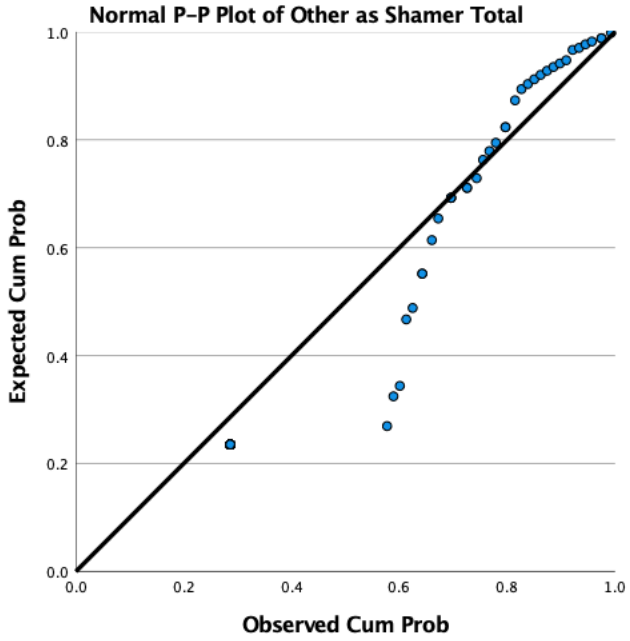

Normal P-P Plot of DASS Stress Total
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

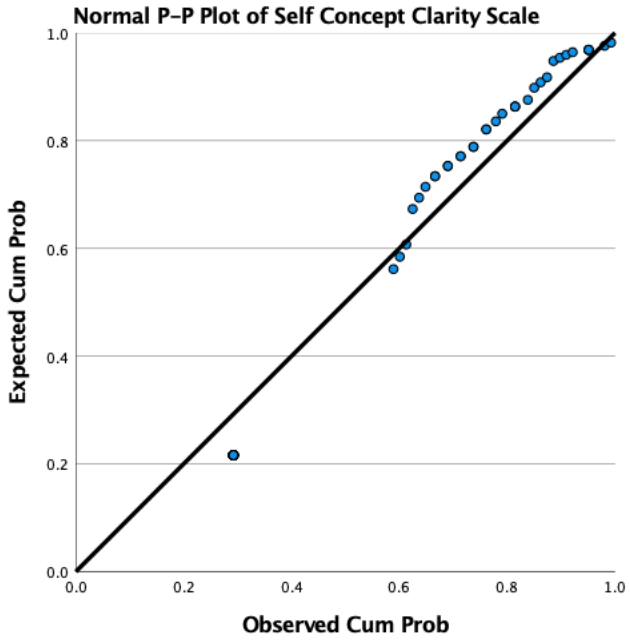

Normal P-P Plot of DASS Anxiety Total
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0


Normal P-P Plot of DASS Depression Total
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

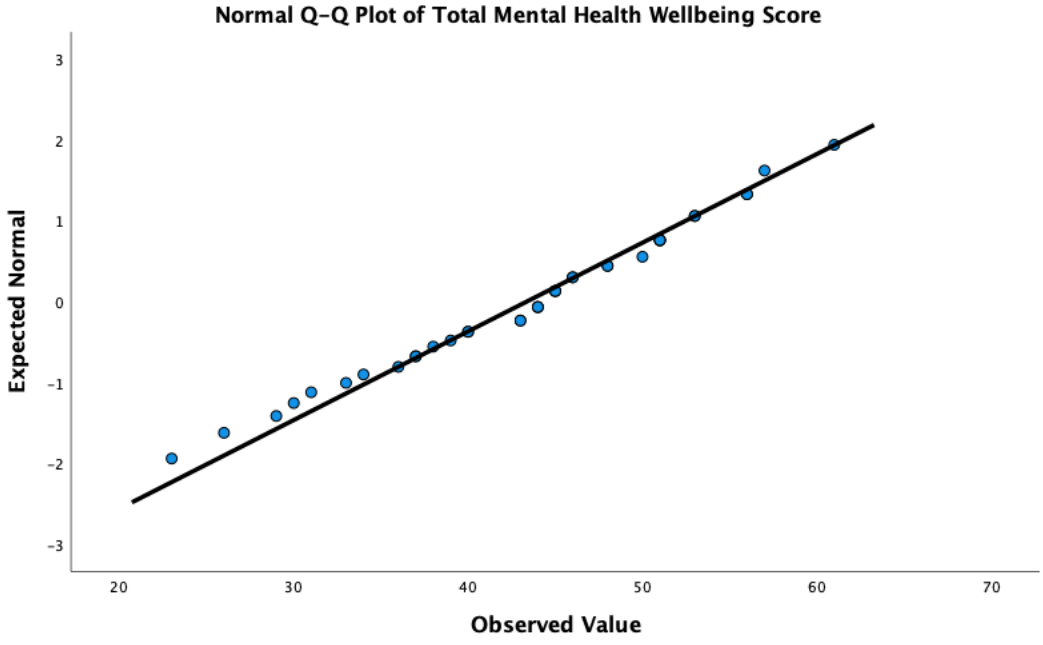

Normal P-P Plot of DASS Total
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

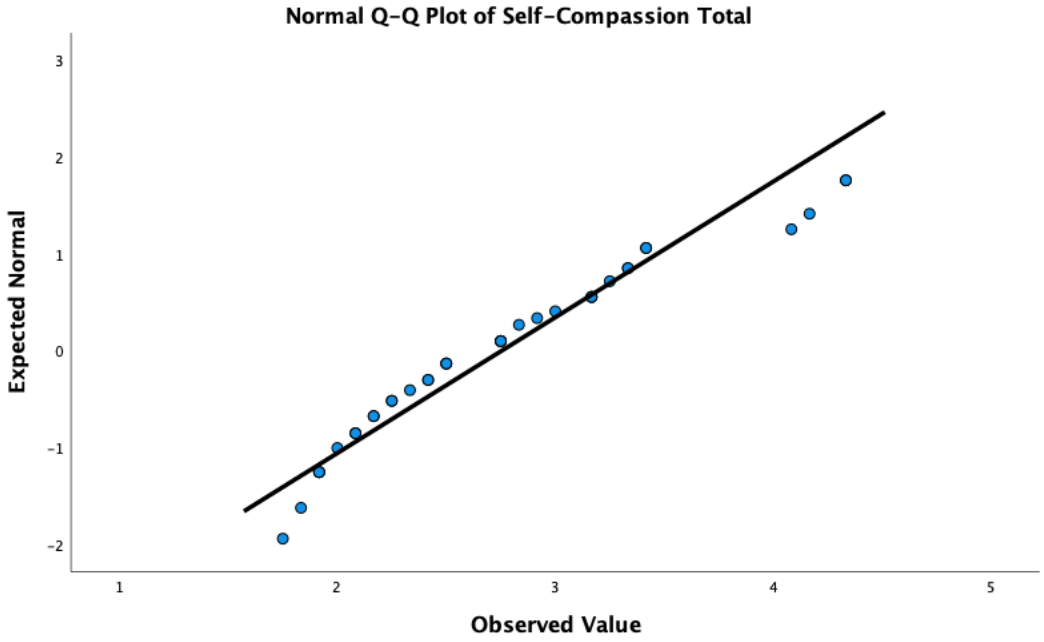

Normal P-P Plot of Self Comparison Total
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

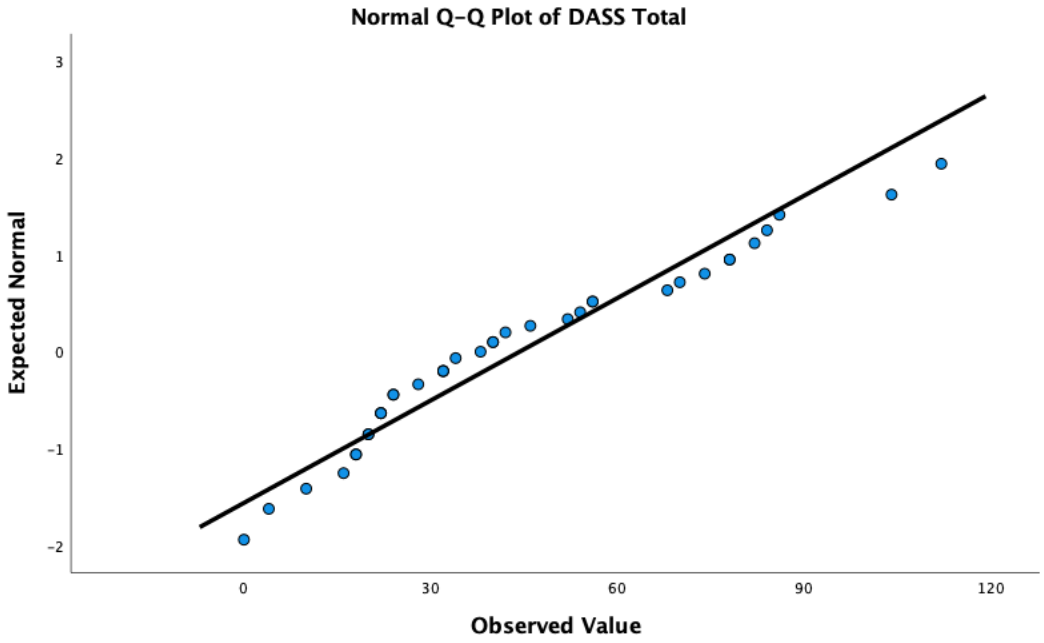

Normal P-P Plot of Other as Shamer Total
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

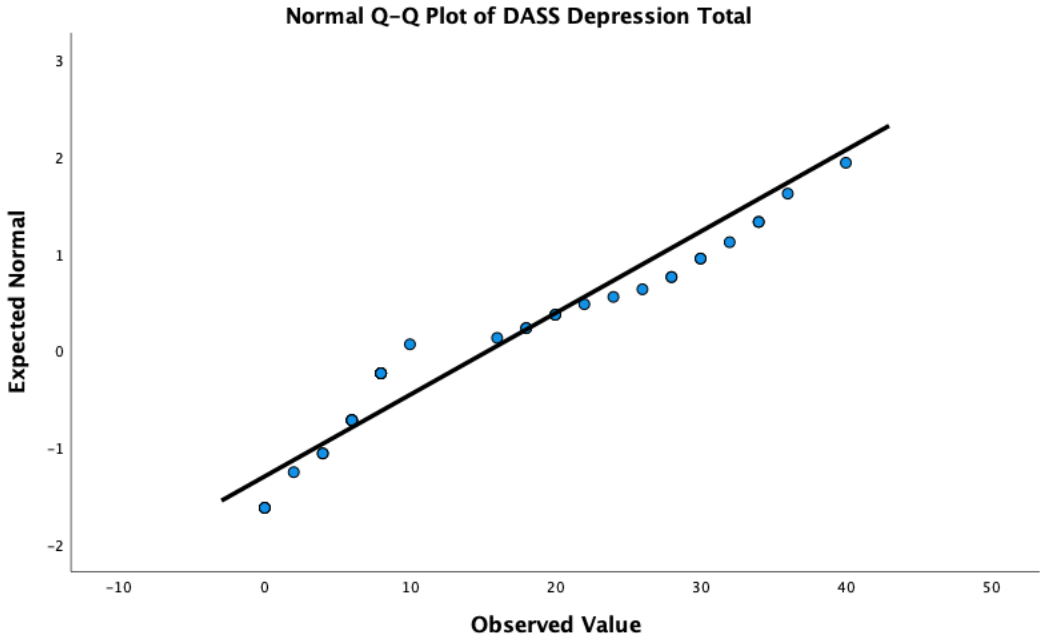

Normal P-P Plot of Self Concept Clarity Scale
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

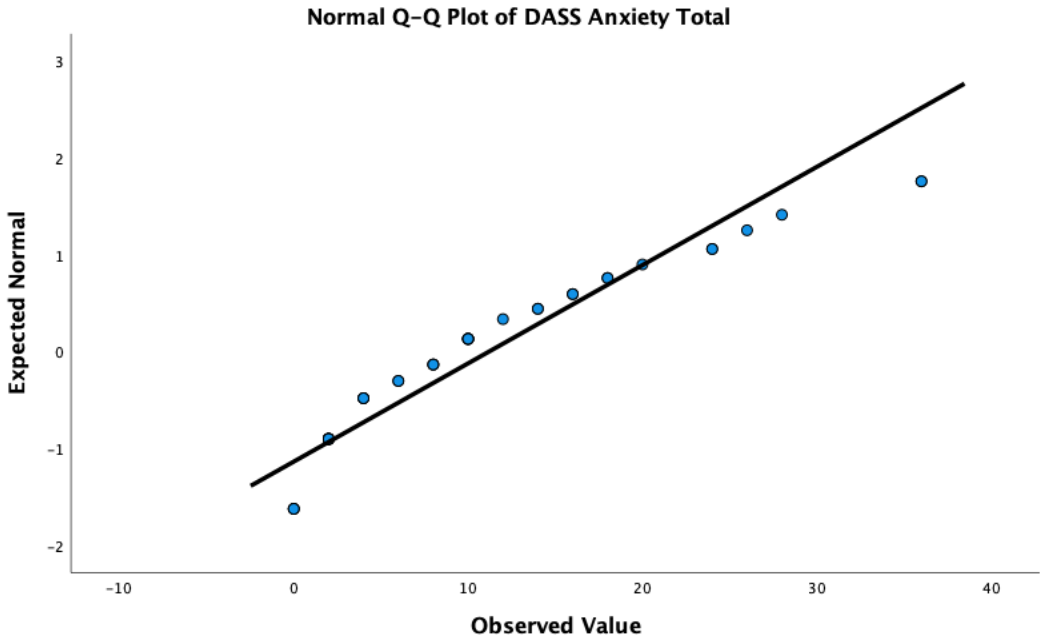
Q-Q Plots

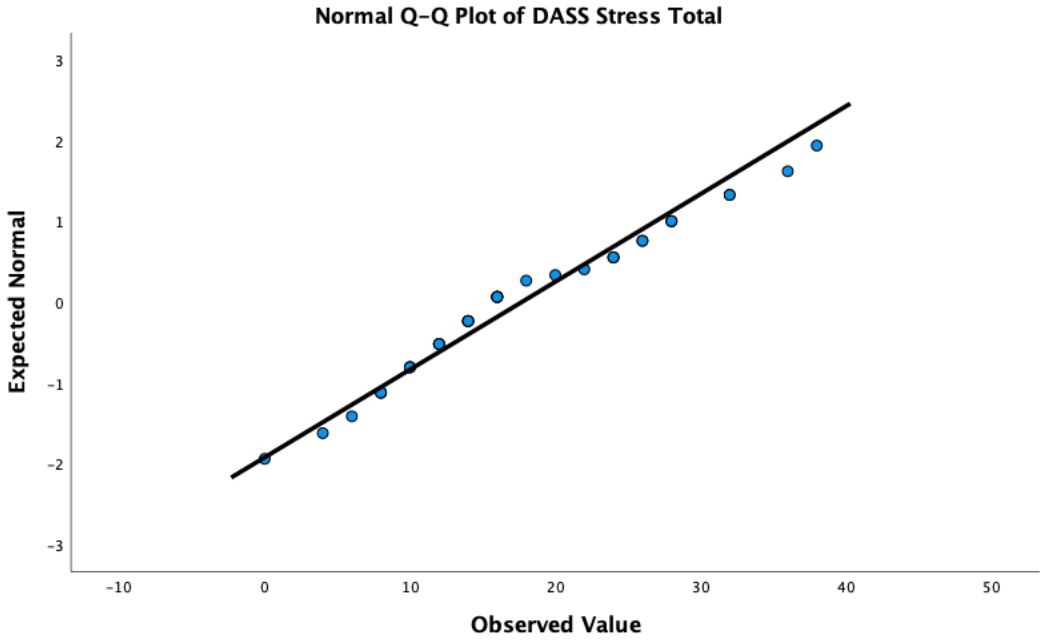

Normal Q-Q Plot of Total Mental Health Wellbeing Score
Expected Normal
Observed Value
3
2
1
0
-1
-2
-3
20
30
40
50
60
70

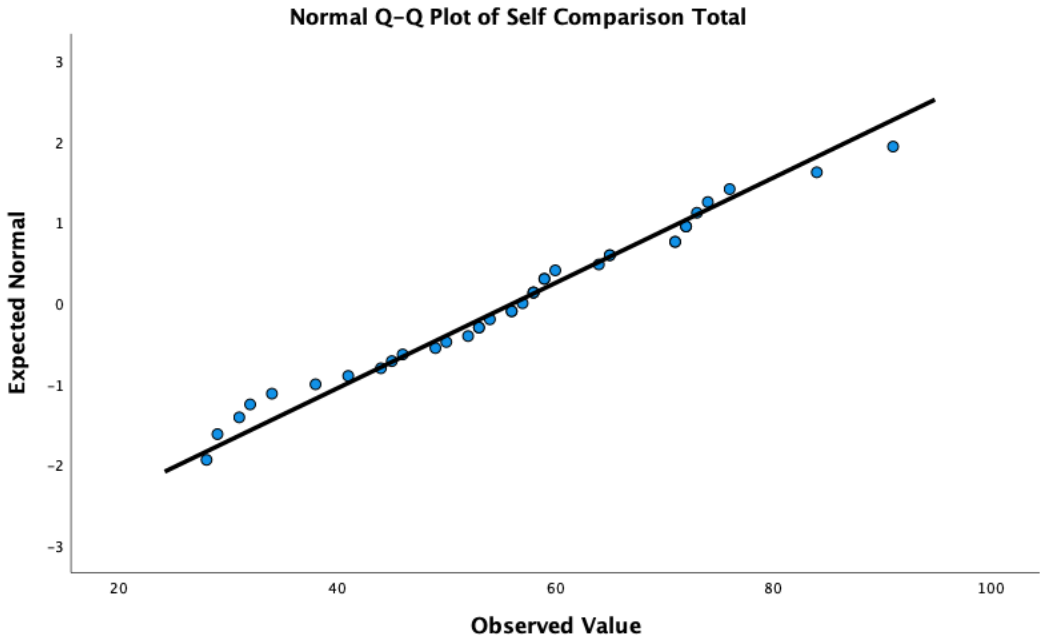

Normal Q-Q Plot of Self-Compassion Total
Expected Normal
3
2
1
0
-1
-2
1
2
3
4
5
Observed Value

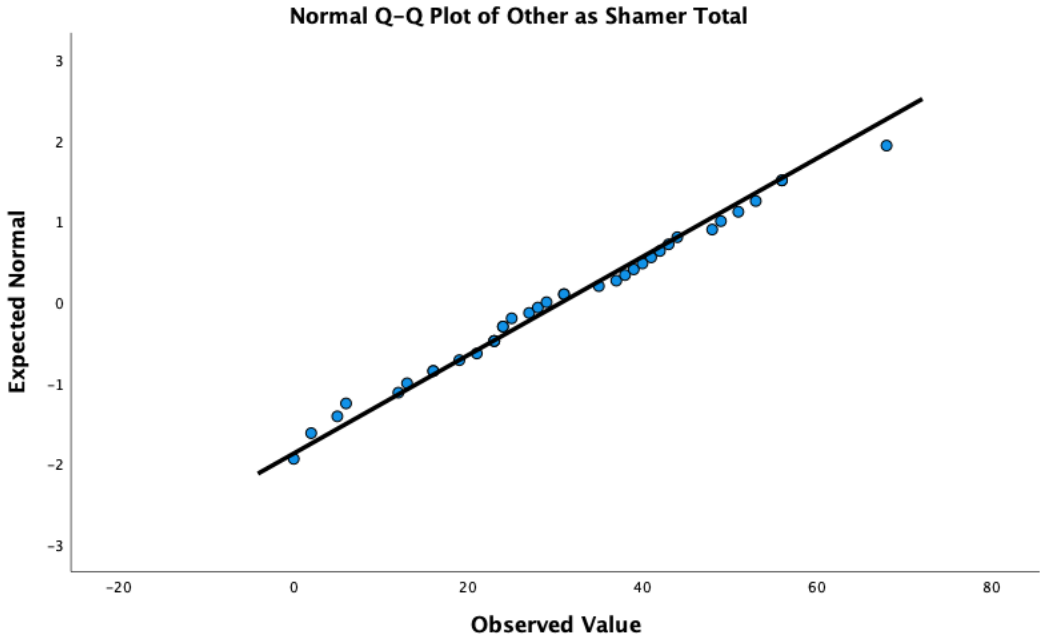

Normal Q-Q Plot of DASS Total
Expected Normal
3
2
1
0
-1
-2
0
30
60
90
120
Observed Value

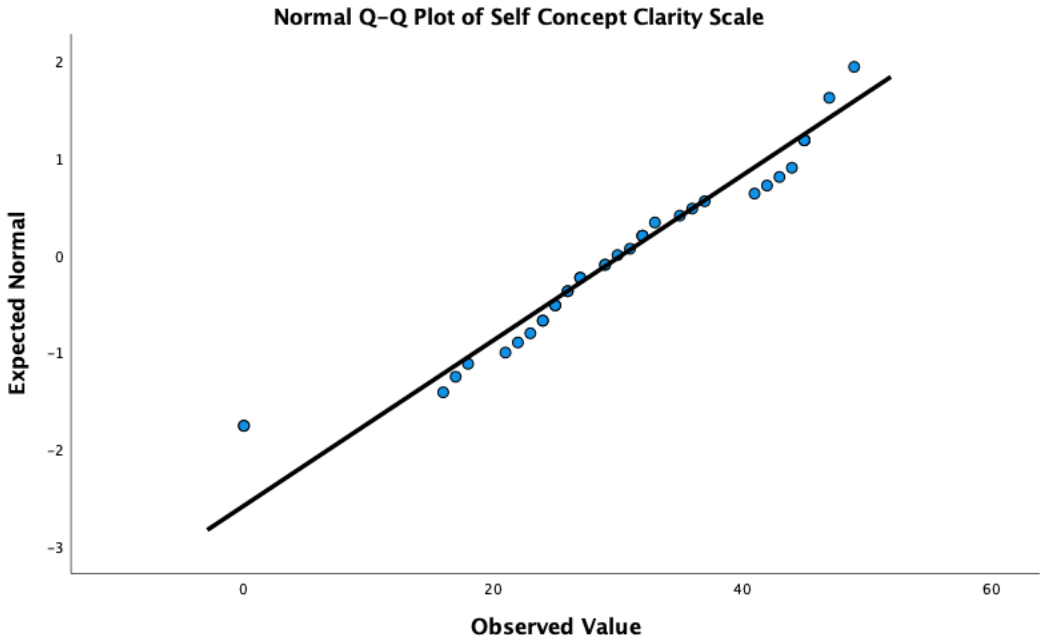

Normal Q-Q Plot of DASS Depression Total
Expected Normal
Observed Value
3
2
1
0
-1
-2
-10
0
10
20
30
40
50


Normal Q-Q Plot of DASS Anxiety Total
Expected Normal
Observed Value
3
2
1
0
-1
-2
-10
0
10
20
30
40


Normal Q-Q Plot of DASS Stress Total
Expected Normal
3
2
1
0
-1
-2
-3
-10
0
10
20
30
40
50
Observed Value


Normal Q-Q Plot of Self Comparison Total
Expected Normal
3
2
1
0
-1
-2
-3
20
40
60
80
100
Observed Value


Normal Q-Q Plot of Other as Shamer Total
Expected Normal
3
2
1
0
-1
-2
-3
-20
0
20
40
60
80
Observed Value


Normal Q-Q Plot of Self Concept Clarity Scale
Expected Normal
2
1
0
-1
-2
-3
0
20
40
60
Observed Value

Appendix W: Z Scores for Non-Normally Distributed Variables

DASS- 21 Stress	DASS- 21 Anxiety	DASS- 21 Depression
2.21	2.51	1.23
1.99	2.51	2.07
1.56	1.30	1.23
1.56	0.49	0.55
1.12	-0.73	-0.62
1.12	1.30	0.89
1.12	0.89	1.73
0.90	0.28	1.56
0.90	1.70	1.06
0.69	-0.12	1.56
0.69	0.28	0.22
0.69	1.50	1.06
0.47	-0.32	0.72
0.25	-0.73	-0.62
0.04	0.69	0.39
-0.18	0.49	0.39
-0.18	0.69	-0.96
-0.18	-0.12	0.05
-0.18	-0.12	-0.62
-0.18	-0.32	-0.62
-0.40	-0.12	-0.96
-0.40	0.08	-0.79
-0.40	-0.93	-0.79
-0.40	-0.93	-1.13
-0.62	-0.93	-0.62
-0.62	-0.12	0.22
-0.62	-0.93	1.40

-0.62	-0.93	-0.45
-0.83	-0.32	-0.79
-0.83	-0.73	-0.79
-0.83	-0.93	-0.62
-1.05	-0.93	-1.30
-1.05	-0.53	-0.62
-1.05	-1.13	-0.62
-1.27	-0.53	-0.79
-1.49	-1.13	-1.30
-1.92	-1.13	-1.30

Appendix X: SPSS Outputs for Multiple Regressions

Regression Model- Wellbeing

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.678[a]	.459	.410	7.011	2.230

a. Predictors: (Constant), Other as Shamer Total, Self-Compassion Total, Self Comparison Total

b. Dependent Variable: Total Mental Health Wellbeing Score

Bootstrap for Model Summary

Model	Durbin-Watson	Bootstrap[a]			
		Bias	Std. Error	95% Confidence Interval	
				Lower	Upper
1	2.230	-.791	.298	.884	2.052

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1378.345	3	459.448	9.347	<.001[b]
	Residual	1622.088	33	49.154		
	Total	3000.432	36			

a. Dependent Variable: Total Mental Health Wellbeing Score

b. Predictors: (Constant), Other as Shamer Total, Self-Compassion Total, Self Comparison Total

Bootstrap for Coefficients

Model		B	Bootstrap[a] Bias	Std. Error	Sig. (2-tailed)	95% Confidence Interval Lower	Upper
1	(Constant)	28.140	-.688	7.927	.002	11.421	42.739
	Self-Compassion Total	3.266	.041	1.510	.033	.157	6.135
	Self Comparison Total	.196	.009	.085	.030	.048	.387
	Other as Shamer Total	-.156	.002	.090	.078	-.308	.036

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Regression Model- Distress

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.715[a]	.511	.467	20.741	.964

a. Predictors: (Constant), Self Concept Clarity Scale, Self-Compassion Total, Other as Shamer Total

b. Dependent Variable: DASS Total

Bootstrap for Model Summary

Model	Durbin-Watson	Bootstrap[a] Bias	Std. Error	95% Confidence Interval Lower	Upper
1	.964	-.177	.221	.417	1.282

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	14844.874	3	4948.291	11.502	<.001[b]
	Residual	14196.423	33	430.195		
	Total	29041.297	36			

a. Dependent Variable: DASS Total

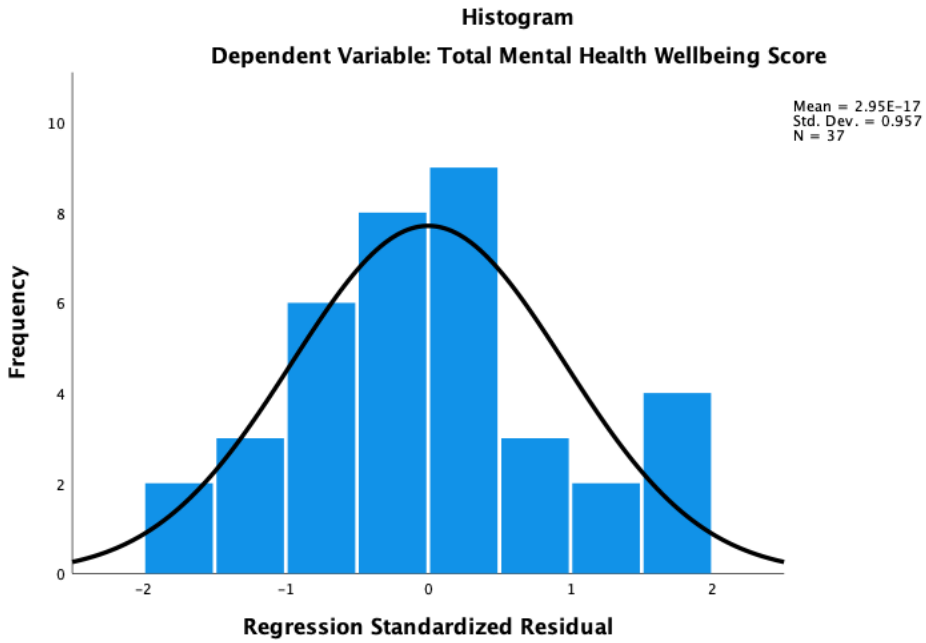
b. Predictors: (Constant), Self Concept Clarity Scale, Self-Compassion Total, Other as Shamer Total

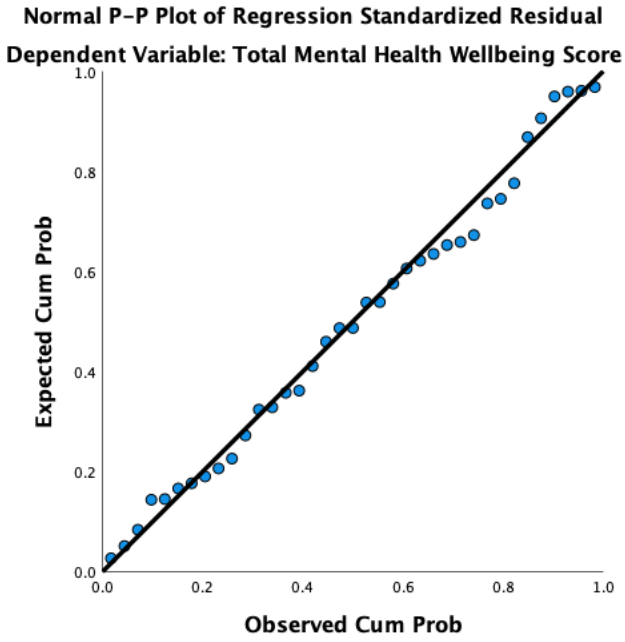
Bootstrap for Coefficients

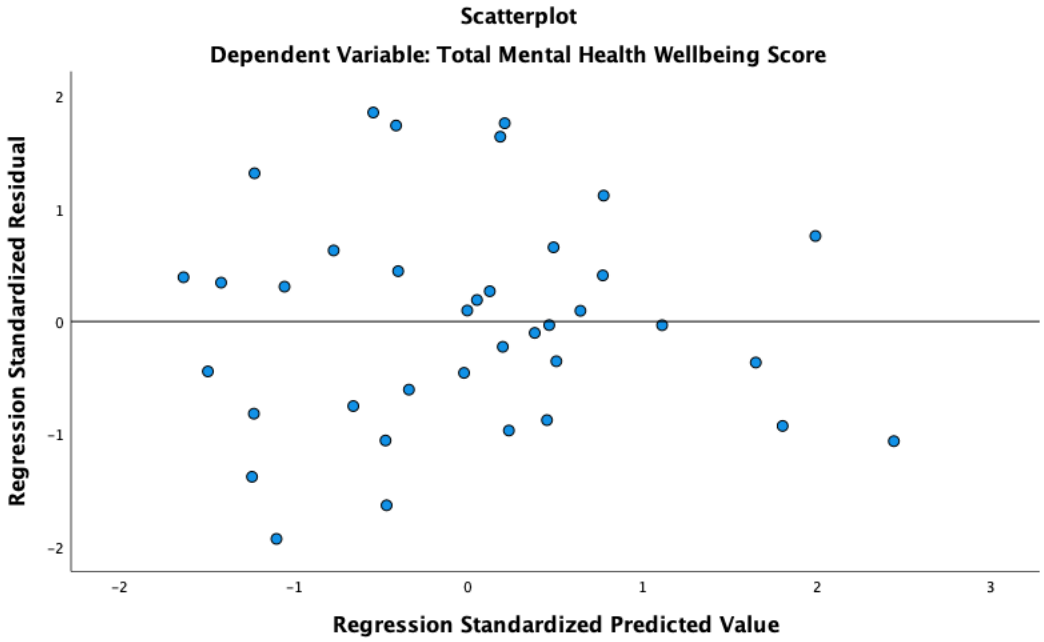
Model		B	Bootstrap[a] Bias	Std. Error	Sig. (2-tailed)	95% Confidence Interval Lower	Upper
1	(Constant)	74.865	5.249	23.092	.002	39.146	132.055
	Self-Compassion Total	-14.546	-1.450	5.811	.019	-28.163	-5.537
	Other as Shamer Total	.736	-.067	.295	.019	-.008	1.184
	Self Concept Clarity Scale	-.434	.020	.353	.202	-1.167	.356

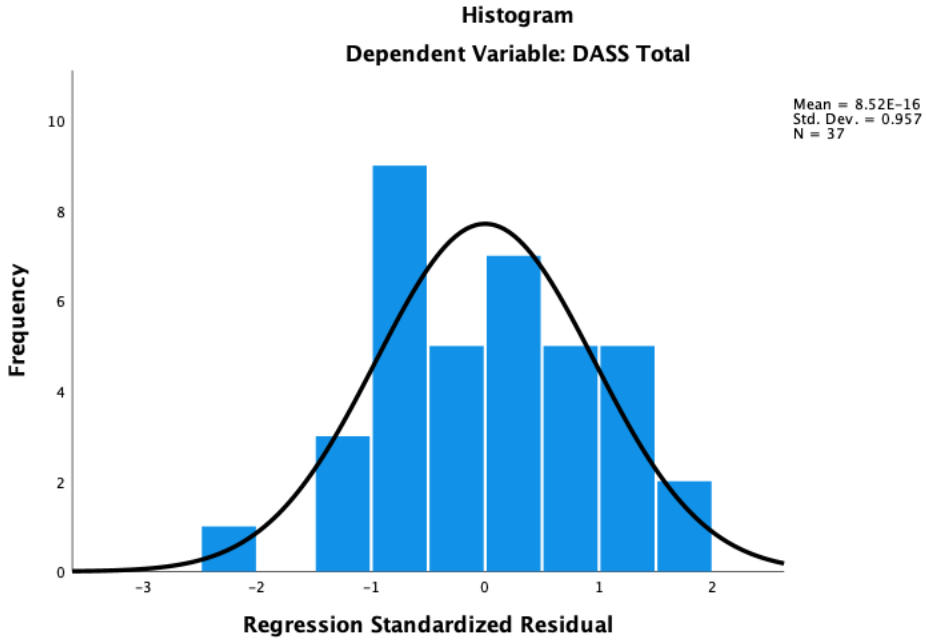
a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

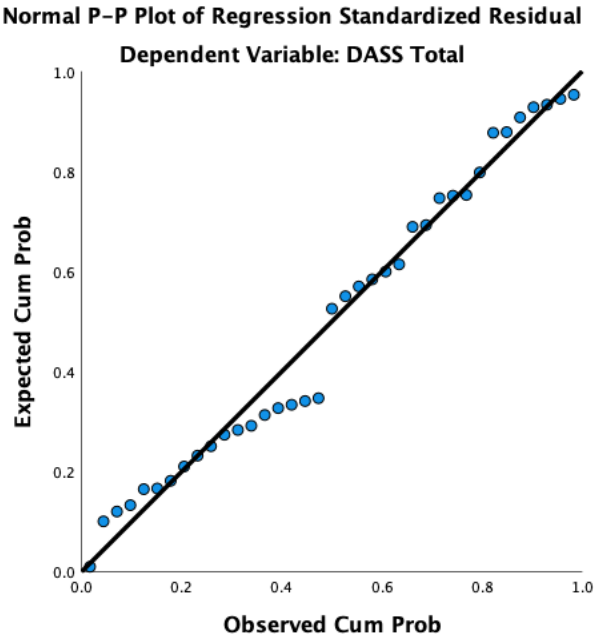
Appendix Y: Multiple Regression Assumption Tests

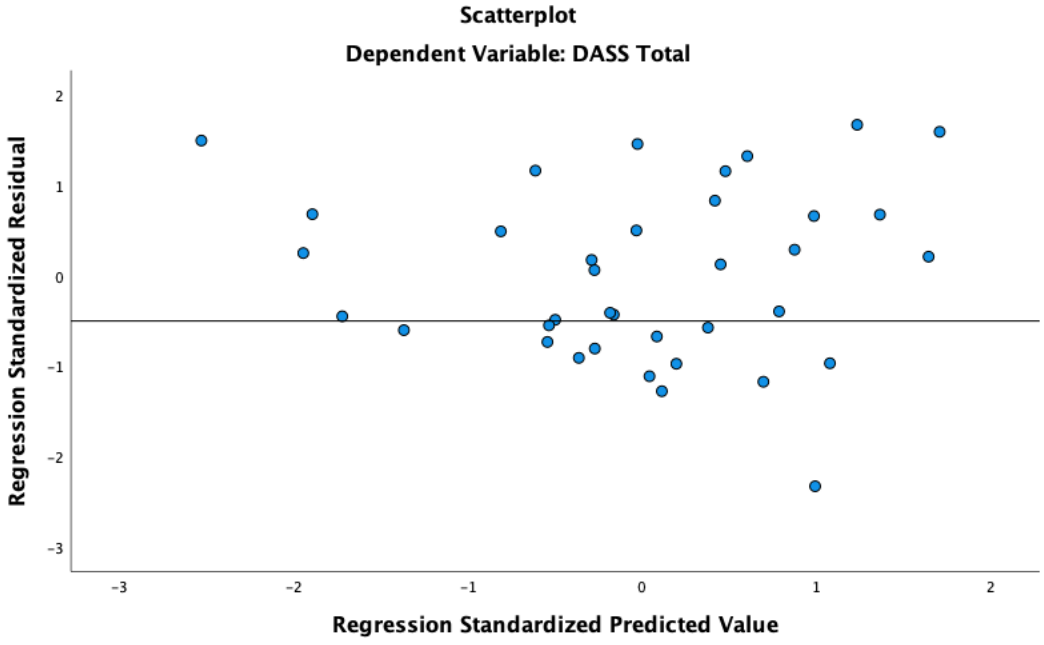





Scatterplot
Dependent Variable: Total Mental Health Wellbeing Score
Regression Standardized Residual
Regression Standardized Predicted Value
2
1
0
-1
-2
-2
-1
0
1
2
3


Histogram
Dependent Variable: DASS Total
Mean = 8.52E-16
Std. Dev. = 0.957
N = 37
Frequency
Regression Standardized Residual
10
8
6
4
2
0
-3
-2
-1
0
1
2


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: DASS Total
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0


Scatterplot
Dependent Variable: DASS Total
Regression Standardized Residual
Regression Standardized Predicted Value
2
1
0
-1
-2
-3

Appendix Z: SPSS Outputs for Moderation Analysis

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change	Durbin–Watson
1	.725[a]	.525	.482	20.437	.525	12.178	3	33	<.001	.913

a. Predictors: (Constant), SCShamemoderator2, Other as Shamer Total, Self-Compassion Total

b. Dependent Variable: DASS Total

Bootstrap for Model Summary

Model	Durbin–Watson	Bootstrap[a]			
		Bias	Std. Error	95% Confidence Interval	
				Lower	Upper
1	.913	-.144	.228	.379	1.302

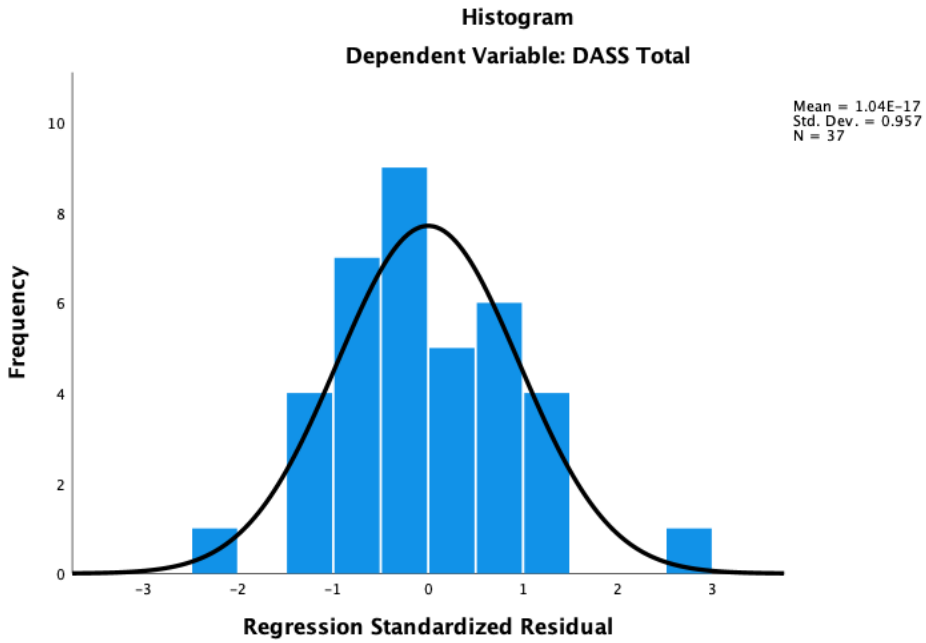
a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

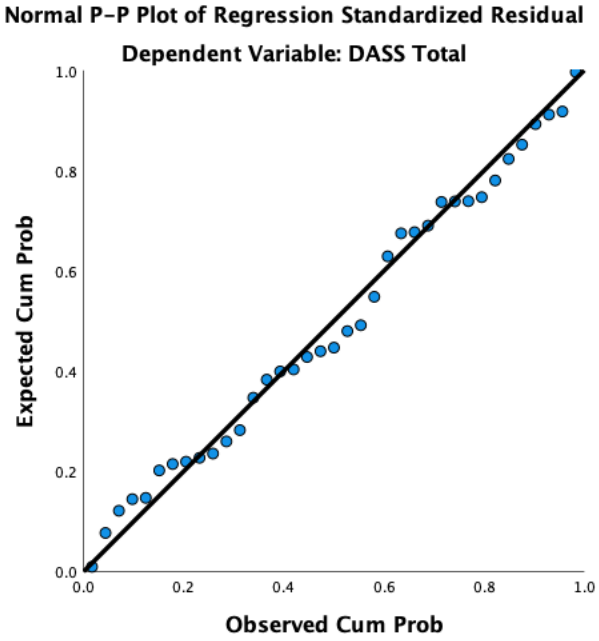
Bootstrap for Coefficients

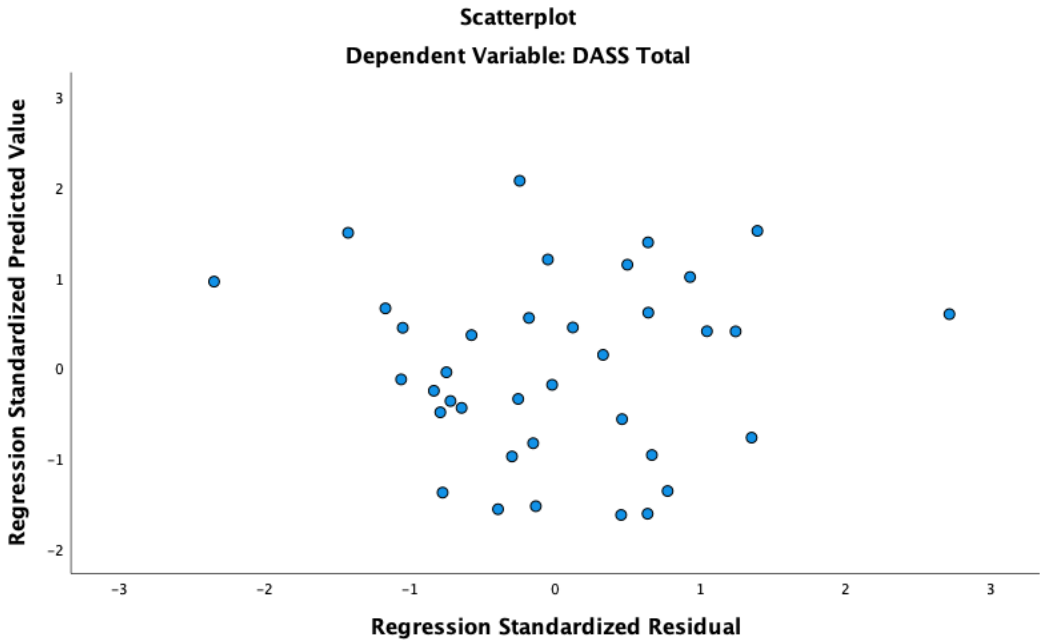
Model		B	Bootstrap[a]				
			Bias	Std. Error	Sig. (2-tailed)	95% Confidence Interval	
						Lower	Upper
1	(Constant)	44.276	3.054	19.592	.031	11.542	84.196
	Self-Compassion Total	-10.579	-.891	5.149	.039	-22.593	-2.965
	Other as Shamer Total	.870	-.039	.326	.010	.200	1.444
	SCShamemoderator2	-7.984	-.619	5.604	.180	-19.330	2.282

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Appendix AA: Moderation Analysis Assumptions Tests

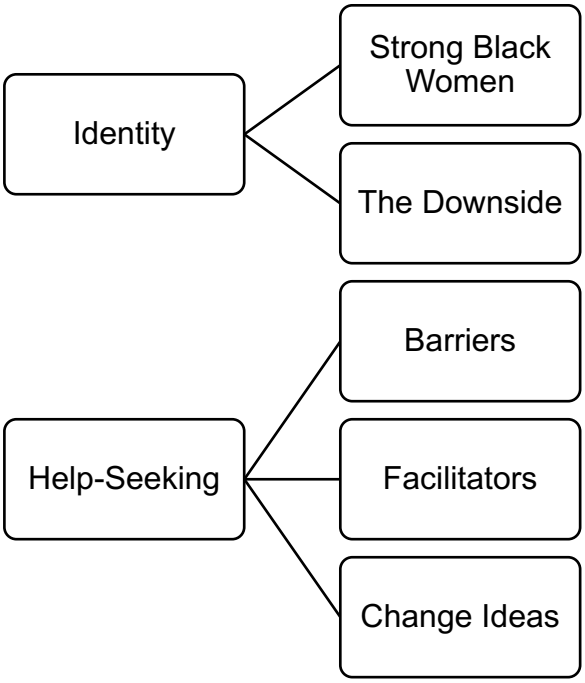




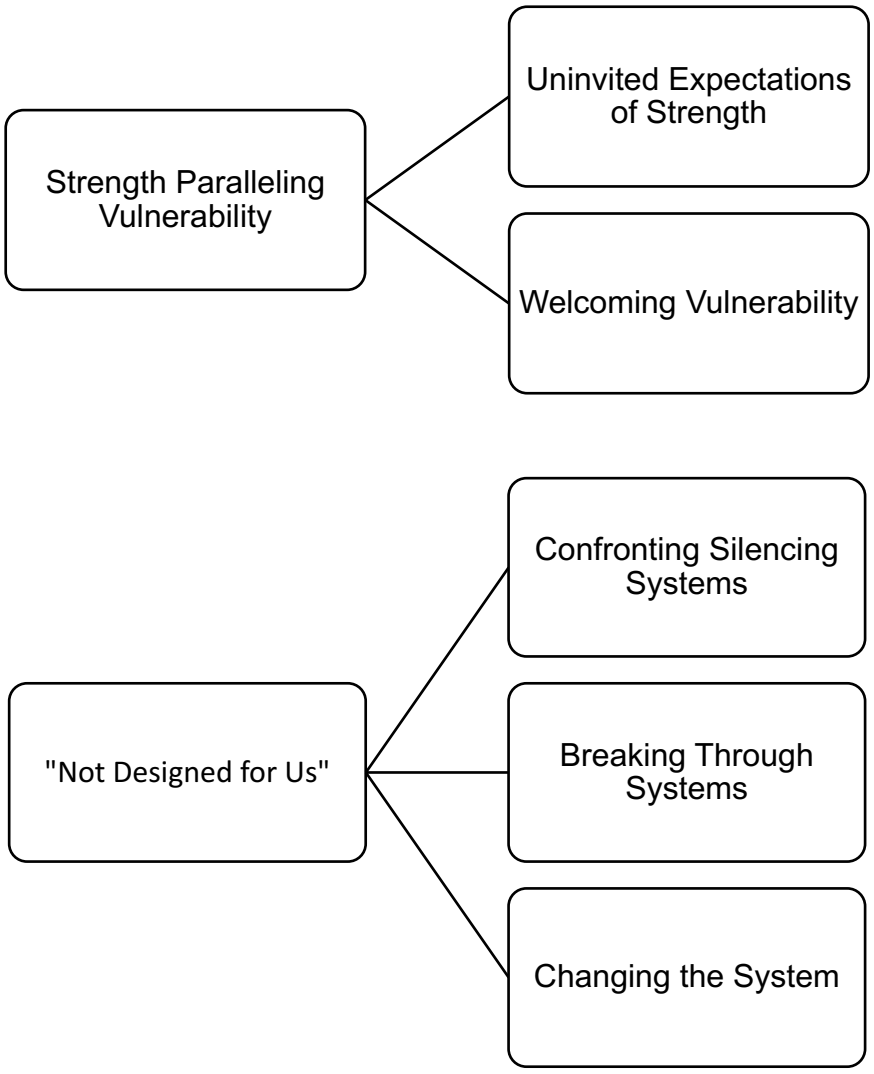

Scatterplot
Dependent Variable: DASS Total
Regression Standardized Predicted Value
Regression Standardized Residual
3
2
1
0
−1
−2
−3
−2
−1
0
1
2
3

Appendix AB: Initial Thematic Maps

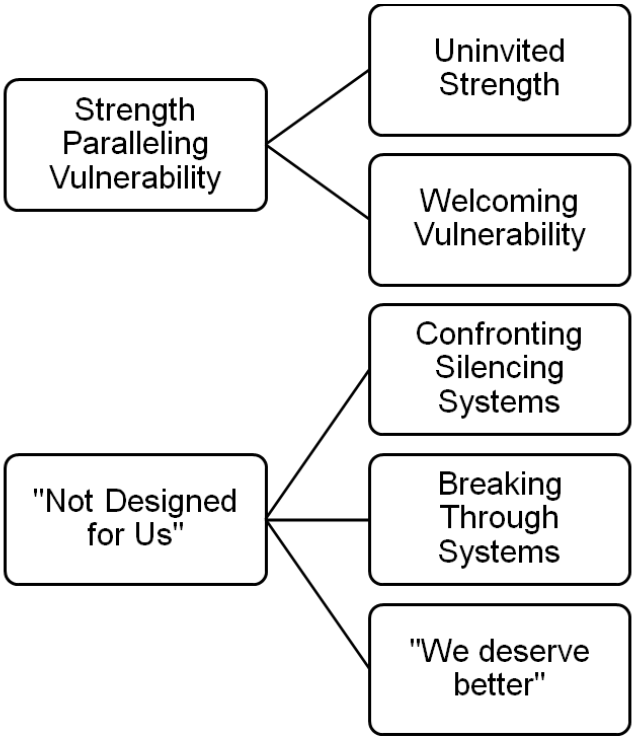
Version 1



Version 2


Strength Paralleling Vulnerability
Uninvited Expectations of Strength
Welcoming Vulnerability
"Not Designed for Us"
Confronting Silencing Systems
Breaking Through Systems
Changing the System

Version 3


Strength Paralleling Vulnerability
Uninvited Strength
Welcoming Vulnerability
"Not Designed for Us"
Confronting Silencing Systems
Breaking Through Systems
"We deserve better"

Appendix AC: Critical Review

Evaluation of the Study's Quantitative Component

Appropriateness of statistical tests	The quantitative analyses facilitated exploration of the associative, predictive and moderating relationships of the variables, thus meeting the study's objectives. The tests employed were appropriate for the sample size (e.g., 10 cases per variable for multiple regression) but as the sample size is relatively small, conclusions offered are tentative and should be cautiously generalised. As such, the generalisability of the current findings is limited and should not be considered applicable outside of the sample demographics (cisgender women who identify as Black) but can tentatively provide understanding of Black survivor's experiences following sexual violence.
Measures	All questionnaires used are established tools chosen on their high levels of reliability and validity within sexual violence research, which warranted use within the current study. The measures were shown to be internally reliable within the study.
Constructs	The exploration of psychological wellbeing and distress outside of a diagnostic perspective was a strength of this study. These constructs are more applicable to non-clinical populations compared to those in traditional psychiatric research (Bergsma & Veenhoven, 2011). Nevertheless, within this study, psychological wellbeing was considered to consist of eudiamonic and hedonic components. As such, the WEMWBS was used to capture feelings and behaviour related to wellbeing. Although the measure has been reliably used to support the eudiamonic-hedonic conceptualisation of wellbeing (Winefield et al., 2012), it may not have captured all indicators of psychological wellbeing pertinent to participants in this study. Cultural factors are argued influential in an individual's perception of psychological wellbeing (Lomas, 2015). Considering the possible migration histories and cultural context of the participants, other indicators of life quality (e.g., community belonging) may not have been captured. Psychological distress is commonly conceptualised as a combination of experiences related to sadness, irritability, anxiety (Winefield et al., 2012). Thereby the use of the DASS-21 which conceptualises psychological distress as experiences of depression, anxiety and stress was appropriate. Furthermore, its use as a measure for general psychological distress has been well supported (e.g., Zanon et al., 2020). Literature has shown that measuring self-concept clarity provides an accurate representation of an individual's sense of identity (Ellison et al., 2019). However, the SCC measure and related research has mostly focused on one dimension of identity, personal identity (Usborne & Taylor, 2010). For minoritised groups, such as Black women, a stable cultural identity may be pertinent for wellbeing (Taylor, 2002). Therefore, the use of the SCC measure within this study may have been limited. Quantitative investigation into the importance and stability of intersecting

	identities could have provided a more nuanced understanding of self-concept for Black women. Shame research can often conflate experiences of shame (Gilbert, 1998). As such, this study's exploration of both internal and external experiences of shame was a strength. The findings displayed the complexity of shame experiences and interesting relationships with self-compassion. Self-compassion was not a significant moderator between external shame and psychological distress, despite the literature suggesting otherwise (Bhuptani & Messman, 2021; Close, 2013). This may have highlighted conceptual issues with self-compassion and its application to shame. Most research has explored self-compassion in relation to internal shame. Although the experience of internal and external shame may be qualitatively similar, they may require different interventions (Callow et al., 2021) and be experienced differently across cultures (Kotera et al., 2021). Therefore, further exploration of how Black women conceptualise shame and self-compassion may be useful. Integrating sociopolitical context into quantitative measures could be considered in future research (Gkiouleka et al., 2018).

Evaluation of the Study's Qualitative Component

Sensitivity to context	The introduction chapter outlined the relevant theoretical, sociocultural and historical context that grounded the current study. The researcher was reflective throughout the process and mindful of her position and identity in relation to the participants and the topic in general. Issues of power and oppression were continually considered via a reflective journal and supervision.
Commitment and rigour	Multiple resources and approaches to data collection as well as analysis were considered to ensure rigour at each stage of the research process. The main concern for the researcher was the needs and voices of the participants. The researcher was committed to maintaining the integrity of the participants' contributions. As such, the researcher was sure to clarify any inaudible information to limit misunderstanding. The researcher was committed to representing the voices of all participants to display the variation and nuance of their stories hence the inclusion of fuller quotes as to not diminish the participants' perspectives.
Coherence and transparency	The researcher documented the process of the research design, method, data collection and analysis, to ensure a coherent and transparent account of the study. Extracts of the researchers' reflective journal and interview transcript are provided for further transparency along with preliminary versions of the thematic maps. Discussion of the study limitations also aimed to provide transparency.
Impact and importance	The study was the first to explore identity and help-seeking with Black women survivors within the UK. The study provides a more nuanced understanding of Black women's experiences following sexual violence and situates their experiences within the wider sociocultural and historical context. The contextualisation of the participants experiences limited pathologisation and facilitated thinking around systemic influences opposed to locating the problem within the participants as has been done historically. As a result, the clinical and policy implications offered broader ideas and considerations to address systemic failings.