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Research Article

A Qualitative Model for Integrative Trauma-Informed Care for Adult Survivors of Childhood Sexual Abuse in Marginalized South African Communities

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Background

Socioeconomic inequality, enforced through racial segregation during apartheid, continues to shape present-day disparities in South Africa. It limits equitable access to essential services and exacerbates health inequities, in particular, access to specialized trauma-focused mental health services in marginalized communities.

Objectives

This study explores the intersections of systemic inequality and sexual violence by developing a qualitative framework for integrative trauma-informed care (ITIC) intended for resource-constrained settings. The study focuses on adult survivors of childhood sexual abuse (CSA) from the Cape Flats region of Cape Town.

Methods

Framed within a critical, feminist community psychology perspective, ITIC sessions were facilitated for 13 adult survivors of CSA, with variation in the number of sessions and the duration of the intervention. Clinical histories were assessed. Applying ITIC, participant-specific narratives, and trauma recovery pathways were analyzed.

Results

The findings highlight the complex physical and mental health needs of participants, given the long interval that had elapsed since their experiences of CSA. These findings informed the development of a multi-component care framework that addresses prolonged trauma suppression among adult survivors of CSA from marginalized communities, such as the Cape Flats. Despite the long time elapsed between CSA and the initiation of ITIC, this form of therapy supported more equitable trauma recovery.

Conclusion

The study develops a qualitative research-informed care framework that integrates various factors associated with sexual trauma. Addressing the complexities in marginalized South African contexts, it highlights the importance of recognizing individual differences in trauma responses, comorbidities related to systemic violence, and pre- and post-trauma experiences, allowing for tailored interventions that may potentially enhance therapeutic outcomes.

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1. INTRODUCTION

Historical inequities and healthcare disparities are intricately linked, particularly in South Africa, where apartheid's legacy persists. Bonteheuwel and Heideveld on the Cape Flats, where the present study was conducted, were designated as sites for the forced relocation of racially classified communities under the Group Areas Act of 1950, resulting in deep-rooted, ongoing inequalities.[1] The systematic exclusion of communities from economic, political, and social participation heightens physical vulnerability and perpetuates cycles of violence.[2] This historical oppression operates in two interconnected ways: First, by maintaining persistent inequality and marginalization through restricted access to resources; and second, by continuing as a dynamic process sustained by social and cultural mechanisms that reproduce power and privilege over time.[3,4] This requires comprehensive restorative solutions in what Malherbe[2(p2131)] refers to as "the crisis of community care." Trauma research, in particular, requires a nuanced understanding of how South African historical and social contexts have shaped and entrenched patriarchal norms that contribute to gender bias and sexual violence.[5,6] In alignment with the 2020–2030 South African National Strategic Plan on gender-based violence and femicide (GBVF),[5] Zungu *et al.*[6] highlighted the urgent need to design and implement evidence-based, community-level interventions that are culturally relevant and tailored. Their findings draw from the first nationwide baseline survey on victimization and perpetration of GBVF in South Africa, underscoring the importance of healing from childhood trauma and improving access to mental-health care. This call aligns with recent decolonial and feminist community psychology scholarship advocating for reflexive, socially accountable trauma care in the global South.[7-13] Building on these insights, we propose that applying an intersectional feminist, trauma-informed lens within restorative, embodied integrative trauma-informed care (ITIC) aligns with critical feminist community psychology frameworks. This approach explores the interconnected causal pathways of GBVF.[14,15]

Trauma-informed care (TIC) is a systemic approach that recognizes the context-specific impact of trauma by creating safe, empowering, and supportive environments across services.[16] Guided by principles, such as safety, trust, collaboration, and cultural sensitivity, developing a community-centered ITIC framework for adult survivors of sexual violence in the Cape Flats can support more contextually grounded and sustainable intervention outcomes. Although specialist therapies, such as eye movement desensitization and reprocessing (EMDR), prolonged exposure therapy, and trauma exposure therapy, have shown effectiveness for complex trauma treatment,[17-19] the clinical applicability in the Cape Flats context remains limited. In addition, the high costs of accessing such services in other areas limit access for most survivors without financial means or universal health care. Moving beyond cognitive-centric and memory-recall approaches, this study builds on the insights of several previous studies,[11,12,20-22] calling for "a situated psychology" and decolonial praxis with social impact, in considering the cultural, historical, and gendered aspects of sexual violence and trauma.[23-28] The study aims to describe the intersections of the micro-, meso-, exo-, and macro-level psychosocial, geographical, structural, and systemic intergenerational contexts of marginalization. Thuthuzela Care Centres offer integrated medical, psychological, and legal support to sexual violence survivors on the Cape Flats, but Bonteheuwel residents face major access barriers due to administrative constraints. Hence, we explored how the operationalization of ITIC phases within such resource-limited, community-based trauma services could best promote trauma integration and equitable physical and mental well-being for the study participants. Consequently, the primary objective of this paper is to develop and describe an ITIC framework for adult survivors of adverse childhood experiences (ACEs) and childhood sexual abuse (CSA) in the Cape Flats.

2. MATERIALS AND METHODS

2.1. ETHICAL CONSIDERATIONS

Good Clinical Practice guidelines outlined by the Health Professionals Council of South Africa were followed throughout the study. The study was approved by the University of the Western Cape Biomedical Research Ethics Committee (BM20/10/07). All participants provided written informed consent for participation and publication of de-identified quotations. Given the sensitive topic, a predefined distress and safety protocol was implemented, including on-site grounding, immediate referral options, and supervisor debriefing.

2.2. REFLEXIVITY

As reflected by Boonzaier,[27] context-specific problems experienced by women in the global South can reinforce colonial narratives that portray them as existing within chaotic, dysfunctional societies, devoid of agency and thus needing to be saved. To the contrary, the research team considered the women's willingness to engage in this type of research not only as a reflection of their resilience but also as a form of resistance to the erasure of their agency. Hence, we adopted a decolonial, feminist community-based qualitative research approach, highlighting significant challenges in accessing appropriate, timely, and specialized trauma-informed therapeutic care. Together, the team's combined expertise enriched the data analysis by integrating clinical, ethical, and global health perspectives, ensuring the findings were both locally grounded and globally informed. Leona Morgan, a clinical psychologist with extensive trauma care experience, applied a deeply embodied, context-sensitive lens to the data, drawing on her clinical background and commitment to ethical, community-based trauma recovery. Sarojini Nadar and Ines Keygnaert, the supervisors of the PhD study, shaped the study through their extensive interdisciplinary expertise and discussions of the methodology and data analysis process. This ensured that the study was grounded in a culturally responsive framework informed by decolonial, feminist, and interdisciplinary principles.

2.3. RESEARCH CONTEXT

The communities of Heideveld and Bonteheuwel on the Cape Flats were established as letting schemes by the Cape Town City Council in the 1960s. The latest South African National Census statistical release[28] indicates that the demographic composition of these areas remains predominantly Colored (95%) and Black African (5%), reflecting the enduring impact of forced racial relocations under the Group Areas Act 1950.[1] These communities are characterized by semi-detached housing and informal backyard

dwellings with residents mainly relying on public transport amid challenges such as gang violence and transport strikes.[29] These context-specific considerations highlight the need for the development of a culturally sensitive, trauma-informed research approach that addresses the unique social and economic challenges faced by survivors of sexual violence.[30]

2.4. STUDY DESIGN

Using a decolonial feminist framework, the methodology was shaped by centering the embodied, lived experiences of the study participants. This framework enabled the study to focus on developing a qualitative community-centered ITIC framework that acknowledges the role of structural inequalities and ACEs in exacerbating and maintaining intergenerational trauma.

2.5. PARTICIPANT SCREENING AND INCLUSION CRITERIA

Research participation presentations were facilitated by Leona Morgan. These presentations took place at a community church in Heideveld and the Bonteheuwel Civic Centre, a historically significant site associated with anti-apartheid activism.

We anticipated that data saturation would be reached with 10–15 participants by: (i) Prioritizing the quality and length of participant engagement, recognizing that meaningful insights and robust research outputs on this topic emerged from a process of trust building and gradual in-depth, nuanced interactions; (ii) employing a community-based approach, that included all community members who actively sought support, were willing to disclose their experiences of CSA and to engage in a series of therapeutic sessions responsive to their respective needs; and (iii) applying the ITIC framework to ensure that the research process was ethically grounded, contextually relevant, and capable of generating comprehensive findings. This deliberate approach aims not only to address the immediate research objectives but also to contribute to the generation of new knowledge that amplifies the voices of marginalized women with an intergenerational history of sexual violence in the Cape Flats. Thirteen women with diverse experiences of sexual trauma, ranging from early childhood trauma and for some continuing into adulthood, participated in the study.[31] The women faced multiple barriers to research participation due to stigma, confidentiality concerns, cultural taboos, and economic hardship, making logistical support essential for their involvement. Consequently, access was given to a church office and a madrassa to conduct the therapeutic sessions. The madrassa, located within the home of a community activist, is a Muslim religious school that serves as both an educational institution and a vital anchor for cultural and spiritual identity. To address transportation barriers and promote inclusivity, support was offered through these accessible community venues and online sessions, ensuring consistent therapeutic support and engagement. The women did not receive any monetary reimbursement for their participation in the study.

2.6. MEASURES

An initial semi-structured interview and clinical assessment by Leona Morgan explored the long-term effects of CSA and current physical, psychological, and psychospiritual distress. The process, as described by Morgan *et al.*,[31,32] began with an introduction to the ITIC framework, emphasizing process-informed consent and the voluntary nature of research participation. The following core ITIC-based clinical observations guided intervention planning for all participants: (i) Trauma recall (vivid memories); (ii) emotional regulation (avoidance/dissociation); (iii) somatic responses (heart palpitations/pressure/pain in various parts of the body); (iv) dissociation (feeling disconnected from body and/or emotions); and (v) self-awareness (gaining insights into trauma's impact on quality of life and relationships). The assessment process combined clinical observation with empathetic engagement, using ongoing feedback to guide care and intervention facilitation. The ITIC process was specifically tailored to each of the participants' needs, carefully pacing the disclosure process while assessing and facilitating embodied awareness of complex long-term trauma suppression. This included: (i) Hypervigilance (stress response); (ii) dissociation mechanisms (emotional numbing, depersonalization, and derealization); (iii) impact on development (attachment and emotional regulation); and (iv) long-term consequences of trauma (depression, anxiety, substance abuse, and memory consolidation). Participants showed various trauma responses, which informed the choice of the ITIC therapeutic phase.

Voluntary trauma self-disclosure was a primary therapeutic objective to avoid potential re-traumatization. The therapist and researcher closely monitored participants' readiness, using gentle prompts and adjusting the pace in line with trust and emotional capacity. When self-disclosure was limited, the following open-ended questions assisted the disclosure process:

- Body sensations and trauma connection: The therapist asked, "What are you noticing in your body as we talk about this?" or "Where do you feel tension or discomfort as you think about that memory?"
- Emotional responses: Questions such as "What emotions are coming up for you right now?" or "Can you describe what it feels like emotionally when you focus on that part of your body?" informed the assessment process.
- Cognitive reflection: Probing also included asking each participant to reflect on how their trauma has impacted their thinking, beliefs, or perceptions of themselves and others.

The number of subsequent follow-up semi-structured interviews and ITIC sessions varied according to each participant's availability, which centered on: (i) Initial trauma disclosure after prolonged trauma suppression and non-disclosure; (ii) narratives of ACEs and CSA; and (iii) integrating embodied awareness, including visceral, interoceptive, and physical sensations, as well as discomfort and/or pain. Assessing trauma integration was a continuous, dynamic process requiring the therapist's attunement to each participant's responsiveness. The goal was to facilitate a safe space that supported gradual bodily awareness and affective regulation, enabling trauma to be processed at a manageable pace and integrated in a way that promoted restored agency. This phased ITIC approach included support between online sessions with continuous participant-specific self-care and grounding measures through sensory engagement and breath regulation. We enhanced rigor by maintaining a constantly updated, detailed distress and safety management assessment.

2.7. DATA ANALYSIS

An inductive, reflexive thematic analysis was conducted through manual coding of transcripts, guided by Braun *et al.*'s[33] reflexive thematic analysis approach. Attending to non-verbal pauses, sounds, and gestures, data analysis included: (i) An integrative analysis of the trauma disclosure processes; (ii) narrative analysis of lived experiences of ACEs and CSA; (iii) thematic analysis of narratives; and (iv) coding and writing reflective memos integrating themes, categories, and phases of the ITIC processes. Leona Morgan engaged deeply with the data, using the transcripts, audiovisual recordings, and clinical notes interchangeably to verify the development of codes and themes. Patterns and themes were identified in a phase-oriented manner and were refined collaboratively and iteratively by all authors. Details of collateral abuse, trauma responses, and coping styles were analyzed through systematic coding and supported by narrative quotes drawn from participants' past and present experiences. These qualitative excerpts serve to illustrate, enrich, and substantiate the analytic findings presented as themes, subthemes, and ITIC foci, as described in Table 1. Identified themes included the operationalization of the ITIC phases, as described in Table 1, and the development of the proposed qualitative ITIC framework from the thematic map is illustrated in Figure 1.

Figure 1 illustrates how identified thematic codes relate across phases of ITIC. Briefly, qualitative excerpts from transcribed data are included to illustrate the thematic development. We did not conduct member checking to avoid potential re-traumatization; instead, the research team systematically reviewed findings to ensure credibility and confirmability.

3. RESULTS

The implementation and assessment of the therapeutic process emphasized the reclaiming of embodied agency and highlighted the complexity of exploring the pathways through which sexual trauma is sustained within the broader context of systemic violence. Table 2 outlines the analytic themes and subthemes identified across the trauma recovery process. These themes reflect how participants moved from initial disclosure and coping toward embodied processing, emotional integration, and relational reconnection. Subthemes capture the nuanced experiences within each phase, supported by analytic narratives and representative quotes. Together, the themes and subthemes demonstrate the importance of safety, somatic awareness, emotional regulation, and community support in facilitating culturally grounded, relational ITIC.

3.1. CLINICAL ASSESSMENT OUTCOMES

The way in which each participant presented herself and disclosed trauma-related experiences, whether voluntarily or through guided therapeutic probing, significantly influenced the clinical assessment and planning of the therapeutic process. These nuanced differences affected the study participants' preparedness for specific therapeutic interventions and the pace at which trauma-focused work could be undertaken. For example, participants who voluntarily disclosed their trauma-related narratives frequently exhibited a heightened sense of comfort or trust within the therapeutic environment, thereby facilitating immediate and direct engagement with trauma processing. In contrast, participants who disclosed their trauma through structured

Table 1. Summary of identified themes, subtheme(s), and ITIC foci

Theme	Subtheme(s)	ITIC foci
Stabilization and rapport-building	(i) Coping style (ii) Decision-making (iii) Defense mechanisms (iv) Dependency patterns (v) Disclosure of trauma (vi) Trauma responses	Activities focused on establishing psychological safety, building trust, and preparing for deeper trauma work
Trauma awareness and narrative	(i) Abuse (ii) ACEs (iii) Autonomy (iv) Abstract beliefs (v) Bodily perception/awareness	Processes that involve recalling and narrating traumatic experiences in a controlled setting
Physical and mental health support	(i) Emotional expression/support (ii) Physical release/improvement	Provision of medical, psychological, and psychiatric services to support recovery
Affective regulation	(i) Emotional neglect (ii) Emotional detachment/numbing (iii) Emotional awareness/processing (iv) Emotional coping	Techniques and interventions for managing emotional states are mindful of each participant's window of tolerance
Trauma processing and integration	(i) Abstract beliefs (ii) Authenticity and disclosure (iii) Bodily awareness (iv) Interpersonal boundaries	Facilitating meaning-making, integration of traumatic memories, and promoting long-term coping strategies
Community-based support	(i) Family/community dynamics (ii) Community expectations (iii) Cultural influence (iv) Stereotypes (v) Cultural beliefs (vi) Career challenges	Collective and social interventions that enhance resilience through peer and community involvement

Abbreviations: ACEs: Adverse childhood experiences; ITIC: Integrative trauma-informed care.

Figure 1. Thematic codes identified across phase-based integrative trauma-informed care

or indirect prompts necessitated a meticulous, stepwise approach concerning emotional regulation and trauma integration, given that their disclosure process was often circumspect or influenced by variables such as fear, mistrust, or prior adverse experiences with disclosure. These findings underscore the need for a flexible, adaptive therapeutic framework guided by ITIC phases, processes, and objectives.

3.2. ITIC SESSION PHASES, PROCESSES, AND OBJECTIVES

The implementation of the ITIC process consisted of four phases, each typically spanning two sessions, although the duration varied depending on each participant's process. Table 3 outlines the objectives of each phase, which guided participants through a progression from establishing safety and trust to sharing initial trauma narratives, developing in-depth trauma and embodied awareness, and ultimately moving towards trauma integration, processing, and final consolidation.

The phase-based body-centered procedures and intended ITIC mechanisms outlined in Table 3 were not sequential but flexible and participant-dependent. The indicated timeframes are guiding principles, dependent on therapists' level of expertise in facilitating trauma integration. Techniques such as breathing or mindful awareness of the body were used to establish both a sense of awareness and a safe space for possible further trauma disclosure and processing during Phase 1. The transition to Phase 2 was facilitated by guiding attention towards the participant's body through a systematic body scan. This helped enhance the awareness of any sensations, tension, or discomfort that may be linked to trauma. By identifying and bringing awareness to these sensations, a bridge between the physical and emotional experiences of trauma was established. This marked the transition to Phase 3, providing a safe space to process the emotions tied to these sensations. During the emotional processing phase (Phase 3), a space was consciously facilitated for affective awareness and regulation, integrating trauma awareness more coherently. The transition to Phase 4 focused on grounding measures and the re-orientation to the present moment. Techniques such as mindful breathing, sensory grounding, and positive affirmations were used, ensuring a sense of closure. By the end of the sessions, the gradual integration of trauma made it possible for participants to return to normal daily life with a reduced emotional charge around the traumatic experience. Each phase served as a stepping stone, allowing a gradual integration process safely and systematically. The enduring effects of prolonged non-disclosure and trauma suppression were complex and evident among all study participants. A detailed account of participants' micro-, meso-, exo-, and macro-level socio-ecological contexts has been outlined comprehensively by Morgan *et al.*[31] However, the findings for three participants for whom the longest time had elapsed since experiencing CSA, that is, Ava, Amber, and Violet, are described in greater detail. Emphasis is placed on the impact of the long-term effects of trauma non-disclosure on their physical and mental well-being, exacerbated by ACEs, leading to compounded vulnerability, which is multiple, overlapping risk factors that interact to heighten susceptibility to various forms of trauma since childhood. Table 4 presents a comparative overview of trauma experiences, contextual vulnerabilities, barriers, and resources by ecological level for Ava, Amber, and Violet. The results illustrate how CSA and systemic factors contribute to deeply embedded, compounded vulnerability and the lack of timely trauma processing and therapeutic support.

Taking the long-term contextual barriers into account, we outline a comparative analysis of the clinical assessment and ITIC components for Ava, Amber, and Violet's therapeutic journeys. Table 5 details how body-centered phases were adapted, focusing on the first interview and ITIC session, highlighting the pace and intensity of trauma disclosure after prolonged periods, often decades of non-disclosure.

Table 2. Summary of themes, subthemes, analytic narratives, and illustrative quotes

Theme	Subtheme	Analytic narrative	Representative quote (participant and context)[a]
Stabilization and rapport-building	Disclosure of trauma	Participants used the first session to rapidly disclose decades of CSA, IPV, and family violence, highlighting the urgent need for safe spaces	"My brain works overtime, my heart works overtime… I need to speak about what happened to me." (Ava, first session, May 21, 2022)
	Coping style	Faith and persistence were framed as survival strategies to access therapy despite fear and isolation	"I need to speak about what happened to me." (Ava, framing disclosure as coping, May 21, 2022)
	Trauma responses	Hypervigilance, sadness, and embodied distress were present, requiring therapist pacing and grounding	"You could never speak up, being helpless as a child to protect yourself." (Therapist, reflecting with Violet, September 22, 2022)
Trauma awareness and narrative	Abuse and ACEs	Narratives revealed CSA, gang rape, IPV and intergenerational trauma, and cumulative harm	"I was shot by my ex-husband, raped at knifepoint at age 14, and gang-raped at 17." (Amber, first interview, September 15, 2022)
	Autonomy and bodily awareness	Survivors described disconnection from their bodies and a desire to reclaim autonomy	"I don't even look at myself." (Ava, reflecting on body disconnection, August 29, 2022)
	Abstract beliefs	Faith and forgiveness were central, with tension between moral duty and anger	"I have prayed about it… I actually hate them for what they have done to me." (Violet, forgiveness struggle, October 09, 2022)
Physical and mental health support	Physical illness and recovery	Survivors lived with chronic illnesses linked to trauma and structural inequities	"I have had a stroke… I'm diabetic with asthma." (Amber, interview, September 22, 2022)
	Emotional distress	Persistent sadness, flashbacks, and mental exhaustion were common	"It pops into my head every day." (Violet, describing flashbacks, October 12, 2022)
	Emotional support	Therapist validation supported emotional release and sustained participation	"Let's see how we can deal with the sadness, little by little, you can cry, it's good, your body carries so much." (Therapist to Amber, September 22, 2022)
Affective regulation	Emotional awareness and processing	Participants gradually tolerated distress and accessed buried emotions safely	"Just tell me as you remember, take your time, and share if you experience any discomfort in your body." (Therapist to Ava, May 29, 2022)
	Emotional neglect	Feelings of being unheard, amplified sadness, and isolation	"No one hears me, that is why I'm so sad." (Amber, crying during disclosure, September 22, 2022)
	Emotional coping	Emotional processing brought moments of calm and relief	"I feel at peace, the sadness is gone." (Amber, post-session, September 22, 2022)
Trauma processing and integration	Authenticity and disclosure	Naming and sharing experiences generated relief and empowerment	"I'm an open book… how my life started, how it is now." (Amber, first session, September 15, 2022)
	Bodily awareness	Somatic prompts helped connect physical sensations with trauma narratives	"You told me you felt that feeling in your heart again, just as you sat down." (Therapist to Ava, May 29, 2022)
	Interpersonal boundaries	Anger was expressed as a rejection of silence and complicity	"I actually hate them for what they have done to me." (Violet, anger processing, October 12, 2022)
Community-based support	Family and community dynamics	Patriarchal norms and stigma limited disclosure and support-seeking	"You could never speak up, being helpless as a child to protect yourself." (Therapist to Violet, October 12, 2022)
	Cultural beliefs and faith	Religious frameworks shaped coping, but also guilt and ambivalence	"I have prayed about it, asked God to forgive them…" (Violet, spiritual struggle, October 12, 2022)
	Collective belonging	Activist and peer groups provided validation and connection	"The activist community group has given me a sense of belonging." (Ava, post-intervention, May 29, 2022)

Note: [a]All names included were de-identified.
Abbreviations: ACEs: Adverse childhood experiences; CSA: Childhood sexual abuse; IPV: Interpersonal violence.

The challenges faced by the study participants highlight the need to explore community-accessible ITIC and the importance of therapeutic approaches that restore safety, emotional regulation, and a coherent self-identity. Specifically, establishing TIC principles as soon as possible, preferably immediately during the first interview/session, is paramount. This process is described by the narrative analysis of Ava, Amber, and Violet's first session encounter.

3.2.1. INTERVIEW WITH AVA

For initial narrative trauma disclosure, Ava entered the session in a state of hypervigilance, disclosing decades of trauma, including CSA, incest, gang rape, and severe family violence within minutes of the initial interview (family dynamics/intergenerational trauma). Despite her tendency to self-isolate, she coped through her faith and

Table 3. ITIC phases mapped to trauma-informed principles with procedures and mechanisms

ITIC phase	Session	TIC principles	Procedures (body-centered)	Intended ITIC mechanisms
Phase 1: Establishment of safety and trust/ trauma disclosure	1–2	Safety, trust, choice	(i) Relaxation and grounding (ii) Assurance of safety and comfort (iii) Focused breathing, supportive silence	(i) Reduce physiological arousal (ii) Build a sense of safety and containment (iii) Establish trust through regulation and presence
Phase 2: Trauma awareness and embodied exploration	3–4	Trust, choice, collaboration	(i) Body scan and awareness (ii) Inquiry into sensations, chronic pain (iii) Validation of bodily-emotional links	(i) Enhance interoception and body literacy (ii) Promote awareness of trauma embodiment (iii) Strengthen therapeutic alliance through shared meaning
Phase 3: Trauma integration and processing	5–6	Collaboration, empowerment, safety	(i) Emotional processing (ii) Locating emotion in the body (e.g., heart, chest) (iii) Allow supportive silence for expression	(i) Enable release and integration of trauma emotions (ii) Support self-awareness and emotional agency (iii) Normalize and validate emotional responses
Phase 4: Consolidation and follow-up	6–8	Empowerment, choice, safety	(i) Re-orientation and closure (ii) Emotional state check-in (iii) Gradual return to present awareness (iv) Reflection and resilience-building	(i) Validate self-regulation and safety (ii) Solidify coping tools and narrative ownership (iii) Encourage sustained healing and autonomy

Abbreviations: ITIC: Integrative trauma-informed care; TIC: Trauma-informed care.

Table 4. Contextual barriers/resources by ecological level (micro/meso/exo/macro)

Category	Main findings
Types of trauma	Sexual abuse: Incest (father, uncles, brother), rape, gang rape
	Emotional and physical abuse
	Neglect (severe and chronic)
Community-level trauma	Homicide, robbery, gun violence
	Displacement, poverty
Family context	Parental death, abandonment, divorce
	Single mothers
	Blended families with limited support
Disclosure patterns	Majority non-disclosure
	Silenced or shamed disclosure
Support access	Informal or absent support systems
	Minimal psychological or trauma-specific interventions
Healthcare access	Mostly public hospital/clinic
	Limited or no healthcare access during childhood
	Most had only a primary or secondary education
Employment and income	The majority are unemployed or minors
	Amber received a disability grant
Compounded vulnerabilities	Co-occurrence of CSA, community violence, and poverty since early childhood
	Lack of disclosure intensified long-term psychological impacts

Abbreviation: CSA: Childhood sexual abuse.

demonstrated significant resilience by fully disclosing what she had experienced:

> "My brain works overtime, my heart works overtime, I don't even look at myself. I need to speak about what happened to me." (Ava, trauma narrative exposure, May 29, 2022)

For the introduction to embodied awareness practices and ITIC, the therapist-researcher established rapport, being sensitive to how Ava presented herself as follows:

> "You told me you felt that feeling in your heart again, just as you sat down." (Therapist, embodied awareness, May 29, 2022)
>
> "Just tell me as you remember, take your time, and share if you experience any discomfort in your body." (Therapist, pacing trauma disclosure and trauma exposure, May 29, 2022)

3.2.2. INTERVIEW WITH AMBER

For initial narrative trauma disclosure, Amber shared as she sat down for the first interview:

> "I want to speak out, I'm an open book, the way my life is, how my life started, how it is now want to speak out, I'm an open book, the way my life is, how my li one is there for me. (she starts crying)" (Amber, trauma narrative exposure, September 15, 2022)

Her childhood was characterized by physical and emotional neglect, displacement, and parental abandonment, and she constantly felt sad and neglected. She was shot by her ex-husband, raped at knifepoint at the age of 14 years, and gang-raped at the age of 17 years, resulting in a pregnancy. At the time of the interview, she was unemployed due to a serious stroke and receiving a disability grant. In her second marriage, she remained the caretaker in the home, seeing to the needs of her children, stepchildren, and husband, despite her physical challenges. To introduce embodied awareness practices and ITIC, the therapist constantly encouraged her to take her time in the disclosure process:

> "Let's see how we can deal with the sadness, little by little, you can cry, it's good, your body carries so much."

Table 5. Comparative analysis of clinical assessment and ITIC components

ITIC components	Ava (53)[a]	Amber (45)[a]	Violet (41)[a]
Emotional regulation, self-care	Chronic sadness, insomnia, lack of self-care, and social isolation	Chronic sadness, suppressed anger, lack of self-care, and social isolation	Chronic anxiety, difficulty reconciling spirituality with trauma, and social isolation
Somatic experiencing	Overwhelm, palpitations, and hypervigilance	Hypervigilance, "my head doesn't feel okay," and physical pain	Hypervigilance, physical pain, and muscle spasms
Trauma narrative exposure	CSA, rape, family violence, flashbacks, fear, intense emotional responses ("it's happening again")	Childhood neglect, emotional or physical abuse, rape, and profound sadness	CSA by multiple family members, intrusive thoughts, and flashbacks
Family dynamics/ attachment	Physical violence, lack of support, and prioritizing others	Emotional and physical abuse, caregiving, and self-sacrifice	Intimacy or trust difficulties, poor boundaries, and self-sacrifice
Intergenerational trauma	Sexual violence, emotional suppression, self-harm, suicidal tendencies, and displacement	Sexual violence, drug abuse, emotional abuse, and displacement	Sexual violence and displacement
Grounding/ empowerment	Dissociation and fatigue ("I forget about myself")	Dissociation ("I block it") and complex physical vulnerabilities	Dissociation, self-blame ("I need to forgive them"), and social avoidance
Community support	Isolation and intermittent church support	Community activist support group	Community activist support group

Abbreviations: CSA: Childhood sexual abuse; ITIC: Integrative trauma-informed care.
Note: [a]Time elapsed since CSA (year).

(Therapist, personal communication, September 15, 2022)

3.2.3. INTERVIEW WITH VIOLET

For initial narrative trauma disclosure, Violet experienced recurrent CSA abuse between ages 5–10 by three trusted males (uncles and a family friend), not disclosing the abuse due to strict religious, patriarchal family dynamics. She felt ashamed but wanted a space for honest disclosure. Despite repeated attempts to forgive the perpetrators, she had been experiencing consistent trauma flashbacks 2 years before the interview, she shared:

> "It pops into my head every day. I have prayed about it, asked God to forgive them, I forgave them, but lately I'm not sure if I have forgiven them. I actually hate them for what they have done to me." (Violet, personal communication, October 12, 2022)

To introduce embodied awareness practices and ITIC, the therapist explained the complex interplay between mind, body, spirit, and soul in processing trauma, emphasizing the importance of addressing the trauma and expressing valid emotions (anger, fear, and unforgiveness):

> "Anger is often more prevalent because of the unanswered questions and the inability to retaliate. You could never speak up, being helpless as a child to protect yourself" (Therapist, personal communication, October 12, 2022).

3.3. ITIC OUTCOMES

For each participant, stabilizing measures were taken to facilitate grounding, embodied awareness, and emotional processing during the sessions. Specific attention was given to: (i) Hyperarousal and the body's stress response, including an exaggerated startle response and difficulty managing daily challenges and stressors; (ii) emotional numbing, reduced emotional awareness and responsiveness, leading to dissociation and disconnection from bodily sensations; (iii) de-personalization, feeling disconnected from the body and self, that leads to a sense of detachment and disconnection from lived experiences of trauma; (iv) de-realization by perceiving the environment as unreal or distant, leading to a sense of disconnection from the world around them; (v) emotional dysregulation and an impaired ability to manage emotions, resulting in mood dysregulation and emotional instability; (vi) memory consolidation by attending the process of consolidating fragmented traumatic memories; and (vii) the disrupting of healthy attachment patterns, leading to difficulties in forming and maintaining healthy relationships. These stabilizing measures, as well as the session outcomes, are described in Table 6. It is important to note that physical status improvements were based on the participants' subjective reports at the time of assessment.

Based on the multilayered results of ecological-level assessments obtained in this study, Figure 2 illustrates the framework for community-based ITIC in marginalized contexts. The rationale for this framework is explained in the discussion section.

4. DISCUSSION

Our results indicate the importance of implementing the multi-component trauma intervention framework while addressing barriers to specialized trauma care, trauma disclosure, and ensuring the inclusion of underserved, marginalized survivors' lived experiences in service design. As recommended by Zungu *et al.*[6] in their nationwide survey, the implementation of the proposed ITIC model in this pilot study advocates for ethical, reflexive, socially accountable, and contextually relevant research. Unpacking the ITIC process, our study confirms that trauma recovery is multifaceted. Physical relief was often experienced after the initial discomfort associated with confronting previously avoided trauma, and episodes of dissociation were acknowledged and carefully managed. These findings suggest that the process of long-term sexual trauma recovery involves a paradoxical relationship between discomfort and relief. Specifically, the need to confront, process, and integrate traumatic experiences can be deeply uncomfortable due to prolonged trauma

Table 6. Stabilizing measures, embodied awareness, affective processing, and outcomes for the longest-living participants since childhood sexual abuse

Participant	Grounding	Embodied awareness	Affective processing	Outcome
Ava	Gradual emotional exposure, emotional validation, and eye contact with the therapist	Sleep disturbances, numbness or paresthesia, hyperarousal, palpitations, chest pressure, fear, anxiety, and muscle stiffness	Intense emotional responses, dysregulation, overwhelm, and numbness	Improved self-care, emotional processing, interpersonal boundaries, and increased self-validation and integration
Amber	Self-awareness, acceptance, emotional validation, and rest or sleep after sessions	Chest pressure, physical exhaustion, chronic pain, immobility, and swelling	Emotional turmoil, sadness, overwhelm, depression, and avoidance	Relief of chest tightness, emotional regulation, and improved self-care
Violet	Gradual physical awareness, safety in disclosure, emotional validation, and in-depth discussion	Diarrhea, dizziness, and muscle spasms	Anger, unforgiveness, and lack of care or protection	Subjective report of long-term relief of fibromyalgia symptoms or muscle spasms, emotional regulation, and improved self-care

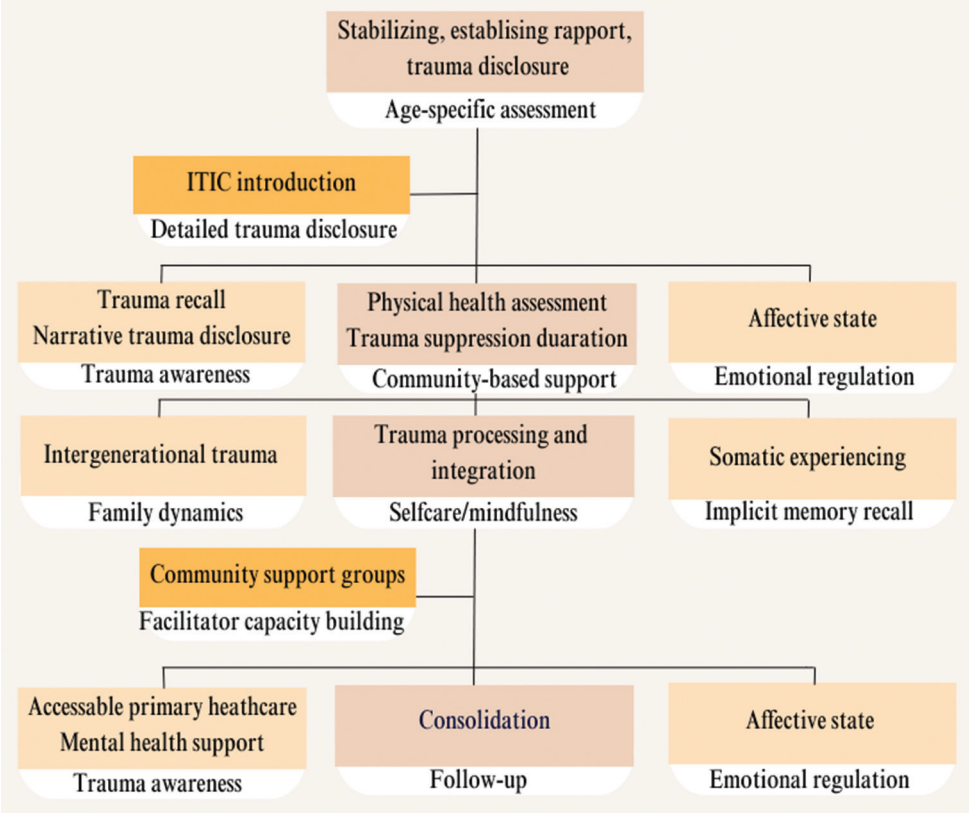

Figure 2. A proposed framework for community-based integrative trauma-informed care (ITIC)
Note: ITIC framework dimensions: Horizontal lines represent the ecological, interconnected ITIC levels. Vertical lines represent the sequential care phases of ITIC.

suppression and dissociation. The nuanced differences in the physical relief reported by participants underscore the need for cautious interpretation of these outcomes. These findings should be understood as reflecting perceived benefits and feasibility rather than symptom remission or sustained clinical improvement, which would require validated measures and longitudinal follow-up. ITIC should be framed as a complementary approach, rather than a substitute for evidence-based trauma therapies such as EMDR, highlighting its potential to enhance engagement and reduce barriers to care in marginalized contexts. Finally, these results should be interpreted within the broader ecological constraints, such as safety risks, transport limitations, stigma, and resource scarcity that shape survivors' experiences and access to TIC.

The findings highlight the variability in individual responses to trauma recovery interventions. Amber and Ava experienced short periods of physical relief, while Violet's subjective relief from the symptoms of fibromyalgia was sustained. Sustaining relearned self-care practices was often challenging, particularly given the compounded effect of ACEs and the lack of community-based support systems. The aforementioned observations indicate the critical need for timely trauma-informed interventions by specialists, as the compounded effect of sexual trauma exponentially worsens over time. Implementing ITIC, which integrates

comprehensive mental healthcare with community-based trauma care, can potentially contribute to the development of an emerging multifaceted trauma care model. We therefore propose a community-based ITIC framework that provides a comprehensive overview of its main components, phases, and dimensions (Figure 2).

The ITIC framework is a stage-gated process anchored in a series of sequential steps (vertical lines) that lead from assessment and stabilization to consolidation and follow-up. However, each of these sequential stages is supported by lateral terminal step(s) (horizontal lines), which contribute to enhancing the rigor of each stage. Progressing through therapy using this approach ensures a holistic model for community-based TIC in marginalized contexts. This process recognizes that trauma recovery requires addressing both the mind and body within the context of community, fostering long-term trauma recovery through a combination of individualized care and social-support systems. Each phase is designed to ensure safety and well-being, progressively moving from disclosure and awareness to deeper emotional regulation and integration of traumatic experiences. Over time, these steps work together and are greatly enhanced with continuous community-based support. By acknowledging the potential for research to trigger or worsen traumatic experiences and intentionally working to minimize harm, this approach integrates both the physical (interoceptive) and psychological aspects of trauma.

This study's strength lies in the in-depth analysis of community-based ITIC for adult survivors of CSA who have experienced intergenerational systemic oppression. Although this study highlights the positive outcomes for participants whose victimization occurred decades ago, a critical observation is that the implementation of ITIC must be timely, i.e., it should be provided as early as possible to avoid any further exacerbation of trauma. The model can potentially be validated and tested in phased feasibility/acceptability studies with a minimal outcome set, evaluating pain interference and process indicators (dose, fidelity, and adverse events) across diverse cultural and socioeconomic contexts to assess its generalizability. When facilitating the community-based ITIC model, mental health practitioners should recognize the trauma recovery process as sequential and multidimensional. Longitudinal designs are needed to capture the model's reflection of dynamic processes over time, while qualitative approaches can verify how well the model aligns with other marginalized communities and contexts.

5. LIMITATIONS

Participant inclusion was limited due to the hard-to-reach population, with participants who shared a specific gender identity and cultural and sociopolitical background. The small-scale, cross-sectional design inherently restricts the generalizability of the findings. Cross-sectional data offers only a snapshot of participants' experiences at a single point in time, thereby limiting the ability to conclude changes or developments in trauma recovery over time. The use of a non-probability, purposive sampling method may have introduced selection bias, as participants who chose to take part might differ significantly from those who did not. In addition, participants were at varying stages of recovery, and their experiences, coping mechanisms, and levels of psychosocial support differed. The recovery process is further complicated by the intersection of multiple structural and contextual factors, such as poverty, inadequate mental health services, housing instability, community violence, and ongoing gender-based violence. Moreover, the study relies on self-reported narratives, which, while valuable for understanding personal meaning-making, are subject to issues of recall bias and subjectivity. The absence of triangulation with other data sources, such as medical records obtained with participant consent, limits the extent to which subjective reports of physical health improvement can be independently validated.

6. CONCLUSION

Similar to a previous study by Bryant,[13] this study focuses, *inter alia*, on culturally grounded and sociopolitical pathways for trauma survivors in marginalized contexts. Community-based ITIC highlights the severity and consequences of systemic and structural segregation in the South African context. By addressing complex comorbidities, the study contributes to a growing body of knowledge that is sensitive to the unique challenges faced by women from intergenerational, marginalized contexts.[34] The results suggest a shift in the narrative from "What happened to you?" to "How did the trauma affect you, your family, and your community?" This study demonstrates that community-centered ITIC can encourage rapid yet contained trauma disclosure. The findings highlight the importance of culturally responsive, relationally grounded approaches that address cumulative trauma and systemic barriers to care. Current findings are viewed as feasibility/acceptability signals with clinical practice implications within the context's constraints. Future research should investigate the feasibility of this model using validated measures to evaluate accessibility, acceptability, engagement, and recovery outcomes. Follow-up studies should be conducted to evaluate the adaptability and scalability of the ITIC model across diverse settings. A phased feasibility trial approach should also be considered. The first phase can involve a pilot implementation in a single community, where the full ITIC model is deployed to assess its acceptability, cultural sensitivity, and initial outcomes involving more participants. In the second phase, the framework can undergo contextual adaptation based on detailed participant feedback. Finally, the third phase can assess scale-up readiness by evaluating infrastructure, training requirements, and policy alignment, and by developing comprehensive training guidelines for facilitators to support broader implementation. This study invites collaborative testing that honors its ethical core while adapting to diverse community realities.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

AUTHOR CONTRIBUTIONS

Conceptualization: All authors
Formal analysis: All authors
Investigation: Leona Morgan
Methodology: Leona Morgan
Writing–original draft: Leona Morgan
Writing–review & editing: All authors

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Good Clinical Practice guidelines outlined by the Health Professionals Council of South Africa (HPCSA) were followed throughout the study. The study was approved by the University of the Western Cape Biomedical Research Ethics Committee (BM20/10/07; approval date: November 20, 2020). All participants provided written informed consent for participation. Given the sensitive topic, a predefined distress and safety protocol was implemented, including on-site grounding, immediate referral options, and supervisor debriefing.

CONSENT FOR PUBLICATION

All participants provided written informed consent for publication of de-identified quotations. The participants did not provide written consent for the original data set to be shared publicly, and due to the sensitive nature of the research, supporting data cannot be made available.

DATA AVAILABILITY STATEMENT

De-identified qualitative excerpts supporting the findings are available on reasonable request from the corresponding author, contingent on ethics approval and participant consent restrictions (UWC BM20/10/07). Full audio/transcripts cannot be shared to protect participant confidentiality.

ADDITIONAL DISCLOSURE

This paper draws on the same research protocol as previously published articles but presents distinct analyses and findings.[31,32] The focus of this paper is specifically on the development of a qualitative framework for an ITIC model, including a detailed analysis of participants for whom the longest time has elapsed since CSA that was not addressed in prior publications.

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