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South African rape survivors' expressions of shame, self-blame and internalized-stigma

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ABSTRACT

Post-rape research and support often focuses on external stigma, yet many rape survivors experience appreciable shame, self-blame and internalized-stigma. Despite a growing literature describing the impact of these feelings on survivors' emotional wellbeing, there has been little research on this in South Africa, where an average of 40,000 rape cases are reported annually. To strengthen our understanding of female rape survivors' experiences and perceptions of shame, self-blame and internalized-stigma, we undertook qualitative research with 16 survivors in eThekwini, South Africa. They participated in 2–3 in-depth and life history interviews, that sought to enable them to express how they made meaning of post-rape internalized-stigma, shame and self-blame, and how these may have influenced their psychological reactions to rape. The paper describes the women's experiences and reactions to the rape and reflects on how their descriptions contribute to theoretical perspectives on shame, self-blame and internalized-stigma. The women expressed feelings of shame, self-blame, and internalized-stigma, describing these as distinct, yet inter-connected. These feelings were a reaction to views expressed by family, community members and service providers, their relationship to the perpetrator, the extent of gossip about the incident and gender norms and rape myths. Furthermore, while the stigma was felt at an individual level, it was driven by external stigma enacted at interpersonal and structural/community levels. Women who had experienced more than one rape, explained this through the internally-stigmatizing notion of being 'rape-able'. This study addresses a significant knowledge gap which could improve contextually appropriate post-rape care services and interventions in South Africa, particularly psychological support for survivors. Finally, while rape survivors should be supported to address their own shame, self-blame and internalized-stigma, external stigma needs to be addressed at interpersonal and structural levels.

1. Introduction

South Africa has an alarmingly high incidence of rape, with its associated health consequences, making rape a significant societal and public health crisis (Abrahams et al., 2020). In the past decade, an average of 40,000 cases of rape were reported to the police annually with most cases involving women and girl complainants (South African Police Services, 2022). Additionally, research and practice-based knowledge, both globally and in South Africa, have suggested that most rape survivors do not report to police, receive post-rape care, nor seek psychosocial support (Overstreet and Quinn, 2013; Abrahams and Gevers, 2017; Machisa et al., 2018; Stangl et al., 2019). Several cross-sectional and longitudinal studies conducted in South Africa have found increased risk for adverse psychological outcomes including post-traumatic stress disorder (PTSD), depression, substance abuse disorders, suicidality and HIV acquisition among female rape survivors compared to women who had not experienced a rape (Kaminer et al., 2008; Abrahams et al., 2013; Elklit and Christiansen, 2013; Mgoqi-Mbalo et al., 2017; Wyatt et al., 2017; Dworkin, 2020; Abrahams et al., 2021; Machisa et al., 2022; Nöthling et al., 2022).

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Many women do not seek help in the aftermath of rape. Research shows this is due to inter-connected reasons, including gendered social norms, stereotypical rape myths that blame women's character, appearance or behavior, rape survivor's personal internal meaning-making, intersectional-stigma and the development of adverse psychological outcomes (Overstreet and Quinn, 2013; Ullman et al., 2014; McCleary-Sills et al., 2016; Dworkin et al., 2017; Stangl et al., 2019; Turan et al., 2019; Abrahams et al., 2021). Many of these factors also drive the high levels of stigma which rape survivors experience, including external stigma, internalized-stigma, shame and self-blame (Aakvaag et al., 2016; Wyatt et al., 2017; Turan et al., 2019; Abrahams et al., 2021). Specific rape myths in the South African context include: that rape is driven by women dressing a certain way or being visibly drunk, women are 'accidently' raped because they 'play hard to get', rape is about men's need for sex, and rapists are always strangers (Gqola, 2015). Furthermore, undermining of a woman's report of rape by a person who she considers as 'important' was shown to negatively impact her emotional wellbeing and drive feelings of self-blame (Abrahams et al., 2013; Wyatt et al., 2017). However, more research is needed amoung women living in urban spaces in South Africa to understand the role of internalized-stigma, shame and self-blame in survivors meaning making regarding their experiences of rape. Gathering women's personal narratives is important for developing contextually appropriate and effective psychosocial responses for South African women post rape.

Rape stigmatisation has been defined as "the process embedded within rape survivors or in their social relationships that devalues, blames, shames, confers labels, and stereotypes their character and trauma" (Pescosolido and Martin, 2015). Since Goffman first wrote about stigma in the 1960's (Goffman, 1963), researchers agree that stigma, including rape stigma, is socially constructed and constantly shifting. Furthermore, rape stigma is driven by gender inequalities and norms and often exacerbated by racial and class inequalities (Pescosolido and Martin, 2015).

Recent research on rape and sexual violence stigma highlights the multiple levels and intersectional nature of such stigma, much of which is building on Stangl and colleagues development of the Health Stigma and Discrimination Framework (Stangl et al., 2019; Turan et al., 2019; Murray et al., 2021). Intersectional stigma recognizes the convergence of multiple stigmatized identities within one person or population group, including race, class, gender, sexual orientation, health status, IPV or rape survivor (Overstreet and Quinn, 2013; Stangl et al., 2019; Turan et al., 2019). These multiple stigmas are not merely additive, their intersecting nature often creates more complex impacts for individuals such as worsening health behaviours and outcomes (Turan et al., 2019), decreasing help-seeking behaviour and deepening the impacts of stigma (Overstreet and Quinn, 2013; Stangl et al., 2019). The Intimate Partner Violence Stigmatisation Model reflects on the multiple levels at which stigma operates, namely individual level, interpersonal level (family and friends) and cultural/structural/community level (Overstreet and Quinn, 2013). These multi-levels intersect, and drive one another, for example negative attitudes from service providers and rape myths, drives internalized-stigma, shame and self-blame at the individual level. As such internalized-stigma, shame and self-blame is frequently an outcome of stigma operating at the interpersonal and community/-structural levels and is not an individual issue. The multiple levels at which stigma operates also limit women's help-seeking behaviours, making survivors less likely to approach health care workers or police who they know or perceive to stigmatize survivors (Overstreet and Quinn, 2013). Recognising the complexity of both intersecting and multi-levelled stigmas experienced by rape survivors is vital for shaping rape prevention and support for survivors.

Goffman's seminal work argues that a stigmatized identity 'denotes a mark of failure or shame' which usually involves negative labels and social exclusion. He identified three forms of stigma, 1) stigma associated with physical health ailments (HIV, mental health issues etc), 2) stigma associated with ones "moral character or behaviour" (smoking, drug use, gender-based violence survivor, sex work etc) and 3) stigma attached to identity (race, gender, religion, sexual orientation etc) (Goffman, 1963; Turan et al., 2019). Stigma is further discussed as external and internalized. External stigma involves other people or groups directing negative behaviours and attitudes towards a person or group being stigmatized. In contrast, internalized-stigma occurs when societal attitudes/beliefs are internalized and become a part of how people perceive themselves (Goffman, 1963). Literature uses both self or internalized-stigma, the authors believe internalized-stigma more accurately reflects that the stigma is internalized *in reaction* to harmful attitudes and norms people experience, whereas self-stigma may imply one stigmatizes oneself, ignoring the external factors. Internalized-stigma is a mindset of negative beliefs, thoughts, and behaviours that manifest in self-blame and shame. Internalized-stigma following rape is largely driven by survivors' cognitive appraisals and beliefs about why the rape occurred, often informed by rape myths and external stigma (Ullman et al., 2014). While internalized-stigma operates at the individual level, it is the enactment of external and/or anticipated stigma at the interpersonal, structural and community levels which drives this stigma. At the individual level there are three mechanisms through which stigma operates namely enacted or externalized stigma (stigma experienced from other people), anticipated stigma (anticipation that stigma will be experienced), and internalized-stigma (enacted or externalized stigma is internalized towards oneself). Furthermore, research exploring HIV-related stigma in South Africa found anticipated rather than enacted stigma to be more prevalent and a greater driver of internalized-stigma (Treves-Kagan et al., 2015), this may well apply with rape-stigma. Studies found that negative or unsupportive responses to survivors' disclosure of rape significantly impacts on their feelings of internalized-stigma, self-blame and shame (Ullman et al., 2014; Sigurvinsdottir and Ullman, 2015; Wyatt et al., 2017). Ullman found in a study in the USA, that how family, friends, community and service providers respond when survivors disclose rape influences how or whether survivors blame themselves, express feelings of internalized-stigma or shame, or experience poor emotional well-being (Ullman et al., 2014). Other research in the USA found negative social reactions at interpersonal (family and friends) and structural levels to rape disclosure to be associated with poorer recovery outcomes such as depression, PTSD, and increased risk of re-victimization (Sigurvinsdottir and Ullman, 2015) and greater barriers to help-seeking (Overstreet and Quinn, 2013).

Self-blame has been described as internalized and cognitive feelings of responsibility for the violence experienced. In some instances it is informed by how women behaved prior to the rape, how they responded during the rape, including a possible loss of self-control during the rape and victim-blaming, often linked to rape myths and gendered stereotypes, in wider society and at multiple levels (Sigurvinsdottir and Ullman, 2015). Two forms of self-blame have been expounded: *behavioral self-blame* which involves the survivor believing the rape is their fault because of their behavior which they believe they can control, and *characterological self-blame*, where the survivor believes the rape is their fault because of their character, that cannot be modified (Janoff-Bulman, 1979). Self-blame among rape survivors has been found to lead to greater psychological distress and increased risk of re-victimization (Dworkin et al., 2017).

The work of Brown has articulated shame as "the gendered psychosocial-cultural construct that is characterised by intensely painful feeling or experience of believing one is flawed, therefore unworthy of love and belonging" (Brown et al., 2011). Studies show that feelings of shame are associated with experiencing violence. Aakvaag and colleagues found that among over 4500 Norwegian participants, all types of severe sexual and intimate partner violence were significantly associated with shame, and that the more trauma survivors experienced the higher the levels of shame became (Aakvaag et al., 2016). A Tanzanian study found many women did not report IPV as they did not want to bring feelings of shame and stigmatisation onto themselves and/or their

families, they were often made to feel ashamed for even *talking* about the violence. The shame experienced at an individual level by women emerged from normative views at interpersonal and structural levels that marriages are private spaces. Further, these women also felt ashamed about *experiencing* violence (McCleary-Sills et al., 2016). Shame following abuse has also been found to lower women's self-efficacy in seeking help and their sense of self-worth, particularly when considering exiting an abusive relationship (Overstreet and Quinn, 2013).

There is a growing body of work, particularly in the global North and conflict settings, that has sought to specifically distinguish internalized-stigma, self-blame and shame as separate although inter-connected concepts of internalized-stigma (Ullman et al., 2014; Aakvaag et al., 2016; Murray et al., 2021). However, the South African context is vastly different to global North settings, and research focused on how rape survivors in South Africa experience and understand shame, self-blame and internalized-stigma, and their impacts on emotional wellbeing is under-researched. Jewkes et al. (2022)'s confirmatory analyses proved validity of a rape internal stigma scale that combined the constructs of internalized-stigma, shame and self-blame among a cohort of 852 rape survivors in South Africa. They reported a high prevalence of rape stigma and that internally-stigmatizing thoughts and external stigma were bi-directionally related, i.e., external stigma was a driver of internalized-stigma and vice versa. Furthermore, prior trauma exposure was an aggravating factor (Jewkes et al., 2022). Notwithstanding, qualitative research is needed to develop a deeper understanding of how rape survivors understand and experience shame, self-blame, and internalized-stigma in South Africa and how these constructs converge, diverge, and overlap, as shown elsewhere (Brown, 2006; Ullman et al., 2014; Aakvaag et al., 2016). While the work from the global North and conflict settings provides valuable frameworks, research has shown the critical importance of local research to support contextual understanding and adaptation of all violence prevention and support interventions (Jewkes et al., 2020). Furthermore, the theoretical constructs of rape related self-blame, shame and internalized-stigma and women's meaning making thereof has not been widely interrogated amongst women in South Africa, and we aimed to address that gap.

The Rape Impact Cohort Evaluation (RICE) study in eThekwini, South Africa (Abrahams et al., 2017) provided an opportunity for us to deepen our understanding of how some South African rape survivors experience internalized-stigma, self-blame and shame. Through qualitative research we sought to describe how these survivors understood, expressed, and made meaning of post-rape internalized-stigma, shame and self-blame and how these concepts may shape the psychological effects of rape. The paper will present the women's experiences, feelings and expressions of post-rape shame, self-blame and internalized-stigma and then discuss how these manifested and whether and how their experiences align with and develop existing knowledge, concluding with recommendations for using this knowledge to improve post rape care services and support.

2. Methods

2.1. Data collection

In 2021, we recruited sixteen female rape survivors from the original Rape Impact Cohort Evaluation (RICE) study (enrolled between 2015 and 2019) to participate in the qualitative study. Survivors were enrolled into the parent study after a recent rape event (within 20 days of a rape incident) and all participants were asked if they were interested in participating in further qualitative research. They were recruited from five post-rape care services (4 Thuthuzela Care Centres (TCCs) and one Crisis Clinic) based in eThekwini, South Africa (Abrahams et al., 2017). TCCs are 24-h, public, one-stop services for rape survivors providing medico-legal assistance, support and counselling services. In 2021 we undertook purposeful sampling of the 27 women who had indicated an interest in the qualitative research, and whose contact details had not changed. We contacted these women telephonically and then undertook recruitment meetings with 22 women who expressed interest, these were undertaken at the women's homes or nearby to explain the study further and invite them to join. Sixteen women gave consent. They were all invited to a first interview, following the first interview we invited women who were comfortable sharing details of their rape experiences, and whose stories appeared to include situations likely to drive internalized rape stigma, for a second interview. The women live in urban settings characterized by extremely high levels of poverty, unemployment, gender-based violence, patriarchy and very limited public services including support for rape survivors. All the perpetrators were men.

We conducted 2–3 qualitative interviews with each woman between November 2021 and June 2022, and involved the same Research Assistants (RA) from the parent study. The RAs are the 3rd, 4th, 5th and 6th authors on this paper. The 8th author was the Principal Investigator in RICE, the other authors are in the same Research Unit, and joined the RICE research team to undertake this qualitative work. Woman participated in a first in-depth interview (IDI), followed by a second interview that was either an expanded IDI (9 woman) or a life history interview (6 woman). Four women were invited back for a third IDI. Audio-recorded interviews were conducted in isiZulu for 30–120 min, and later translated and transcribed into English. Researchers also kept observation notes capturing observations about the woman such as her life circumstances, wellbeing or apparent triggers. All participants and the research team were provided with regular de-briefing and psycho-social support as needed. The research team held bi-weekly de-briefing sessions as well as attending a 6-week course with a trauma counsellor who provided skills on self-care, processing vicarious trauma etc. Participants had individual sessions after each interview with a registered counsellor and were also provided with an information sheet with details of support services. Furthermore, the project had a psychologist to support staff and participants as needed.

The first interview focused on re-establishing trust (as these were 1–2 years after completion of the parent study), discussing the details of the rape(s) and how they dealt with the event. The second interview, as either an IDI or Life History interview, delved deeper into the impact of the rape on their lives, who they told, reactions they received, their feelings and how these shifted over time, particularly exploring concepts of shame, self-blame, internalized-stigma and emotional wellbeing. For the Life History interviews, the researchers drew a timeline with the participant as a visual aid to support the participant to dig deeper and narrate and recall the incident, her reactions and emotions and any changes over time (Luke et al., 2011; Scorgie et al., 2021). Following the first IDI, some women were purposively selected to participate in Life History (LH) interviews (while others did a second expanded IDI), the criteria for inclusion in a LH interview included women who appeared to be comfortable delving deep into their feelings and experiences and therefore who were more likely to respond to the opportunity to share more details. A second criteria for selection was women with greater complexity in their experiences and where we needed more data to understand their lives and experience fully. Due to the potentially triggering nature of the discussion, the interviews were halted as needed when the participants, and in some cases the researchers, experienced strong feelings, crying, distress or simply needed a break (Table 1).

2.2. Data analysis

Inductive analysis was undertaken collaboratively among all team members to enable exploration of the women's stories, experiences, and feelings. All transcripts, full descriptive narratives of the photographed life history timelines, and researchers' observation notes were analysed. Our analysis drew from participants' expressions of their feelings at different points during and after the rape as well as underlying meanings related to their expressions of their feelings, behaviour, responses and interactions, or lack thereof, with other people in their lives. We used a

Table 1
Participant characteristics (names are pseudonyms).

Name (age)	No. of children	IDI or Life History (LH) interview	Summary details about perpetrators and the incident
Amahle (26)	0	IDI x2	Family member
Anele (29)	2	IDI x3	A stranger who offered to take the survivor to a person who would give her a job.
Khaya (29)	1	IDI x2	Male stranger who grabbed her when walking home at night.
Lindelwa (30)	0	IDI x2 LH x1	1st rape - brother 2nd rape – stranger
Londi (34)	3	IDI x1 LH x1	Two strangers from the community.
Nokuphila (24)	1	IDI x2	Acquaintance who was asking her out. Flatmate later informed her he was a serial rapist.
Nokwazi (37)	2	IDI x2	Her casual partner from the adjacent community.
Nonku (38)	0	IDI x2 LH x1	Acquaintance from university, not a close friend.
Phumzile (29)	2	IDI x2	Friend of her partner, raped her while partner was asleep next to her.
Samu (26)	?	IDI x2	Ex-partner, dated at school she had fallen pregnant, he left her. Raped her many years later, family accepted hush money (R1000) from perp for the rape, arranged by the police. She did not want to take the money.
Sbusi (25)	1	IDI x1 LH x1	Stranger, suspected to be a security guard at public hospital, from local community.
Sinazo (25)	2	IDI x3	1st rape - taxi driver, stranger. 2nd rape - community member, his family was wealthy, accused her of lying. 3rd rape - community member.
Sthembile (33)	2	IDI x2	Unknown
Thabi (36)	2	IDI x1 LH x1	Ex-partner, Police Officer, who was married, now deceased.
Thuli (38)	0	IDI x1 LH x1	1st rape - Bosses associate 2nd rape - ex-partner. Arrested and sentenced.
Zama (37)	2	IDI x2	From the community wanting to date her. Serial rapist. His family had resources to bribe her to drop charges.

first set of codes to organize the data that included a code for shame, self-blame and internalized-stigma, and this paper focuses primarily on those. Themes that emerged within the data around the three concepts and beyond were identified and discussed, inconsistencies reconciled, and sub-themes agreed.

Throughout the research project, the team conducted reflexivity exercises to examine, acknowledge, recognize and minimize, where possible, our power and positionality (both with participants and within the research team). This enabled us to continually reflect on our inherent power and positionality as researchers and our impact on data collection and analysis, and the positionality of the more experienced researchers within the team.

Ethical approval was obtained from the South African Medical Research Council, Human Research Ethics Committee, EC019-10/2013, amended approval September 13, 2021. Written informed consent was obtained at the beginning of each interview, and participants' identity has been anonymized across all data. Participants were each given R250 (approx. US$15) per interview for their time.

2.3. Research preparation

The research team worked collectively to develop a shared understanding of the concepts and appropriate research methods to explore these concepts. We began with exploring literature on rape-related internalized-stigma, shame, self-blame and disclosure, most of which is based on data from the global North. We then spent three days in a workshop examining the literature, reflecting on our own life experiences and discussing how to explore the concepts with rape survivors in eThekwini. We also reflected upon how these concepts could be discussed in isiZulu, the local language of most participants. Following that we revised the interview guides, in some cases adding prompts based on our discussions and translated them into isiZulu. During translation the isiZulu speaking colleagues were mindful to ensure the concepts were translated in a way that retained the essence of the concepts in contextually meaningful ways. We also discussed our shared commitment to ensuring that survivors' own interpretations, voices and lived experiences emerged, to do so our research approach was informed by decolonial, reflexive and feminist practices (to be discussed in detail in a forthcoming publication).

3. Results

3.1. *"Everyone knows you've been raped, and they look at you badly" - shame and anticipated-stigma*

Several women spoke about feelings of shame and anticipated that the community would stigmatize them once they found out they were raped. Many of them mentioned feeling that 'everyone knows they've been raped', referring to their own thoughts about what others would think. Some said they thought community members would see them as 'the other' and worried that people would label them, laugh at them and point fingers, saying or thinking 'that's the girl that got raped'. Several women were concerned that their partners would see them as 'dirty'. It was evident that these feelings made them feel diminished and took away their confidence to leave home or socialize and many avoided spending time with friends, family or in the community.

Snazo, raped by a stranger, articulated feelings of shame because people knew her story and this made her dread social interactions in the aftermath of the rape and even several years post rape. She indicated that she felt shame after her mother "*told a neighbour (and) now everybody in the community knows*":

> "I *was ashamed, I didn't go to school when it had just happened. The other kids informed the teachers … I was self-conscious, I am no longer the person I was, and I worried about how the boys and girls at school will look at me since something like this happened to me … Even now, I sometimes feel ashamed knowing that people know my story."*

Similarly, Amahle spoke about feeling ashamed because she felt that everyone was watching her or knew her story: "*I was feeling very ashamed it was like all eyes are on me, but I recovered slowly"*.

Thabi, who was raped by an ex-partner who was a police officer, mentioned that she was worried about how her husband would feel, "*I was worried that my husband was going to see me as dirty*". This reference to feeling 'dirty' appears to reflect feelings of shame about being raped.

3.2. *"**Ngazizwa ngilula" - being 'rape-able' and cursed,** internalized-stigma*

Several survivors spoke about being 'rape-able' following rape, mentioning that after experiencing rape, they felt 'marked' and anticipated that they would be targeted by perpetrators and be raped again. This spoke to the idea that survivors felt labeled and stigmatized by others, as well as believing they were 'stained' by the rape, leading to internally-stigmatizing feelings.

Thuli, who was raped twice and experienced two attempted rapes,

believed there was something within her that only potential rapists could see. She expressed the notion that she was a person destined to be raped saying: "*Ngazizwa ngilula (I felt easy [to be raped]), I felt like a person living to be raped*". Sthembile, raped by a stranger, talked about being 'marked' using the metaphor of a dog bite: "*If you are raped you are like someone who was bitten by a dog, now all dogs want to bite you.*" Snazo, who was raped three times, believed that the men loitering in her community could sense that she had been raped and will rape her again: "*I sometimes feel that other men in my area look at me in that way, maybe one day they would want to take advantage of me because something like this [rape] happened to me*." Zama also supported this notion when she said, "*Once you've been raped, you'll be raped again*".

Some of the women also discussed how they viewed the notion of being 'rape-able' as a curse which required ritual cleansing to ward off the 'bad luck' and prevent subsequent rape. Zama emphasised the need to be cleansed to prevent her being raped again, and Snazo echoed this:

> ***Snazo**: Maybe as* per *Zulu belief it [repeated rape] is because you weren't cleansed. You have to be cleansed and the clothes that you were wearing you must burn them.*
>
> ***Interviewer**: What kind of cleansing?*
>
> ***Snazo**: The Zulu type of cleansing, maybe to cleanse yourself to not have bad luck if someone sees you or for someone to think of that when they see you.*

3.3. *"I felt like I let it [the rape] happen." - self-blame*

Three survivors blamed themselves for the rape. Lindelwa, who was raped twice, expressed a sense of self-blame for the second rape because she had begun to drink and party a lot after the first rape. She mentioned that she believed her behaviour led to her second rape and HIV infection. Snazo, when speaking about the third time she was raped, also mentioned that perhaps she had let it happen as she was drinking heavily. When asked to describe how she felt after the rape, she said: "*I felt like I let it happen, I don't know. The fact that I drank to the extent that I don't even feel it when someone touches me.*".

Neither woman talked about assuming blame for their first rapes, however, following the second rape, they had been drinking heavily and blamed themselves because of their choices and behaviours following the first rape. In both cases the heavy drinking appears to have been maladaptive coping mechanisms following the rape.

3.4. *Internalized-stigma resulting to not being believed, or being blamed, by family and community*

Several women spoke about not being believed when they told people they had been raped or feeling they were being blamed by family or community members for 'allowing the rape'. This made them feel they would be stigmatized by others and often avoided people for fear of such stigma being enacted. These women experienced internalized-stigma because of what others actually said, or what they feared people were saying, about the rape. Sometimes the external blame also led to feelings of shame.

Zama who was raped by someone who wanted to date her but was later discovered to be a serial rapist said she expected to be stigmatized following the rape, she believed people were blaming her and she feared leaving her home: "*Sometimes when you are raped people look at you badly and people blame you as if you are the one who asked for that*". Zama's feelings were likely exacerbated by the fact that many community members did not believe she had been raped. She recalled that she overheard community members saying the perpetrator was her partner (which he was not), and that she was never raped and was being 'wicked' for alleging rape.

Thabi's feelings of shame, mentioned above, may have been exacerbated as she was also stigmatized by her husband's family who blamed her for the rape. Although they had always thought poorly of her, their negative attitudes towards her worsened following the rape.

3.5. *"It is not my fault."- refusing to accept blame or stigma for the rape*

Some survivors refused to accept blame for the rape and therefore it did not manifest as internalized-stigma, self-blame nor shame, even though in some cases, women were explicitly told by family and service providers that they should have behaved differently to avoid being raped. When blamed for the rape, these women responded differently from those mentioned in the section above, they did not internalize it as internalized-stigma, shame or self-blame nor did they avoid people because of being blamed.

Anele, who was pregnant at the time of the rape, did not fight the perpetrator and was told by the healthcare worker (HCW) that she was naïve for not seeing the potential risk of trusting someone and going into a secluded forest with a stranger. However, she rationalised that she should not blame herself because she believed he was taking her to get a new job. When she was raped, she was afraid and did not resist because she was doing what was best for herself, and her pregnancy. Anele was saddened because the HCW blamed her when she sought support.

> *"It was very painful, when she [HCW] said 'Can someone be fooled like that for work? Don't you know that there is no such thing, how can a stranger fool and lead you into the jungle …. no, no you are careless'."*

Some survivors said that family, friends and community members blamed them for the rape, but they did not agree with them. In Zama's case, community members and the police refused to believe her and blamed her for being drunk at the time of the rape, she overheard someone at church saying, "*She is speaking lies about Mzo, maybe she was drunk*." But she insisted that she was not drunk and couldn't blame herself for being raped by a man known to have raped others before her. She was even prepared to undergo a medical examination to prove that she was not drunk at the time of the rape. Nonku also acknowledged that although many survivors blame themselves, she would not accept that saying, "*It is not my fault, I know some people keep asking themselves 'why me'. But this can happen to anyone, from a small child to grannies*".

3.6. *"I felt regret" - but not self-blame*

While women in first interviews often said they did not blame themselves for the rape, some survivors added to what they told us in later interviews, sometimes reflecting on regret about particular actions which may have put them at heightened risk for rape. However, their regret did not appear to lead to self-blame, i.e. they did not accept responsibility for being raped, despite their regret of certain actions. Regret in these cases appears to be about an acceptance, perhaps even disappointment, that they failed to identify risks and avoid them, and this contributed to the rape. These women seem to have adapted a strategy that avoided blaming themselves for their rape while being retrospectively reflective about alternative and self-protecting choices they could have made, or make in the future, to reduce their risks to rape exposure.

We observed this with Anele. She was initially very clear that she was not to blame. However, in her second interview she mentioned that after the nurse and community members repeatedly told her she was naive for trusting the perpetrator and she shouldn't have gone with him, she appeared to start having regrets about her actions, mentioning thoughts such as "*I don't know why I was so stupid to have gone with him, I knew these things happen*". Despite referring to herself as 'stupid', her narration of events implied that while she regrets her choice she does not accept that it was her fault the rape occurred despite her poor choice to accompany him.

Others also expressed ideas that they 'should have known better'. Snazo's mother said she had been reckless and that she should have avoided dangerous situations, she told Snazo that she "*should not have*

walked around during the night". Snazo went on to say at one point that she shouldn't have chatted with the perpetrator and 'gone along with it all'. Thabi felt regret that she had got into the car with the perpetrator, her ex-partner from several years back, "*I thought that if I hadn't taken that lift it wouldn't have happened … I felt that regret …*" At face value, these women may appear to be blaming themselves, however, closer reading of the transcripts seems to reveal that they were reflecting in hindsight that they could have done things differently which may have kept them safer, but without taking responsibility, nor blaming themselves, for the violation.

3.7. Impact of shame, self-blame, and internalized-stigma

Women in the study mentioned a variety of ways in which feelings of shame, internalized-stigma and, to a lesser degree, self-blame following rape influenced their sense of self and emotional wellbeing. Several women self-isolated and withdrew from others, even in cases where they had supportive networks. This seems to have been in response to internalized feelings of shame and anticipating external stigma. Snazo, Sibusi, Lindelwa, Amahle, Phumzile and Khaya all chose to spend a lot of time alone in the period immediately following the rape. Both Amahle and Phumzile had family who would have supported them, but they chose not to access them. Amahle said she had a very supportive family, especially her brother and father, while Phumzile locked herself in her flat despite her mother and aunt being supportive and available to help. After a while Phumzile started spending time with friends because they did not talk about the rape, she said she did this so she could have company without having to talk about the rape. Women often self-isolated to avoid talking about the rape. Furthermore, the women mentioned that when they did talk about it, many preferred to talk to other rape survivors, who understood their experience.

As already mentioned, some of the women started drinking or partying excessively following the rape, Anele, Lindelwa and Zama all mentioned this as a strategy, albeit maladaptive, to avoid thinking about the rape. Anele, went through two bouts of heavy drinking after the rape to avoid thinking about it, when asked if she did anything new following the rape, she referred to her drinking to forget.

> ***Anele**: I think it was because of the rape because I used to stay home alone, and those memories would keep coming back until I decide to go out …*
>
> ***Interviewer**: As you drank what was on your mind or what change did you want to see?*
>
> ***Anele**: I wanted to forget about everything, listen to music and I would feel better when I go back home, then I'd take a bath and sleep.*

4. Discussion

This study explored the experiences of female rape survivors from eThekwini, South Africa, how they understood, expressed, and made meaning of rape-related shame, self-blame and internalized-stigma and how these concepts impacted on their emotional wellbeing. They expressed their feelings of shame, self-blame, and internalized-stigma as distinct concepts, however we also found that in many cases they intersected and drove each other. Despite recognising that the rape was a violation, most of the women mentioned feelings of shame and internalized-stigma. The findings indicate these feelings were driven in part by the views expressed by family, community members and service providers; their relationship to the perpetrator; the extent of gossip about the incident and the pervasive, unequal, gender norms and rape myths. This supports research indicating that while internalized-stigma manifests at an individual level, it is often driven or exacerbated by external stigma which is enacted at, or experienced from, the interpersonal (family and friends) and community/structural levels (Overstreet and Quinn, 2013). Strong feelings of self-blame were expressed among some who experienced multiple rapes. Survivors reflected that they had internalized some of the blame directed at them by family, friends, service providers and community members, and over time this emerged as self-blame or internalized-stigma. Importantly, where expressions of self-blame emerged, it was in later interviews, where we assume more trust had been established with the researcher, and because the second interviews went into more depth around individual meaning-making. These findings align with Goffman's work where he spoke of three key forms of stigma (Goffman, 1963), two of which were significant drivers of the stigma these women experienced, namely having a 'spoilt identify' both as rape survivors and women with rape-related trauma and poorer mental health.

When speaking about shame, survivors expressed it as believing they were smelly or dirty, desiring to be invisible and wishing to avoid seeing other people. Avoiding people post rape, which a number of the women did, is particularly worrying as this can lead to further isolation and loneliness at a time of heightened vulnerability (Aakvaag et al., 2016). The survivors' expressions in our study align with the work of Kennedy and Prock (2018), and Brown (2015), who have defined shame as "a moral emotional response, in which the survivor feels deeply unworthy, defective, and debased in comparison to others" (Kennedy and Prock, 2018). These authors also found, similar to what our women expressed, that shame was associated with experiencing external stigma or blame and/or internalized-stigma following sexual assault (Brown, 2015; Kennedy and Prock, 2018). These discussions of shame also reflect the multi-layered notion of rape stigma women experience, the women's internalized feelings of shame at the individual level, are driven by the social, external stigma enacted at the interpersonal and community level. Furthermore, it appears the shame is heightened when they intersect with internalized-stigma. These findings are important as the authors are not aware of other work in eThekwini which has explored rape-related shame, as such it provides an important contribution to the theocratical framing of rape-stigma in South Africa.

The survivors' expressed many feelings of internalized-stigma, some of which co-occurred with shame, however, they also expressed feelings not linked to shame such as looking down on oneself, agreeing with derogatory and critical labels they believed others were applying to them, and accepting their rape as 'unsurprising' because of who they are. These feelings of internalized-stigma appeared to often be driven by an internalization of anticipatory or enacted external stigma which they believed others were directing at them, such as thinking (anticipating) that if others knew about their rape they would stigmatize them, blame them, think less of them and so on. This finding on rape related anticipatory stigma concurs with other scholars who explained it as "a belief by the survivor that, should she reveal the abuse or assault to others, she will be stigmatized as blameworthy and lesser" (Goffman, 1963; Overstreet and Quinn, 2013; Kennedy and Prock, 2018). The women also anticipated not being believed or being told that they should have behaved differently to avoid being raped. Women mentioned higher levels of perception of external stigma where the perpetrator was from the community, when the perpetrator was unknown to the community these feelings were lower. This reflects higher levels of victim blaming associated in acquaintance rape compared to stranger rape found in US studies (Bieneck and Krahé, 2011). The findings also concur with other research which found that in circumstances where the survivor was drinking alcohol, this played an exacerbating role in victim blaming (Gravelin et al., 2019).

The women who expressed self-blame had all been raped repeatedly and developed these feelings following multiple rapes, feelings largely driven by common rape myths. In most cases they developed maladaptive coping mechanisms of drinking and partying which they felt made them responsible for their rape. Scholars have attributed survivor's self-blame as developing from pervasive stereotypical rape myths that stigmatize women survivors, by asserting that 'women who dress, look or act in certain ways deserve to be raped and can be apportioned judgement for their role in inciting the perpetrator behaviour'. In a

similar manner, stereotypical myths are often premised around beliefs that 'women need to avoid certain spaces and behaviors to avoid being raped' (Grubb and Turner, 2012; Van der Bruggen and Grubb, 2014, Gravelin et al., 2019). These myths at structural and interpersonal level drive enacted stigma leading to self-blame at the individual level. Seemingly for these women, notions of self-blame, driven largely by common rape myths, only emerged after a first rape, perhaps speaking to the impact of intersecting rape stigma's with already existing feelings of internalized stigma driving the self-blame, as well as heightened emotional vulnerability or PTSD following their first rape. Interestingly some women expressed regret about certain choices/actions rather than self-blame. They focused on their 'poor decision-making' which heightened their risk of rape, despite disappointment about certain choices they did not internalize this as self-blame, despite external blame from others. This included regret about their actions prior to the rape such as: drinking and partying too much which placed them at risk, having poor judgement, and questioning how they could have been 'so careless'. This response is noteworthy and could perhaps be seen as a healthy coping mechanism. More research is needed to understand how these women avoided allowing their regret to become self-blame, with a possible exploration of whether they experienced any other stigmatized identities, and how experiencing, or not, intersecting stigma may have an effect here.

Research has shown previous rape is a risk factor for revictimization, a risk driven largely by marginalised women's structural vulnerability to rape (Gidycz and Kelley, 2016). However, this research adds novel findings about revictimization to the literature. Some women who expressed feelings of shame and internalized-stigma introduced the notion of being 'rape-able', that following a rape they perceived that they became easy targets for repeat rape. This revealed their sense that rape was like a label that one walks around with, which is visible to everyone, supporting Goffman's notion that a stigmatized identity, in this instance following rape, is a label that 'denotes a mark of failure or shame'. The survivors' feelings of being 'rape-able' were primarily driven by the women's internalization of pervasive feelings of external or anticipatory stigma, influenced by local patriarchal gendered norms, rape myths, negative reactions when disclosing and whether she had been raped previously. The women did not mention structural drivers of rape. This finding is noteworthy as it reveals the idea that rape can operate in a way that it becomes part of a person's defining character. This may also link to the notion of characterological self-blame as first discussed by Janoff-Bulman, where the women begin to feel their character now makes rape unavoidable (Janoff-Bulman, 1979). This reflects an emotional response driving survivors' feelings of being at risk, it is important to understand this perception and consider how to accommodate these feelings of rape survivors in work on preventing revictimization and offering emotional support to survivors. It is also noteworthy that these feelings are driven by stigma enacted at the interpersonal and structural level, yet they manifest as stigma at the individual level, understanding how these multiple levels of stigma intersect is important for appreciating where interventions need to occur. The authors are not aware of this concept of 'rape-ability' being discussed in literature before, and as such it is an important addition to understanding survivors' emotional responses to rape and re-victimization, and how it affects survivors' sense of self and identity in a South African context.

Some women mentioned undergoing ritual cleansing post rape, to avoid re-victimization, and most who participated in them appeared to feel it assisted them. These ceremonies appeared to also support the women to reduce their sense of internalized-stigma. Research and public media speaks about ritual cleansing post rape as being relatively common across Africa, especially where rape is considered a sexual taboo (Porter, 2015). However, the details about these rituals and their use in different communities is complex and, in some cases, contested. Indeed, a South African artist-activist Nondumiso Msimanga, argues that within Zulu customs there is no specific ceremony for rape survivors, something she discovered after being raped, when her mother struggled to find a ceremony specific to cleansing the rape. She eventually performed the uMemulo ceremony for her daughter as a "gesture of love and support". Msimanga believes such ceremonies are powerful in addressing the survivor's grief, supporting her to find peace and addressing any lingering fears of men (Moncho-Maripane, 2019). This research did not explore these ceremonies in-depth, and as such cannot comment on what was performed, and for exactly what purpose, however, we note that further research on this may prove helpful to support survivors with practices that provide emotional healing post rape.

The women's expressions of internalized-stigma, shame and self-blame following rape aligns with a continuum developed by Kennedy and Prock which captures sexual abuse survivors' feelings (Kennedy and Prock, 2018). They reviewed 123 American studies on sexual assault and examined women's experiences of self-blame, shame, internalized-stigma, anticipatory and external stigma. They suggest that when survivors are stigmatized by others and society (external stigma), through for example, victim blaming, rape myths or negative reactions to disclosure, rape survivors internalize the messages which manifest as shame, self-blame, internalized stigma and anticipatory stigma, all of which negatively impact their wellbeing. They place these concepts on a continuum, from the right it includes 'negative social reactions to disclosure', 'anticipatory stigma' (both external stigma), 'internalized/self-stigma', 'shame' and 'self-blame', on the far left. They posit that shame and self-blame are dependent and occur as a reaction to anticipated or experienced external stigma. However, they stress that shame and self-blame are separate and should not be conflated as internalized-stigma. Their approach resonates with our findings that the women experience and express these feelings as different in most cases. It also offers an important insight suggesting that exploring these critically important concepts as different, yet intersecting, may provide more understanding of the many emotions rape survivors experience. Most of the women in our study spoke about their feelings shifting and re-occurring. As such, the women's experiences have added to Kennedy and Prock's continuum by highlighting that it is not a linear flow from one feeling to the next, rather survivors' feelings often move back and forth over time, they have also shown the model to have applicability in the South African context (Kennedy and Prock, 2018). Many of the women also spoke about withdrawing from activities they previously enjoyed and self-isolating. These responses have been identified in the "Why Try" effect and Modified Labelling theory, as typical behavior by people who experience internalized-stigma (Corrigan et al., 2009).

These women's feelings and expressions post rape support findings in much of the literature, mostly from the USA and conflict settings, (Brown, 2006; Overstreet and Quinn, 2013; Wyatt et al., 2017; Kennedy and Prock, 2018; Turan et al., 2019), and confirm that these ideas resonate with women in South Africa, where little work of this nature has been undertaken.

The research points to key recommendations which can contribute towards the improved wellbeing of rape survivors including further developing the theoretical understanding of the distinction, and intersectionality, between internalized-stigma, self-blame and shame in South Africa; reducing external and internalized rape-stigma; improving post-rape care services and developing rape survivors' resilience.

These women's experiences have highlighted a compelling need for evidence-based interventions that purposefully address rape survivor's feelings of internalized-stigma, shame, and self-blame. To do this evidence-based interventions need to work with women, to understand how they experience these different yet intersecting emotions post rape, how their emotions shift over time and what is needed to support survivors to build personal resilience and emotional wellbeing. Additionally, rape survivors are not homogenous and have different emotional responses, which are informed by context, previous trauma(s), responses to disclosure etc, as such interventions and support must be contextually adapted and flexible to individuals unique, and shared, needs. Therefore interventions, whether immediate containment support, longer-term

therapeutic support or group-based interventions, need to reflect on how shifting emotions and local context impact on what support is provided to rape survivors at different stages in their post rape journey. This aligns with other research questioning what support is needed when, in particular the effectiveness of early therapeutic interventions for rape survivors (Szafranski et al., 2017). Furthermore, interventions focused on reducing rape stigma need to develop a multi-level approach to reduce the onus for change being only on the survivor. They must address stigma at the interpersonal (friends and family) and structural level (healthcare, police and legal services, churches etc). Therefore, while rape survivors should be supported to address their own shame, self-blame and internalized-stigma, interventions need to operate at all levels for meaningful change.

Finally, although rape survivors found it challenging to identify and talk about their feelings of shame, self-blame and internalized-stigma post rape, many mentioned finding the interview process healing and cathartic. Highlighting that research with rape survivors is traumatic but possible, through careful consideration of the methods and researcher training and reflexivity – all of which is critical to reduce harm to, and increase the voices of, survivors.

The study had some limitations, the first being that the data was collected 2–3 years after the rape therefore the participants recall could have been biased. However, the long period post rape also provides an opportunity to hear about the survivor's full post-rape experience. Secondly, we recruited women from post-rape services, as such the results only speak to the experience of rape survivors who have reported their rape, women who do not report rape may have very different experiences and responses. We therefore cannot comment on how this may manifest for rape survivors who do not seek care. Furthermore, most of the women had received no or inadequate psycho-social support post rape, which may have limited their reflections as their emotions were often still very 'raw'. The limited psycho-social support available in the public sector may have heightened feelings of shame, internalized-stigma and self-blame which may have been lower amongst a cohort who had received better support. Additionally, many participants did not have the language (even in their home language) nor familiarity with discussing 'raw emotions' which may have supported them to express and articulate these complex feelings. To address this, we ensured that the researchers were of a similar age, gender and race and came from similar contextual settings. Furthermore, the researchers underwent extensive training and mentoring to support the women to identify and reveal these expressions/feelings and reflections through nonlinear questioning etc. Finally, with qualitative research one is never sure what is not being said, which is important when exploring emotional concepts.

5. Conclusion

This study provides critical and under-explored insights from rape survivors in eThekwini, South Africa on their experiences of shame, self-blame, and internalized-stigma. It addresses a significant knowledge gap which may inform and improve contextually appropriate post-rape care services and programmatic interventions, particularly to guide *what* support to offer rape survivors and *when* to provide support. Based on these women's experiences and supported by the limited South African literature on the topic, we recommend that rape survivors' recovery and resilience strengthening may be more effective if they are given an opportunity to explore their feelings of shame, self-blame and internalized-stigma, either in the context of a facilitated group, or individually. Ideally any group intervention would be co-developed with rape survivors to ensure its relevance and efficacy (Mannell et al., 2023). Finally, while the recovery and healing needs to occur at the individual level, much of these women's internalized stigma, shame and self-blame was driven by anticipated and enacted stigma at interpersonal and structural levels, highlighting the need to target prevention interventions at multiple levels, especially with community members and service providers.

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Declaration of competing interest

The authors have no competing interests.

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