OUT IN THE WILD

The Experience and Perception of Therapeutic Change By Women Survivors of Child Sexual Abuse As Result of Wilderness Therapy

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Declaration

I, the undersigned, hereby declare that the work contained in this thesis, unless specifically indicated to the contrary, is my own original work, and that I have not previously submitted it in its entirety or in part at any university for a degree.

Sr M Ulrike Diekmann

Sr M Ulrike Diekmann

25 October 2004

Date

DEDICATION

"We must not forget how the girls and women
who have been victimised actually go on surviving,
and we must celebrate each and every one of their efforts to do so,
even the ones that at first glance may seem negative."

(Gilmartin, 1994, p. 7)

To all SURVIVORS, especially
the brave women who participated in this research!

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Abstract

In a resource-rich environment, WS of CSA, wanting to enter therapy in order to deal with their early life trauma, can choose from an array of potential treatment modalities. One such intervention is called wilderness therapy. Although a number of studies have investigated various facets of this fairly new therapeutic modality, this is not the case for WS as potential clients. This study with its focus on how WS of CSA experience and perceive therapeutic change as a result of participating in wilderness therapy, intended to explore how this intervention facilitates change. The research aimed to elicit phenomenological insights that could assist in the development and refinement of the therapeutic approach and its intricate constituents.

The sample included twelve WS of CSA (21 years and older) of whom four took part in a four-day therapeutic wilderness experience in the Drakensberg Mountains, a World Heritage Site, while another four joined a traditional time-limited therapy group. Four participants opted to withdraw from the study. Factors that influenced the decision to withdraw were explored.

Ethical considerations necessitated a pre-interview with each participant. It allowed the researcher to screen each WS for her suitability, but also to identify her unique therapeutic needs, while also providing an opportunity to acquaint her with the research project as a whole, and more specifically with the respective therapeutic intervention.

The researcher gathered interview data after each intervention, which after transcription was analysed using an experience-near, phenomenological research model (Colaizzi, 1978; Giorgi, 1994; Polkinghorne, 1989) that included validation through the participants. The themes that the participants of each group described were analysed and then presented in diagrammatical form. A comparison of the results elicited elements common to both therapeutic interventions, but more importantly the unique features of wilderness therapy. These included (a) the reality of therapeutic change in terms of CSA-related issues, (b) nature as a significant therapeutically containing space, and (c) silence as a tool for facilitating catharsis. The reality of post-hike depression and the change-inducing quality of anticipatory anxiety evolved as other significant elements of therapy within a nature setting. The themes were examined in greater depth leading to the conclusions that wilderness therapy is a valuable therapeutic modality for WS of CSA, possibly best used as an adjunct, and offers unique therapeutic change mechanisms to these trauma survivors. Because of its exploratory nature, the study was unable to outline these mechanisms in more detail and hence suggestions for further in-depth research were made.

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Preliminary Comments

1. Frequently used abbreviations and acronyms

Throughout the text of the study the following abbreviations and acronyms have been used for the sake of brevity:

CSA	-	child sexual abuse
NPAT	-	National Peace Accord Trust
SAPS	-	South African Police Services
WS	-	woman survivor (both singular and plural)
WS of CSA	-	woman survivor of child sexual abuse (both singular and plural)

2. Gender Statement

Research indicates that the majority of the victims of child sexual abuse are women (Berliner & Elliott, 2002; Hooper, 1992). This thesis captures a study done with the help of some of these women. That is not to downplay the fact that boys, like girls, are being sexually abused (Finkelhor, 1994; Goldman & Padayachi, 2000), and men of all ages can struggle with the effects of such abuse (Putnam, 2003). For the sake of practicality and with deep respect for the women who participated in the study, references and discussions have been phrased in terms of the female gender.

CHAPTER ONE

INTRODUCTION

1. The context – or 'setting the scene'

The past decades have seen a dramatic increase in research on various aspects of child sexual abuse (Briere, 1992b; Browne & Finkelhor, 1986a; Finkelhor, 1990; Koss, 1990; Sprei, 1987). Childhood sexual abuse (CSA) has indeed become the subject of both scientific and public concern in the United States, in Britain and many other countries (Finkelhor, 1994) including South Africa (Madu, 2001b). After the independence of South Africa in 1994, the government acknowledged as part of its commitment to the hitherto disenfranchised of the country its wider social concern for women, children and families. This pledge led to an increased focus on CSA, a phenomenon previously observed elsewhere (Breines & Gordon, 1983, in Adams, Trachtenberg & Fisher, 1992). It brought a growing public awareness. Increasingly, parents and concerned citizens have notified professional agencies about abuse (Brosig & Kalichman, 1992; Lewis, 1997; Madu, 2001b). At the same time, 'survivors' emerge: they are victims who speak out to acknowledge their trauma and enter a process towards healing (Dippenaar, 2002).

One of the determining factors for the augmented interest and concern is the awareness that the sexual abuse of children is a serious mental health problem, both because it is so widespread and because of increasing evidence of its short-term and long-term traumatic effects (Herman, Russell, & Trocki, 1986). It has been argued that sexual abuse has detrimental consequences for the well-being of victims, in terms of their interpersonal, cognitive, emotional, sexual, and physical integrity. Especially worrying is the fact that many victims do not receive immediate assistance as their abuse remains unreported and undisclosed. This can have significant clinical implications (Faulkner, 1996). Serious psychological problems can develop with the manifestation of symptoms often being delayed until adulthood (Browne & Finkelhor, 1986a). Depression, self-destructive behaviour, anxiety, feelings of isolation and stigma, poor self-esteem, difficulty in trusting others, a tendency toward revictimisation, substance abuse, social isolation and/or sexual maladjustment are common (Classen & Yalom, 1995; Finkelhor, 1990; MacDonald, 2001). Koss (1990) and Herman (1997) found that victims of sexual abuse are more likely than non-victims to develop psychiatric problems, while Ganje-Fling and McCarthy (1996) stress the distortive impact CSA can have on the spiritual growth and development of the victim.

As much as research has shown the potential negative effects CSA can have, these vary across the survivor population (Bagley &Thurston, 1996; Simonds, 1994). CSA does not automatically lead to later psychological problems (Alexander, 1992a; Collings, 1997; MacDonald, 2001). Other aspects such as family dysfunction (Melchert, 2000) and developmental maturity (Hermann et al., 1986) might have to be factored into a possible etiological exploration.

Cruz and Essen (1994) underscore the necessity to assess and identify the unique effects of the experience of child sexual abuse for each individual so that an effective treatment strategy can be developed. Various clinical interventions have been devised to offer assistance for victims who seek to address the effects of the abuse (Classen & Yalom, 1995; Leehan & Wilson, 1985). Treatment strategies include assessment, crisis intervention, short- and long-term individual counselling, structured and unstructured group therapy, as well as marital and family therapy (Briere, 1989; Classen & Yalom, 1995; Courtois, 1999; Shapiro & Dominiak, 1990; Sgroi, 1982).

Adjunct therapies have been advocated as playing a vital role in addressing specific biopsychological and/or sociocultural deficits, when these emerge within different treatment phases (Classen & Yalom, 1995; Cruz & Essen, 1994). One such complimentary form of intervention is wilderness therapy, which has been applied as an intervention for survivors of sexual abuse since the 1980's (Powch, 1994). It is distinct from ecotherapy or adventure-based programmes in that it occurs within a natural, outdoor setting away from urban and/or semi-urban environments. It places the participant in a surrounding devoid of other people and familiar amenities (ibid.).The programme itself consists of conducting a programme of individual and group-centred therapeutic techniques, facilitated by qualified professionals with the aim to heal the "brokenness experienced in body, spirit and relationships" (Conner, 2000, p. 3). Russell and Hendee (1999) are more specific when stating that wilderness therapy involves the use of tasks designed to address problems and behaviours, cultivate personal and social responsibilities, and strengthen emotional growth within individualised treatment plans executed in a wilderness setting. These 'wilderness experiences' are seen to amplify psychological awareness and through activities structured with specific goals in mind to accelerate healing through inviting psychological shifts and changes (Hough, personal communication, 2003; Powch, 1994).

Studies have investigated the benefits of such intervention. Wilderness therapy has been found to increase a sense of wholeness as well as to facilitate spiritual and psychological healing (Taylor, 2001), to deepen the sense of self (Bandoroff & Scherer, 1994) and self-awareness through facing trust and fear issues (Taylor, 2001), and to improve self-concept, esteem and confidence (Levine, 1994). Yet voices of caution prevail. Some researchers question the methodological soundness of many inquiries into effectiveness of this therapeutic modality (Driver, Nash, & Haas, 1987, in Duncan, 1998). Others query the lack of consistent findings in terms of the sustainability of these benefits over time (Bandoroff & Scherer, 1994).

Despite the voices of caution, wilderness therapy is attracting attention, not only by therapists, but also by those seeking healing. It has been utilised for diverse populations such as war veterans suffering with PTSD (Hyer, Boyd, Scurfield, Smith, & Burke, 1996), youth at risk (Fletcher & Hinkle, 2002), and victims of torture (NPAT, 2001). Other researchers advocate its use also for WS of CSA (e.g., Asher, Huffaker, & McNally, 1994; Levine, 1994). They stress however that it should not supersede or replace traditional forms of therapeutic intervention, but rather supplement them.

As it is a new discipline, wilderness therapy remains a diverse, complex, and little known subject area (Duncan, 1998), especially with regard to WS of CSA (Asher et al., 1994). Descriptive accounts of strategies and efficiency studies exist (Schell-Faucon, 2001), but little is known about women's subjective experience of this form of therapy, as well as of their perception of how it facilitates change. This exploratory study seeks to investigate the experiential response of WS of CSA to wilderness therapy. It aims to identify how a selected group of WS of CSA subjectively experiences such time-limited therapy, and emphasises their descriptions of felt and/or perceived personal change. This study is therefore conceived as a phenomenological inquiry focusing on client perceptions of the mechanisms of change, as a result of the exposure to therapeutic processing in a wilderness setting.

1.2 Incidence and prevalence in South Africa

Much of the epidemiological research that seeks to document the extent of CSA in terms of its incidence and prevalence (Peters, Wyatt, & Finkelhor, 1986) has been conducted in the United States of America and Britain. South African researchers have also been interested in the issue

(e.g., Collings, 1997; Levett, 1989; Madu, 2001a, 2001b; Russell, 1986, 1997; van Niekerk, 2004).

Sexual abuse of children is said to be on the increase in South African society (Child Abuse Action Group, 2001). The South African National Council for Child Welfare (2002) placed this increase at 16.8% for 2001. However, exact figures for the incidence of child abuse in South Africa are not known since the SAPS statistics give an indication of the extent of the abuse, but this may reflect patterns of reporting, rather than actual incidence (Lewis, 1997).

In South Africa, as worldwide, the actual prevalence of CSA remains equally uncertain (Black et al., 1994, in Lewis, 1997; Goldman & Padayachi, 2000). For example, the recent report of the South African Human Rights Commission asserts that indications exist that more than one third of South African children will have been subjected to sexual abuse by the time they reach the age of 18 years (The Natal Witness, 2 May 2002). This statement concurs with a widely quoted estimate of the South African prevalence rate (Russell, 1986). It is also consistent with findings for South African female student samples by both Levett (1989) and Collings (1994) who obtained a prevalence rate of 35 %. The quote by Vogelman and Eagle (1991) certainly has current significance:

> ... what statistics are obtainable seem to indicate that such violence is at least as high as in other parts of the world, and often far higher. It is generally established that the incidence of violence directed at women in particular tends to reflect the general level of violence expressed in any society. South African society in all its heterogeneity is an extremely violent society with levels of violence increasing rather than decreasing. It is not surprising that in this context violence against women is prevalent. (p. 210)

This research will focus on South African women who are survivors of CSA.

1.3 Aetiology

A number of theoretical models have been formulated that propose to explain the occurrence of child sexual abuse. In understanding the forces impacting on the occurrences of sexual abuse, one might refer to fundamental assumptions of psychoanalytic theory, regarding the role of unresolved *Electra*-conflicts in CSA (Adams et al., 1992) that tend to place the blame on survivors and exonerate perpetrators (Blume, 1990). Further understanding may be gained by considering psychodynamic descriptions that emphasise the psychopathology of the perpetrator,

the survivor and/or family members, in particular the mother. The offender, it has been argued, might be an emotionally deprived individual (Meiselman, 1978), seeking the resolution of unmet dependency needs (Furniss, 1991) or preferring sexual gratification within a family (Mrazek, 1981). Many mothers of sexually victimised children have been found to have experienced childhood deprivation and/or sexual/physical abuse themselves (Summit, 1983) and tend to be dependent and insecure women, who are socially isolated and unable to stand up to the perpetrator (Mrazek, 1981; De Young, 1982). These female caregivers have also been described as depressed women, who have poor relationships with other members of the family and are frequently pressured into extricating themselves from their role as mother and wife (Gomes-Schwartz, Horowitz & Cardarelli, 1990). An unavailable mother can trigger the process of parentification in a child, which in turn can create role-reversal to such a degree that a child takes over the duties of the wife, including sexual ones (Butler, 1986; Chase, 1999; Gelinas, 1983).

Sociological explanations have declared CSA to be a social phenomenon. Low socio-economic status has been said to be a powerful risk factor for both physical and sexual abuse. However, this argument has not been supported by the epidemiological research (Finkelhor & Baron 1986; Finkelhor, 1993; Putnam, 2003). Social isolation (ibid.; Mrazek, 1981), as well as external stressors such as divorce and subsequent remarriage (Russell, 1986), broken homes (Putnam & Trickett, 1993) and stress because of unemployment, illness and bereavement (Mrazek, 1981), have been associated with the onset of child sexual abuse. The deterioration of social mores and values has been said to have created a climate of escalating violence which promotes the exertion of force and power by males in personal relationships, including those with children (Briere, 1989; Madu, 2001b; Lewis, 1997; Vogelman & Eagle, 1991).

With the rise of feminist thought, the focus of the aetiological discussion around CSA has shifted. The observation that the majority of perpetrators are males, has given rise to the question of what role societal concepts, such as patriarchy and masculinity, play in the incidence of CSA. Pagelow (1984, in Guma & Henda, 2004) indicates that "studies in gender violence suggest that the patriarchal ordering of gender relations is the overarching factor which determines that women are the main targets of family violence" (p. 103). The basic premise of patriarchy is that women and children are the private sexual property of men (Brownmiller, 1975, in Vogelman & Eagle, 1991), who therefore have a 'right' to abuse them (Briere, 1989; Hall & Lloyd, 1989). Consequently, forcing women to render sexual favours to men, especially within families, is

implicitly condoned (e.g., Blume, 1990; Butler, 1986; Gomes-Schwartz et al., 1990; Herman, 1981). Gilgun (1991, in Goldman & Padayachi, 2000) links sexual conquests and aggression further to the concept of masculinity. The process of socialisation prescribes male and female roles in terms of an imbalance of power between men and women. Boys learn that it is socially acceptable to express masculinity through being controlling, and to consider women to be weak and controllable. Girls, on the other hand, learn to accept their gender-based inequality and subordinate status in society as normal (Marshall & Herman, 2000, in Guma & Henda, 2004). Additionally, female children are taught that they can only obtain power through their association with, or by being the possession of, a man (Lyra & Hirschman, 1983, in Morgan, 1995). These factors implicitly reinforce the belief in men that they have a right to the attention and sexual favours of the women in the family. Cossins (2000, Guma & Henda, 2004) therefore concludes that in cultural frameworks where male dominance is normative, sexual abuse of children allows a man to feel powerful and masculine.

Finkelhor (1984) argues against a single-factor approach to explain why men abuse women and children, opting rather for an integrated frame, constituted by the interaction of individual and societal factors. His empirically based model points to various "embedded, multilevel and entwined causal factors" (ibid., p. 251) associated with CSA. He believed that sexual abuse could occur if four conditions would be met:

1. A potential offender needed to have some motivation to abuse a child sexually.
2. The potential offender had to overcome internal inhibitions against acting on that motivation.
3. The potential offender had to overcome external impediments to committing sexual abuse.
4. The potential offender or some other factor had to undermine or overcome a child's possible resistance to the sexual abuse. (p. 174)

It has been justifiably countered that Finkelhor does not address the 'why' but rather the 'how' of CSA. Yet, it seems that his emphasis on four factors foreshadows that not one single theoretical perspective will ever succeed in explaining the complexity of CSA. In terms of South Africa, several aetiological pathways have been explored. For example, Townsend and Dawes

(2004) propose that the poverty experienced by certain families might increase a child's vulnerability to sexual abuse for two reasons.

1. Poor families are at times characterised by emotional withdrawal and emotionally distant parenting. This type of parenting style has been found to be a feature of a sexually abusing person (Briggs & Hawskins, 1996, in ibid.).
2. Many poor parents find it difficult to provide adequate supervision for their children. When parents cannot pay school fees, children stay at home, but are left unattended while their caregivers try to find some source of income. Because of difficult home conditions, children may also stay away as long as possible, before returning home at night. Both of these conditions "reduce the caregiver's ability to monitor the child's whereabouts and render the child vulnerable to sexual abuse in the neighbourhood" (Dawes, 2002, p.6., in ibid.).

Guma and Henda (2004) stay within the feminist framework and argue with Maitse's (1997, ibid.) that the prevalent societal framework in South Africa is one of patriarchy. They suggest that it has at its core, the acceptance of gendered social divisions with sexist undertones, but has also influenced the development of a "rape culture" (ibid., p. 103), in which violence against children and women has become tacitly accepted.

Factors related to HIV/AIDS also contribute to the high rate of CSA in South Africa. Reports in the media have referred to the so-called "cleansing myth" (Townsend & Dawes, 2004, p. 71), which suggests that having sexual intercourse with a virgin will cure a sufferer from the infection. Studies suggest that the myth might be related to the drastic increase in very young child victims of sexual abuse (Madu & Peltzer, 2001, in ibid.). However, not everyone supports this view (Jewkes, 2004). Equally, the HIV/AIDS pandemic has led to the formation of many child-headed households, where adult supervision and support are lacking. These "unprotected children" (Townsend & Dawes, 2004, p. 72) are particularly vulnerable as victims of CSA, especially as they often get involved in so-called survival sex (ibid.)

CHAPTER TWO

THE EFFECTS OF CHILD SEXUAL ABUSE

2.1 Introduction

Literature on the effects of CSA tends to categorise the consequences into those that emerge shortly after the abuse experience, and those that develop later in the life of the survivor (e.g., Browne & Finkelhor, 1986a; Cole & Putnam, 1992; Finkelhor, 1990). The use of the term 'long-term effects' is unquestioned. The same cannot be said about the collective term for symptoms observed soon after the abuse. In some circles, the phrase 'initial effects' has been given preference over 'short-term effects'. The latter term implies that the effects experienced within two years of the termination of the abuse are time-limited, an assumption that has not been validated by research (Beitchman, Zucker, Hood, DaCosta & Akman, 1991; Browne & Finkelhor, 1986a).

When reflecting on the initial and long-term effects of CSA, certain factors need to be taken into account. Firstly, a definition of CSA is required that delineates the framework for the discussion of the effects associated with sexual victimisation. Secondly, research has indicated that certain factors mediate the effects of CSA. Thirdly, and closely connected, it has been argued that resilient children who have been sexually abused may not display any lasting consequences. And fourthly, methodological problems in researching the phenomenon prevail.

2.2 Definitional issues

Finkelhor and Berlinger (1995, in MacDonald, 2001) state that sexual abuse is not a disorder but an event or process. As if to support this argument, DSM-IV-TR has not outlined criteria to characterise CSA as a disorder, except for referring in Code V61.21 to sexual abuse of a child (Mannon & Leitschuh, 2002). CSA indeed has many unique manifestations, which cannot easily be captured under one definition. To arrive at a clear and precise definition of CSA for the purposes of research has not been easy, and a great deal of latitude has been exercised (Browne & Finkelhor, 1986b; Levett, 2004). Often broad definitions of CSA have been used with researchers, lawmakers, and clinicians often struggling to reach consensus about the definition of each of the words making up the term CSA (Haugaard, 2000).

Hall, Kassees and Hoffman (1987) have described CSA as consisting of "a sexual act imposed on a child who lacks emotional, maturational, and cognitive development" (p. 85). Finkelhor and Brown (1986) describe CSA as consisting of two overlapping but distinguishable types of interaction. Firstly, it includes forced or coerced sexual behaviour imposed on a child, and secondly, the sexual activity between a child and a much older person, whether or not obvious coercion is involved. A common definition of the construct "much older" is five or more years. Bagley and King (1990) extend the above definitions by arguing that CSA should be construed as any sexual activity or experience imposed on a child, which is unwanted by the child at the time, and which may result in emotional, physical, or sexual trauma. Sandler and Sepel (1990, in Lewis, 1997) define CSA as

> any sexual activity, whether it be ongoing or a single occurrence, ranging from sexual overtones to sexual intercourse, between a sexually maturing or mature person and an unconsenting or consenting child who is cognitively and developmentally immature. This pertains whether or not the perpetrator has himself/herself committed the sexual act or has permitted or encouraged the child to indulge in any sexual activity. (p. 213)

No agreement has been reached about delineating parameters for CSA, especially in operationally defining the concept for research. Hence, differences concerning the definition of sexual abuse prevail. These differences involve questions about whether or not non-contact abuse should be included, whether or not to include incidents involving same age peers as perpetrators, what age demarcations to use, and how to decide when certain forms of parental behaviour cease to be developmentally appropriate and become sexually abusive (Haugaard, 2000; Rind, Tromovitch, & Bauserman, 1998, in Leitschuh, 2002; Wyatt & Peters, 1986).

Furthermore, it has been queried whether the following factors should be included in a definition of CSA:

- the degree of sexual contact (Alexander, 1992a);
- the effect of cultural attitudes impacting on the definition of sexual abuse (Hall et al., 1985);
- the degree of coercion employed by the perpetrator (Veleur, Hughes, & de Rios, 1986);
- the differentiation of sexual abuse from emotional and physical abuse (Alexander, 1992a).

The term CSA will be employed in its broadest sense for this research study, thereby acknowledging the diverse definitions. Using the definition of the United Nation it will refer to

> contacts or interactions between a child and an older or more knowledgeable child or adult, when the child is being used as an object of gratification for an older child's or adult's sexual needs. These contacts or interactions are carried out against the child using force, trickery, bribes, threats or pressure. Sexual abuse can be physical, verbal or emotional and includes: touching and fondling of the sexual portions of the child's body... sexual kissing... penetration... exposing children to adult sexual activity or pornographic movies and photographs... having children pose, undress or perform in a sexual fashion... peeping into bathrooms or bedrooms to spy on a child. (NGO Group 2002)

2.3 Mediating factors

Not all those who experience childhood victimisation go on to develop either initial or long-term problems (Kendall-Tackett, Williams, & Finkelhor, 1993; Saywitz, Mannarino, Berliner, & Cohen, 2000). Certain intrapersonal and/or systemic factors can moderate the harmful effects of CSA (Classen & Yalom, 1995; Hall & Lloyd, 1989; Mullen & Fleming, 1998). These variables are often interrelated and thus their relationship to the onset of initial and long-term effects requires further investigation (Beitchman et al., 1991).

2.3.1 Duration and frequency of the abuse

The duration and frequency of CSA have been correlated with the traumatic impact of the experience on the child. Duration refers to the length of time the abuse lasted, while frequency pertains to the commonness of the occurrence of the abuse. There has been strong evidence supporting the fact that the duration and frequency of the abuse is positively correlated to the severity of its long-term consequences (Browne & Finkelhor, 1986b). However, the evidence does not seem to be conclusive (Classen & Yalom, 1995). Even a single incident can trigger significant problems in WS of CSA (Hall & Lloyd, 1989).

2.3.2 Age of onset

It has been argued that the younger a child is at the start of the abuse, the more devastating the effects (Gil, 1983, in Hall & Lloyd, 1989; Meiselman, 1978; Russell, 1986). The fact that the child is more impressionable and vulnerable at that early stage of her life, was offered as a possible explanation (Browne & Finkelhor, 1986a; Stein, Golding, Siegel, Burnam, & Sorensen, 1988). However, other researchers found that the negative impact is greater if the child is older. Studies with abused pre-schoolers, for example, indicated that they indeed presented with less psychological problems than did older children (Gomes-Schwartz, Horowitz, & Sauzier, 1985). The debate remains unresolved, as later research did not support these findings (Finkelhor, 1986;

Friedrich, Urquiza, & Beilke, 1986) and some studies did not establish any age-related correlation at all (Sauzier, Salt & Calhoun, 1990).

Beitchman et al. (1991) offer one possible explanation for the inconclusive results. They argue that, on assessment, the full extent of the effects of the abuse may not be evident as each developmental stage is likely to need unique stage-specific defense mechanisms to deal with the abuse. Classen and Yalom (1995) agree and assert that children deal with trauma differently at different ages. They contend that, for example, children of pre-school age might use their newly developed capacity to dissociate as protection against the effects of the abuse. Adolescents who have acquired the ability to process experiences cognitively might label the sexual contact as consensual (Gomes-Schwartz et al., 1985) and thereby temper possible emotional responses.

Retrospective studies of adults with variables controlled for duration and severity, might assist in unravelling the question about age of onset as a possible moderating variable.

2.3.3 Type of sexual abuse

Empirical evidence about the interdependency between the type of abuse and its damaging effects is inconclusive (Russell, 1986). Research however suggests that the more invasive the sexual contact has been, the more traumatising the experience is likely to be (Classen & Yalom, 1995). Hence, sexual activity involving completed or attempted intercourse, fellatio, cunnilingus, analingus or anal intercourse is thought to have a greater negative impact than would fondling or touching the child (Beitchman et al., 1991; Russell, 1986).

2.3.4 Relationship with the abuser

In South Africa, the majority of sexual abuse experiences are carried out by adults known to the child but who are not close relatives (Hooper, 1992). More severe consequences have been reported when a father or a father figure committed the abuse (Cole & Wodger, 1989; Russell, 1986). Russell (1986) suggests that it has to do with the extent of betrayal of trust that is experienced by the victim, while Classen and Yalom (1995) point to emotional closeness as another important variable. Hence, the abuse by other trusted adults such as neighbours or babysitters with whom the victim has close bonds could be perceived as more damaging than the victimisation by a distant relative (Friedrich et al., 1986; Hall & Lloyd, 1989).

2.3.5 Use of force

A number of studies have confirmed that there is an association between the force or violence the abuser used, and the degree of later effects (Russell, 1986). Steele and Alexander (1981) showed that evidence based on anecdotal accounts and case studies suggests that the less force and coercion is used during the abusive act, the less harmful it is likely to be for the child. Other studies have challenged this association (Anderson et al., 1981, in Browne & Finkelhor, 1986a), claiming that lack of coercion is related to increased guilt and self-blame.

2.3.6 Number of abusers

It has been stated that more severe traumatic effects are felt in children who have experienced sexual abuse at the hands of several perpetrators (Beitchman et al., 1991; Browne & Finkelhor, 1986b; Hall & Lloyd, 1989). A research study with 85 children, aged 3 to 12, using multiple regression suggests that besides the invasiveness and duration of the violation, the number of perpetrators impacted negatively on the severity, and hence the increase in a the variety and degree of behaviour problems in the victim (Friedrich et al., 1986).

2.3.7 Disclosure of the abuse

Another factor that has been cited as a moderating variable is whether or not the abuse was disclosed. Telling someone can bring the protection needed to avert the impact of long-lasting and frequent victimisation (Kelley et al., 1991, in Hooper, 1992; MacMartin, 1999). Research has been undertaken in order to ascertain whether delayed disclosure would increase negative effects. Bagley and Ramsay (1986) demonstrated an increase in impairment related to withholding disclosure. However, on analysis of other factors associated with the experience, a nonsignificant relationship was established between disclosure and the increased negative effects (Browne & Finkelhor, 1986b). Similarly, Sauzier et al. (1990) showed that children in the Tufts study (1984, in Browne & Finkelhor, 1986a) who did not report the abuse did not necessarily experience greater distress. They appeared to have coped better and not to have displayed the anxiety and hostility found in those children who had disclosed the abuse.

2.3.8 Reaction to disclosure

Children often feel ambivalent about the sexual abuse they suffered and hence are reticent to report it (Hooper, 1992). The type of response of those who have been told, and specifically

parents and adult caretakers, is believed to be of importance in terms of the impact on the child's experience of the abuse.

Positive responses such as maternal warmth and support received from a non-abusive parent or from a well-functioning family have been found to mediate the severity of the effects of the abuse (Alexander, 1992b; MacDonald, 2001).

Negative responses to the reporting have been related to an increase in the detrimental effects on the child (Anderson et al., 1981, in Browne & Finkelhor, 1986a; Putnam, 2003). Gomes-Schwartz et al. (1990) emphasise the response of a mother as non-abuser as key in the child's attempts to deal with the effects. Negative responses such as anger, disbelief and blame only increase the child's distress as she feels betrayed for not having been protected (Kelley, 1988a, in Hooper, 1992). Sauzier et al. (1990) support those observations by highlighting that children who have been blamed or punished for the disclosure, tended to exhibit greater psychological problems.

2.3.9 Ethnicity

The effects of CSA have been observed in children from different ethnic backgrounds (Putnam, 2003). Ethnicity, as a potential mediating effect, has however not been adequately researched to provide conclusive understanding (Roosa et al., 1999, in MacDonald, 2001). Nevertheless, preliminary research suggests that it may influence symptom expression (Putnam, 2003).

As can be seen above, there are many mediating factors, which may assist the child in dealing with the abuse, or may further exacerbate the effects. Research has aimed to ascertain the nature and extent of moderating factors in assisting a child to overcome the effects of the abuse. However, the findings remain inconclusive (Beitchman et al., 1991; Berliner & Elliott, 2002). Mediating variables do exist and serve only as a guide in terms of predicting possible consequences of CSA (Hall & Lloyd, 1989). Sexual abuse can and does have negative consequences for a child, even when various mediating factors have been present at the time of the abuse (ibid.). It must always be remembered that each child is unique and requires special consideration. Furthermore, these mediating factors may indeed assuage the effects, but might also intensify them.

2.4 Resilience

There seems to be no consensus about the question whether sexually abused children will exhibit difficulties in later life (Browne & Finkelhor, 1986b). On the one hand, studies suggest that children who have experienced abuse displayed more emotional and behavioural problems than their non-abused peers (e.g., Green, 1993; Sirles et al., 1989, in Gomes-Schwartz et al., 1990). Yet, on the other hand, not all sexually victimised children show signs of emotional distress or clinical symptoms (Kendall-Tackett et al., 1993; Saywitz et al., 2000).

The concept of resilience deserves mention here since it seems imperative to understand the factors that might influence and shape a child's capacity to minimise or overcome the damaging effects of adversities such as CSA. Not much research seems to have been undertaken to establish what role resilience can and does play in sexually abused children; yet different and even divergent theoretical perspectives prevail.

At one end of the continuum, there are the 'pro-incest' groups who claim that sexual contact between adult and child can have psychological benefits in terms of the development of the child (Pomeroy, 1976, in Blume, 1990). Yates (1976, in Adams-Tucker, 1984), for example, argues that sexual experiences for children under eight years of age with a compassionate adult, will afford the child a safe and natural way of learning about sexual sensuality. This argument implies that sexual interaction is not necessarily experienced by children as abusive and hence will not lead to a sense of having been victimised.

A less extreme view was proposed by Lynch (1988) who showed that some children remain problem-free even though they were sexually abused for other reasons than those proposed by the 'pro-incest' lobby. She argues that children, who are resilient to the potentially adverse consequences of childhood sexual abuse, may have several protective or mediating processes that operate in their life. For example, they tend not to have either perinatal problems or developmental or behavioural abnormalities prior to the abuse. These children are further found to be of above-average intelligence (Gomes-Schwartz et al., 1990) and possess a highly developed sense of self-esteem and self-worth, high levels of ego-control and an internal locus of control for good events and external attributions of blame for unpleasant events (Heller et al., 1999, in MacDonald, 2001). Westerland (1992) confers that the 'lucky women', meaning those survivors who coped, are those who engaged in positive dissociation; that is, by regarding the

abuser with contempt or pity, by belittling the incest experience and by excluding it as part of identity development.

Finkelhor (1990) reports in his review that almost every study on the impact of CSA has found a large number of survivors with little or no apparent symptomatology. Such research outcomes could reflect problems with measurement or definitional variations, with methodological issues or denial in children at the time of their first assessment. However, Finkelhor (ibid.) hypothesises that those children who have experienced less severe forms of sexual abuse and who have adequate psychological and social resources to cope with the trauma of the experience might be asymptomatic. It appears that the proportion of sexually abused children who present with no detectable symptoms varies across studies from 21% to 49% (Berliner & Elliot, 1986, in Melchert, 2000; Saywitz et al., 2000). According to one study, 70% of those children will remain symptom free later in life (Kandell-Tackett et al., 1993).

Despite these views a more recent review on the consequences of CSA inferred that the majority of researchers agree that sexual abuse during childhood will be detrimental to the child victim.

2.5 Methodological issues

Much research into the effects of CSA has been conducted. However, many authors have enumerated methodological problems (e.g., Briere, 1992a; Browne & Finkelhor, 1986a; Levett, 1989) that prevent researchers from formulating conclusive research findings. A few of these problems will be highlighted:

1. Peters et al. (1986) point out that different definitions of what, at minimum, constitutes CSA have been used. Such differences obviously impact on estimates of sexual abuse prevalence in any given sample (Haugaard, 2000). It can further be assumed that researchers who choose to focus on earlier or more intrusive forms of abuse might report more extreme outcomes than those using broader definitions (Peters, 1988).

2. Issues related to research design can hamper the process of generalisation. Many studies have relied on clinical populations (e.g., Briere & Runtz, 1987; Bryer, Nelson, Miller, & Krol, 1987) or other subject groups such as university students or professionals (Collings, 1997; Levett, 1989), which are not representative of the general population. Not all have used

control and/or comparison groups, thereby compromising the validity of the outcome measures that were used (Briere, 1992a). Different data collection techniques from retrospective interviews to questionnaires (Levett, 1989; Collings, 1997) have been utilised, with some tools being more likely to elicit report biases (Briere, 1992a) or a refusal to respond (Levett, 1989) than others. Sampling of participants has taken into consideration different age ranges and gender criteria. However, it usually does not control for ethnicity, socio-economic status, geographic location or other possible family or abuse variables, all of which might contribute to the outcome effects in CSA (Mrazek, 1981; Sauzier, et al, 1990). Even where these varying aspects are acknowledged, the type and extent of sexual abuse reported by the subjects often differs significantly from group to group (Briere, 1992a). However, often the reliance on cross-sectional rather than longitudinal designs has the consequence that the psychological functioning of individuals, before and after sexual abuse, cannot be ascertained (ibid.). Closely connected is the issue of measurement systems, which are at times "questionable" (ibid., p. 200) as some lack reliability, validity and appropriate standardisation, while others may be insensitive to abuse-specific symptomatology.

These thoughts provide but a taste of the difficulties encountered by researchers engaging in the study of the psychological sequelae of CSA. The large body of research however points to the fact that the sexual victimisation of children may have harmful initial and long-term effects (Briere & Runtz, 1988; Cole & Putnam, 1992; Putnam, 2003; Ratican, 1992; Sauzier et al., 1990). This claim warrants further investigation and a second wave of research, that is, "the development of more tightly controlled and methodologically sophisticated studies that seek to disentangle the antecedents, correlates, and impacts of sexual abuse" (Briere, 1992a, p. 202).

2.6 Initial effects of child sexual abuse

Notwithstanding the fact that some children are resilient or that mediating factors might lessen the impact of the abuse, more often than not sexually abused children struggle to come to terms with the detrimental effects of their victimisation. Initial effects in this context refer to the reactions that are experienced by victims of sexual abuse within two years of the termination of the abuse (Browne & Finkelhor, 1986b). Reports have highlighted a broad spectrum of symptoms, which can be grouped in the following four broad categories (Gomes-Schwartz et al., 1990), with some children displaying symptomatology that extends beyond any one category.

2.6.1 Behavioural problems and problems in social functioning

Research has identified a broad range of behavioural problems in victims of child sexual abuse. These range from poor school performance, truancy, running away, withdrawal, sleeping and eating disturbances, antisocial behaviour, aggression and disruptive acting-out behaviour in the family or other social contexts (Briere & Runtz, 1988; Browne & Finkelhor, 1986b; Conte & Schuerman, 1988; Friedrich et al., 1986).

Behavioural problems typically manifest in interpersonal relationships. Finkelhor and Browne (1985) link a feeling of mistrust and a sense of having been betrayed to children withdrawing from close and intimate relationships. They are hence often described as having difficulties making friends, as perceiving themselves to be different and as socially withdrawn (Classen & Yalom, 1995; Mullen & Fleming, 1998). Sauzier et al. (1990) also found a lack of socially valued interpersonal skills in school-aged children who had experienced CSA.

School aged victims of CSA often exhibit academic problems (Lewis, 1997; Putnam & Trickett, 1993). Victims have been found to perform erratically at school (Dippenaar, 2002). More than non-abused children, they fail the school year, absent themselves from certain classes, or drop out of school (Rust & Troupe, 1991). Intrusive thoughts or flashbacks could produce concentration difficulties and attention deficits (Putnam, 1993). Attempts to forget or dissociate from the CSA might generalise to non-selective forgetfulness that could influence the child's academic performance (Pinegar, 1995, in Dippenaar, 2002). Sexually abused adolescents caught up in the turbulence of puberty experiences often display 'acting-out' behaviour (Runtz & Briere, 1986). It may manifest in the form of running away (Herman, 1981; Gomes-Schwartz et al., 1985), display of aggression and hostility (Conte & Schuerman, 1988), or abuse of alcohol and other substances (Classen & Yalom, 1995; Runtz & Briere, 1986). Adolescent victims have also been found to marry early (Meiselman, 1978).

2.6.2 Inappropriate sexual behaviour

In terms of sexual behaviour, it has been claimed that a sexually abused child may respond to the abuse in one of two ways. Firstly, clinicians, such as Sgroi (1982), have described phobic reactions and sexual inhibitions. Secondly and more commonly, victims have manifested sexualised behaviour, which seems to be a relatively constant marker of CSA during the years prior to puberty (Friedrich & Grambsch, 1992; Putnam, 2003).

The Tufts study (1984, in Browne & Finkelhor, 1986a) demonstrated that sexually inappropriate behaviour is the most common symptom among pre-school children and one of the most prevalent symptoms among school-age children. In pre-school children, the behaviours included having had sexual relations, open masturbation, excessive curiosity, and frequent exposure of the genitals. The research undertaken by Sauzier et al. (1990) confirmed some of these results. For example, they found that 27% of their cohort of sexually abused pre-school children showed higher levels of sexual behaviour than other non-abused children. The behaviour included both sexual relationships and the display of inappropriate sexual behaviour. They argued that the reason for that behaviour might be an attempt by the children to gain mastery over the confusing feelings that were aroused by the sexual stimulation. Sexual feelings hence are present before puberty because of an artificially accelerated sexual development (Bukowski, 1992). Gomes-Schwartz et al. (1990) add that these symptoms may be indicative of the child's attempt to process an incomprehensible experience. However, even adolescents may display evidence of sexual acting out in the form of promiscuity or homosexual contact (Beitchman et al., 1991; Classen & Yalom, 1995) with an increased risk of early pregnancy (Herrenkohl et al., 1998, in Putnam, 2003). Child sexual abuse has also been directly or indirectly linked to entering prostitution and being a victim of sexual violence on the street (Bagley, & Young, 1995; Simonds & Whitbeck, 1991).

2.6.3 Psychological effects

Fear, anger, guilt and shame are the most common initial effects documented (Browne & Finkelhor, 1986b; Conte & Schuerman, 1988). The emotional state of the abused child can encompass discomfort, states of anxiety and dysphoria, but also extreme despair (Herman, 1992). Symptoms of depression are commonly found, with accompanying impaired self-esteem and feelings of helplessness (Browne & Finkelhor, 1986b; Sauzier et al., 1990). Beitchman et al. (1991) reported similar symptomatology for sexually abused adolescents.

Anger and hostility are reportedly common in sexually abused children (Lewis, 1997). As children are unable to cope with their angry emotions, repression is a frequently used defence mechanism (Sgori, 1982). Anger might be experienced towards the perpetrator, but also towards significant others who failed to protect them from the sexual violation and who in their opinion should have protected them.

Meiselman (1978) has shown that victims of CSA also display feelings of fear and helplessness manifested through nightmares, clinging behaviour, somatic complaints or hypervigilance. Furthermore, heightened anxiety may be evidenced in limited impulse control, enuresis or sleep disturbances. This anxiety might be closely connected to a sense of powerlessness in response to the violation experienced by the abused child (Finkelhor & Browne, 1985), which results from the repeated penetration into the child's space, both bodily and emotionally, often accompanied by manipulation and coercion.

Beitchman et al. (1991) surmise that there is a relationship between sexual abuse and symptoms associated with post-traumatic stress disorder (PTSD) and invite further studies "to examine to what extent it is specific to sexual abuse per se" (p. 547). Finkelhor (1990) however sees such focus on diagnostic formulation as potentially harmful, as it could lead to the dismissal of some of the more unique effects of sexual abuse in individual children.

2.6.4 Effects on self-esteem

Reports on the effects of sexual abuse on self-esteem in children have been conflicting. In the Tufts study (1984, in Browne & Finkelhor, 1986a) no significant differences in self-esteem were established in the various age group. Others such as Oates, Forrest, and Peacock (1985) found that children who had undergone sexual trauma exhibited significantly lower scores in self-concept as measured by the Piers-Harris Children's Self-Concept Scale. Oates (1989) in another study reported a reduction in self-confidence in various groups of sexually abused children and adolescents. It has however been ascertained that the development of the self in a victim of sexual abuse is impaired (Cole & Putnam, 1992). The traumatic sexual experience impacts on the victim during a vulnerable phase in identity formation and prevents her from attaining a positive sense of self (Bukowski, 1992; Putnam & Trickett, 1993).

2.6.5 Physical and somatic complaints

Children who have been sexually abused have also been reported as displaying a number of physical and somatic complaints. Physical symptoms might stem from the sexual offence itself: vaginal scarring, bruised bodies, and broken bones (Russell, 1995); or as autonomic reactions to anxiety or symptoms which have physiopsychological origins such as headaches or fatigue (Dippenaar, 2002). Other difficulties may include sleep disturbances and alterations in eating patterns (Anderson, 1981, in Browne & Finkelhor, 1986a; Gomes-Schwartz et al., 1990; Putnam,

1993). Self-abusive behaviour such as self-starvation, obesity, substance abuse and suicide following CSA have been described as ways to punish or annihilate the body in order to prevent further sexual interest or abuse (Collings, 1997). Repetitive self-mutilation is another form of self-abuse (Goodwin, Simms, & Bergman, 1979, in Runtz & Briere, 1986). Herman (1997) describes it as a way through which the victim of CSA may attempt to terminate the feeling of threat and inner pain accompanied by a compulsion to attack the body.

For some young girls an additional complication and result of the sexual offence may be pregnancy (DeFrancis, 1969, in Browne & Finkelhor, 1986b). This however does not hold true for all victims because of mediating factors such as age and fertility. Consequently, the generalisability of the claim is debated (Meiselman, 1978). Another concern that has increasingly been raised is the possibility of HIV/AIDS infections (Dippenaar, 2002; Lindegren et al., 1998; Parillo et al., 2001, in Putnam, 2003), especially within the South African context (Jewkes, 2004; Madu, 2001b). Although not all victims contract HIV/AIDS, children subjected to sexual abuse are at greater risk to be infected.

2.7 Long-term effects

Therapeutic work can help children deal with the trauma of CSA. However, a child who has never spoken about her experience might have been denied the "opportunity to develop into a healthy, intact adult" (Blume, 1990, p. 13). Time does not necessarily heal the wounds inflicted by the perpetrator. Adults who were sexually abused as children frequently present with long-term effects (Briere & Runtz, 1987). Research studies that aimed at categorising these effects elicited divergent sequelae (Cole & Putman, 1992; Cruz & Essen, 1994; Ganje-Fling & McCarthy, 1996; Gelinas, 1983). However, empirical confirmation is still lacking for most of them (Conte & Schuerman, 1988; Finkelhor, 1986). What has become clear though, is that these effects do not form a neat, definable picture or syndrome (Killian, lecture 2003). Most victims present with their own unique struggles, be they maladaptive behaviour patterns and/or psychological problems. What can be said however is that CSA has been found to have a fragmenting quality. It can result in the destabilisation of self-esteem, the evolution of increased self-blame and a variety of clinical symptoms that in turn impact on the victim as a person and as a social being (Cruz & Essen, 1994).

2.7.1 Nosological disorders

Victims of CSA are more likely to develop psychiatric disorders in adulthood than non-victims (Koss, 1990), especially when the abuse was severe in nature (Read, 1997). Research has provided evidence for a number of psychiatric disturbances in WS of CSA:

- major depression (Bagley & Young, 1990; Briere, 1992b; Browne & Finkelhor, 1986b; Gelinas, 1983; Peters, 1988; Putnam, 2003) and more frequently, bipolar depression (Hyan, Friedman & Dunner, 2000);
- PTSD (Beitchman et al., 1991; Briere, 1989; Finkelhor, 1990; Lindberg & Distad, 1985)
- suicidal ideation (Bagley & Young, 1990; Bryer et al., 1987; Koss, 1990; Wyatt et al., 1992);
- panic disorder and phobia (Briere, 1992b);
- schizophrenia (Read, 1997);
- obsessive compulsive disorder (Hall & Lloyd, 1988);
- multiple personality disorder (Cole & Putnam, 1992) with borderline personality disorder most frequently cited (Bryer et al., 1987; Cole & Putnam, 1992; Koss, 1990; Mullen & Fleming, 1998);
- substance abuse disorder (Beutel, 1999; Young, 1990, in Cole & Putnam, 1992);
- eating disorders (Messman-Moore & Long, 2002).

Less attention has been given to somatic effects. However, symptoms such as pseudoseizures, pelvic pain and gastrointestinal disturbances (Briere & Runtz, 1988; Bryer et al., 1987) have been reported. Equally, sleep difficulties with nightmares, raised anxiety states and increased tension levels are common in women who have been sexually abused as children (Browne & Finkelhor, 1986b).

2.7.2 Intrapsychic effects

Low levels of self-esteem are viewed to be a fundamental difficulty for many adult survivors of CSA (Beitchman et al., 1992; Hall & Lloyd, 1988). For example, a study conducted by Romans et al. (1996, in Mullen & Fleming, 1998) indicates a clear relationship between poor self-esteem in adulthood and a history of CSA, especially with more intrusive forms of abuse involving penetration. Aspects that were involved were an increased expectation of unpleasant events and a sense of lacking the capacity to influence external events. Other manifestations of low self-esteem that have been cited include negative self-image and powerlessness (Briere, 1989; Hall &

Lloyd, 1989); a sense of isolation, stigmatisation, defilement, shame, guilt, self-blame and worthlessness (Herman, 1992).

Other emotional reactions commonly found are guilt and a feeling of responsibility for the sexual abuse that can be generalised to many situations and relationships (Hall & Lloyd, 1988; Ratican, 1992). A sense of guilt is often accompanied by anxiety or inner tension (Browne & Finkelhor, 1986b), which is not surprising since the victim's developing sense of security and belief in a safe and just world was violated when she was a child (Briere, 1992b). Considerable anger and rage, manifesting in outbursts of aggression plus the inability to solve conflicts amicably, have also been shown to prevail (ibid.)

It must also be remembered that sexual abuse is a trauma to the body (Mills & Daniluk, 2002; Putnam & Trickett, 1993; Simonds, 1994) that changes the individual's relationship with her physical self. WS tend to hate their bodies, find them ugly and experience alienation from them (Blume, 1990; Herman, 1987; Ratican, 1992). Rather than being connected with the body, many WS of CSA find they are not in tune with their physical sensations and emotional feelings since they defend against them by virtue of intellectualisation and dissociation (Feinauer, 1994). This can lead to eating disorders (Oppenheimer et al., 1985, in Hall & Lloyd, 1988) and to compulsive work patterns (Simonds, 1994).

2.7.3 Interpersonal issues

One long-term effect of CSA is a deep-seated sense of betrayal. The violation destroyed the victim's capacity to trust others and hence many women survivors try to protect themselves by isolating themselves or withdrawing socially (Blume, 1990; Classen & Yalom, 1995). They find it difficult to form close and intimate relationships (Cole & Putnam, 1992), be it with women or men, with parents or children (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Gelinas, 1983).

Adult survivors who find themselves in relationships can have problems with sexual expression (Westerland, 1992). Some act out compulsively while others avoid any form of sexual experience (Briere, 1992a; Classen & Yalom, 1995; Finkelhor, Hotaling, Lewis & Smith, 1989; Mullen & Fleming, 1998). Promiscuous behaviour among WS of CSA appears likely (Cole &

Putnam, 1992; Gelinas, 1983) as are sexual dysfunctions such as problems with arousal or inability to have an orgasm (Gelinas, 1983; Jehu et al., 1984, in MacDonald, 2001).

Many WS of CSA experience revictimisation through rape or non-consensual sexual experiences later in life, which has been linked to their apparent emotional vulnerability (Blume, 1990; Briere, 1992a; Courtois, 1999; Messman-Moore & Long, 2002; Ratican, 1992; Russell, 1986; Wyatt, Guthrie & Notgrass, 1992).

2.7.4 Intrafamilial problems

It has been argued that CSA can affect parenting (Furniss, 1991; Goodwin, McCarthy, & Di Vasto, 1981, in Browne & Finkelhor, 1986b; Hall & Lloyd, 1989). Wade (2000) states that early abuse can stifle a child's emotional development, so that as a parent, she is emotionally younger than her own children, and hence finds it difficult to respond to their needs. They often lack confidence and a sense of control in rearing their own children because they themselves lacked positive role models. Consequently, they are more likely to indulge their children and struggle with setting limits (Cole & Woolger, 1988). Tharinger (1990) adds that mothers who are adult survivors of CSA may find it difficult to socialise their children in terms of their sexual development and therefore abrogate that parenting responsibility. Equally, they might find it difficult to show closeness and affection since such moments of intimacy are endowed with sexual connotations (Hall & Lloyd, 1989).

In terms of marital relationships, severe forms of sexual abuse were found to be significant predictors of later marital disruptions that often lead to divorce (Finkelhor et al., 1989) or separation (Fleming, 1997, in Mullen & Fleming, 1998). Women survivors are also more likely to have husbands or adult partners who abuse them (Hall & Lloyd, 1989). A study reported that 49% of the participating WS of CSA stated that they were living in domestic violence situations where battering was a common occurrence (Briere 1984, in Browne & Finkelhor, 1986b). It has been argued that the CSA may have taught the victims that being passive and selfless is a value and that they thereby become increasingly vulnerable to abusive adult relationships (Briere, 1992b; Finkelhor & Browne, 1986).

2.7.5 Social functioning

Besides struggling with relationships, WS of CSA often find their social functioning

compromised. Thus, for example, Browne and Finkelhor (1986a) highlight the link between CSA and later prostitution by victims of sexual abuse. Others point to an association with later substance abuse (Beutel, 1999; Briere, 1992a; Hall & Lloyd, 1989; Mullen & Fleming, 1998) with alcohol and psychoactive drugs seen as a means to escape the pain of upsetting memories that are often accompanied by anxiety spells and depressive moods (Beutel, 1999; Briere, 1992b).

Educationally and professionally, WS of CSA often do not cope (Hall & Lloyd, 1989; Mullen & Fleming, 1998). The experience of CSA can disrupt early education and prevent victims from mastering basic academic skills, thereby setting them up for later failure and underachievement (Blume, 1990; Hall & Lloyd, 1989). They may also present with poor memory and learning problems as adults (Siegel & Romig, 1988, in Ratican, 1992). These factors help explain why unemployment is more likely in samples of incest survivors, regardless of educational levels, than in samples of non-victims (Russell, 1986).

2.7.6 Cultural aspects

As development of a child tends to be arrested at the age at which the abuse occurred, so is the spiritual development arrested (Ganje-Fling & McCarthy, 1996). The God-image may be childlike or totally denied and the moral concepts of good and evil rigidly polarised. A WS of CSA might embrace an identity as sinner and "may be afraid that God will punish her" (Blume, 1990, p. 124). Indirectly, Ganje-Fling & McCarthy (1996) argue that some of the effects of abuse such as mistrust, despair, anger and conflicts about responsibility and forgiveness distort the faith of a victim to such a degree that it blocks the survivor from accessing spirituality as a possible coping mechanism and source of healing. In a national telephone survey, Finkelhor et al. (1989) established that adult survivors of CSA expressed significantly more disenchantment with organised religion than non-victims, which they hypothesised is a direct reaction to the moral hypocrisy of their, often, conventionally-religious abusers.

In summary, it can be stated that a large body of research documenting initial and long-term effects of child sexual abuse exists. A number of researchers have contended that despite the wealth of correlational research evidence of particular pattern of symptoms, the characteristics of a unique reaction to CSA is yet to be discovered (Alexander, 1992a). Cole and Putman (1992) clarify that to date no longitudinal study has investigated the direct correspondence between

childhood effects of the abuse and adult symptomatology. Methodological problems are also quoted as hampering the validation of most of the research findings (Briere, 1992a). Beitchman et al. (1991) state that the existing body of empirical research on the effects of CSA is found lacking and fails to provide a sound knowledge base for the appropriate provision of treatment services in this field. There is consequently an urgent need for on-going research in the area.

CHAPTER THREE

THE TREATMENT OF CHILD SEXUAL ABUSE

3.1 Introduction

Not all those who have been sexually abused as children need or seek treatment. Some adolescents have been found to avoid dealing with the abuse (Shapiro & Dominiak, 1990) while some children remain asymptomatic and exhibit no delayed onset of difficulties (Putnam, 2003). Similarly, some adult survivors have reported no, or very few symptoms (Berliner & Elliott, 2002). Each survivor, whether child or adult, is unique and differs from all others in her response to the trauma of CSA. Some will develop a unique pattern of coping skills and defences (Simonds, 1994); others display their specific brand of psychopathology, never becoming a carbon copy of another survivor (Nurcombe, Wooding, Marrington, Bickman & Roberts, 2000). Hence, it is unlikely that one kind of treatment suits or benefits all women survivors (ibid.). In response to the presenting symptomatology, the therapeutic intervention needs to be chosen carefully. Thus, the therapist is invited to suggest an individualised treatment plan that outlines a therapeutic process with clearly stated goals and strategies catering for the unique needs of the individual survivor (Courtois, 1988; Hecht, Chaffin, Bonner, Worley & Lawson, 2002; Sgroi, 1988).

Literary reviews to date suggest that studies into the efficacy of existing treatment modalities, such as individual, family or group therapy, have not elicited definite evidence for the superiority of one approach over another (e.g., Finkelhor & Berliner, 1995; Nurcombe et al., 2000; O'Donohue & Elliot, 1992). The lack of rigorous empirical research studies has been blamed for the inclusiveness of these findings (Beutler & Hill, 1992; Gomes-Schwartz et al., 1990; Nurcombe et al., 2000). Hence, practitioners are left to their own clinical judgment, "tempered by the realities of client need, staffing and workload", when choosing the intervention for their psychologically struggling clients (Hecht et al., 2002, p. 167). At times a combination of treatment modalities might be indicated (Cruz & Essen, 1994), while for specific symptoms and conditions of WS of CSA interventions exist that have proven to be effective (Goldfried, Greenberg, & Marmar, 1990, in Beutel & Hill, 1992.). Consensus prevails that indeed these 'abuse-related' (Cruz & Essen, 1994), 'abuse-focused' (Hecht et al., 2002) or 'abuse-specific'

(Finkelhor & Berliner, 1995; MacDonald, 2001) treatment strategies are preferred approaches to treating WS of CSA.

Joy (1987) proposes that therapeutic approaches aiming to assist survivors of CSA need to:

- encourage the expression of abuse-related feelings;
- promote an integration of the past experience while also facilitating a better; understanding of family and interpersonal dynamics;
- help the client to develop positive self-feelings;
- assist the victim to develop a greater ability to trust (also Killian & Brakarsh, 2004).

Thereby, the sexual abuse victim can be guided to see the link between the abuse and the prevailing distress and work towards an improved well-being (MacDonald, 2001).

3.2 Issues in therapeutic intervention

Many individuals who were sexually traumatised early on in life "experience life as overwhelming in many domains and those who seek treatment often present with a complex array of difficulties and concerns" (Berliner & Elliott, 2002). For this reason therapeutic work often involves a lengthy and emotional process (Sgroi, 1982). However, not all issues can be addressed at the same time. Interventions need to be focused insofar as they first of all seek to address key issues that most severely impact on the sexually abused individual. Nurcombe and his colleagues (2000) state that treatment targets post-disclosure and mediating factors. It also aims to rework childhood experiences and boundary issues and thereby to facilitate the victim's movement towards slow individuation (Briere, 1992b).

Besides addressing presenting clinical dysfunctions, literature suggests that ten specific impact issues prevail that need attention (Beutler & Hill, 1992; Long, 1986; Sgroi, 1982; Rose, 1991).

3.2.1. The 'damaged goods' syndrome

Sexual abuse victims battle with what has become known as the 'damaged goods' syndrome. It is linked to the injury sustained during victimisation, but also to the fear of physical damage or retaliation, and is often aggravated by a community's response of curiosity, pity or disgust when it hears about the abuse. Treatment should therefore begin with a comprehensive physical

examination of the child victim and in case of physical damage medical attention should be provided immediately. If there is no evidence, this needs to be emphatically conveyed to the sexually abused person and the family.

The fear of unsalvageable physical damage may start in childhood and then persist into adulthood. WS of CSA may construe repeated experiences of revitalisation as evidence that they are in some way perceived by themselves and others as 'damaged'. Assisting the survivor to externalise and reattribute the blame for the abuse may help to ameliorate this issue.

3.2.2 Guilt

After a child has disclosed the sexual abuse trauma, she often feels overwhelmed by guilt. There are several possible explanations for this phenomenon. Firstly, she might take responsibility for the sexual acts that took place, especially if her family blames her for the abuse. Secondly, she might feel guilty for not having kept the secret as she was told to do by the perpetrator. The guilt might be intensified if the perpetrator had successfully manipulated the victim into believing in the specialness of the relationship, albeit an abusive one. Thirdly, the victim might accept sole responsibility for the painful period that ensued for the family after the disclosure. This might be perpetuated by overt or covert accusations made by individual family members to that effect. If any of these conditions prevail, a therapist needs to convey consistently to the child and her family that she can neither be held responsible for initiating the abuse nor disclosing of the same.

Adult women who experienced CSA also report guilt responses, especially when they had not had the opportunity to deal with the abuse issue around the time of the abuse (Briere, 1989; Classen & Yalom, 1995). The therapeutic process can help a survivor to identify and understand the source of her guilt feelings, as much as assist her to make a clear distinction between appropriate and inappropriate attributions of responsibility for the sexual activity (Gelinas, 1983).

3.2.3 Fear

Fear, which arises from various sources, is a common theme for sexual abuse victims. A child might fear that she will be separated from, or abandoned by, the family if she speaks about the abuse. She might also be terrified of actual physical damage or experience traumatising nightmares or flashbacks. Victims of CSA may also experience the fear of revictimisation and

reprisal from the offender after disclosure has occurred. Whatever the origin of the fear, the child victim needs support in identifying her fear, and in expressing and coping with the fears in a constructive way. Interventions aimed at improving the safety of the child's home environment and strengthening supportive relationships in the family context may assuage the child's fears.

Adult survivors similarly face fears of revictimisation, which are often the result of recurrent dreams and intrusive recollections of the abuse. Concrete strategies aimed at dealing with stress, anxiety and lack of assertiveness might prove beneficial.

3.2.4 Depression

Individuals who have been sexually abused often display symptoms typically associated with depression. A child, for example, might withdraw from any contact with her world or develop physical complaints prior to, and while, disclosing the abuse. Similarly, an adult survivor might become depressed when memories of the CSA surface. Potentially, these memories create a sense of loss in the victim. The previously healthy relationship with her parents is compromised, as is the role assigned to her in the family. But more so, she is faced with the loss of the innocence of childhood. Self-denigratory cognitions, already present at the time of the abuse, might add to the mood disturbance later in life. In therapy the WS of CSA needs to be invited to express the feelings that are associated with the various mood symptoms, while cognitive restructuring programmes might succeed in improving her mood and distorted cognitions.

3.2.5 Low self-esteem

Low self-esteem in a survivor of CSA has been associated with the victim blaming herself for having participated in the abuse. It has been argued that sexual abuse victims utilise primitive defense mechanisms such as dissociative splitting in order to be able to control the guilt, anxiety and shame related to the abusive experience (Shapiro & Dominiak, 1990). Splitting leads to developing in oneself separate intolerable representations of the self or others as bad, unworthy or malevolent. Thus, a child might deny the abuser's exploitation and displace the feelings of malevolence onto herself. Treatment consequently would include assisting the abused person to move towards acknowledging and integrating the disowned aspects of herself. Group psychotherapy appears to be most beneficial when dealing with these issues (Sprei, 1987). The support of the group, through the common experience of the participants, can provide opportunities for transformation of negative self-concepts (Collins, 1991).

3.2.6 Repressed anger and hostility

A sexually abused person might hold intense anger towards the perpetrator for the sexual violation, but also against family members for not having protecting her against the abuser. This anger often remains unexpressed except through symptomatology such as depressive or physical problems, aggressive fantasies, or psychotic episodes (Rose, 1991). The adult client, who allows herself to be angry and assertive, might experience it as an enactment of unconscious retaliatory fantasies, and might feel that she is destructive and sadistic, and therefore deserving of rejection. Therapy consequently should aim at normalising anger, teaching the victim to use anger as the basis for self-affirmation and assertion, and increasing her ability to endure aggressive affects without acting out destructively. Group therapy approaches might assist by providing a platform where the survivor can verbalise her angry and hostile feelings and learn to differentiate the expression of these affects from action (Collins, 1991).

3.2.7 Inability to trust

An individual who was sexually abused as a child often finds it difficult to trust. The trust was broken (a) through the violation of her personal space and the disregard of her dignity, but also (b) through the lack of concern for her reactions to the abuse by a known and hitherto trusted adult. The experience of satisfying and emotionally corrective interpersonal relationships in the form of a containing and facilitative therapeutic alliance or a therapeutic group should be seen as a crucial element in the treatment of the client.

3.2.8 Role boundaries

The structure of a family is normally defined by virtue of set boundaries that clarify the roles of both adults and children in the system. In a highly dysfunctional family boundaries become easily blurred. Children are therefore pushed into assuming the adult role of another member in the family. If this member is, for example, a sexually non-compliant mother, the child might be seen as a substitute for the father and hence is likely to be sexually violated (Furniss, 1991). Therapy needs to focus on assisting the family system to redraw appropriate role boundaries for the child victim. Interventions that incorporate role-playing and role-modelling components may help in minimizing the survivor's role confusion (Collins, 1991).

An adult survivor might find herself having to take on pseudo-adult responsibilities or repeating adult relationships reflective of the ones she had with the abuser. It is crucial that these patterns

of interaction are explored and counteracted through psychotherapy.

3.2.9 Psychosocial developmental tasks

Assuming adult responsibilities and worrying that peers might be aware of the abuse can hinder an abused child in completing necessary developmental tasks, such as developing a new and positive sense of self (Cole & Putnam, 1992; Putnam & Trickett, 1993). Hence, pseudomature child victims need permission to renounce any adult responsibilities, and accept those appropriate to their age. Thereby, they are freed to work towards the completion of appropriate developmental tasks.

In the case of WS of CSA, it has been found that the abuse experience has prevented them from experiencing exploratory relationships with the opposite sex (Berliner & Elliot, 2002). Often, adult survivors need assistance with forming healthy relationships based on interdependence. Group therapy, as well as communication training, have been used to facilitate interpersonal learning and to improve deficiencies in social and relationship functioning (Jehu, 1988; Yalom, 1985).

3.2.10 Self-mastery and control

A victim of CSA might also develop a distorted sense of self-mastery. Thus, her independence to choose is compromised, as are her rights to take full responsibility for her actions, and to claim her progression towards independence and autonomy from her family. As a consequence, adult survivors of CSA often display minimal assertiveness (Meiselman, 1978), which might be related to the experience that passive acceptance of the abuse was rewarded, while assertive behaviour was labelled as futile, especially in the face of harm. Assertiveness training can potentially reverse these effects and enhance a survivor's ability to regain control over her life (Jehu, 1988).

3.3 Treatment approach

Two points require reiteration:

- Each individual case of sexual abuse is unique.
- A vast array of treatment issues, both abuse-specific and general, exist.

It is therefore imperative that the therapist pose the question, "What treatment, by whom, is most effective for this individual with this specific problem, under which set of circumstances, and how does it come about?" (O'Donohue & Elliot, 1992, p. 226). This deliberation is required before the initiation of treatment. Practically this means that the complex reality brought by the sexually abused client to therapy is carefully assessed (Berliner & Elliott, 2002; Briere, 1992b; Hecht et al., 2002). Based on this initial assessment, the therapist can decide what therapeutic approach and format to use in order to assist the specific client.

3.3.1 Treatment phases

Treatment of the sexually abused person might move through three phases, that is, crisis intervention, short-term therapy or long-term therapy, or take the form of a combination of these three possibilities.

Crisis intervention is often necessary when a child, during the assessment, presents with unusual behaviours that appear to be directly linked to the abuse experience (Adams-Tucker, 1984; Saywitz et al., 2000). Treatment at this stage focuses on helping the victim to cope with medical and legal procedures, as well as with the separation and removal from family and home, if necessary (Long, 1986). This supportive type of intervention can strengthen the coping capacities of a child victim, and possibly halt the progression of traumatisation (Sgroi, 1982). It allows the therapist to establish a trusting relationship with the child victim before commencing a more in-depth involvement (Porter, Blick, & Sgroi, 1982).

Not all children benefit from crisis intervention. Some child victims of sexual abuse require short-term therapy, which is conceptualised as a therapeutic process lasting up to six months. Its aim is to support the child in her family circle or community. If the perpetrator and the victim are not part of the same family unit, and the parents are supportive, the therapeutic process might succeed in resolving the victim's difficulties and dysfunctional behaviour patterns (ibid.).

Children, who take longer in developing a trusting relationship with a practitioner, might need long-term therapy, as might those faced with complicating issues such as their parents denying the abuse or being unable to support the victims. Lengthy therapy is also indicated for the initial bonding or re-bonding process between mother and child (Long, 1986).

Normally these three phases are mentioned in relation to children at the time of the actual abuse. However, they are equally applicable for WS of CSA. If, and when, a traumatic event in adulthood launches a woman into displaying an acute or chronic manifestation of symptomatology related to the sexual victimisation as a child, she might require crisis intervention and short-term therapy. Jehu (1988) recommends that long-term therapy is indicated if (a) a severe abuse history prevails, (b) a high degree of dysfunction in the family system is observed, (c) a poor support network exists, and (d) adequate short-term intervention is unavailable.

3.3.2 Stages of treatment

As elsewhere within the therapeutic field (e.g., Egan, 1998), practitioners treating clients who present with psychological issues associated with CSA, stress the importance of using a stage approach to therapy (e.g.; Cruz & Essen, 1994; Simonds, 1994). Most commonly described is a three-stage model that aims to provide a framework, whereby the abuse victim is able to move towards resolution (Courtois, 1997; Cruz & Essen, 1994; Sgroi, 1988; Simonds, 1994).

3.3.2.1 Early stage

The aim of the early stage of intervention is to contain the WS of CSA. The following tasks are utilised to achieve the goal:

- establishing a therapeutic alliance;
- educating the client with regard to long-term effects;
- evaluating the present state and obtaining a detailed clinical history;
- planning treatment collaboratively;
- managing any crisis that might loom or that has occurred;
- developing 'healthier' coping skills while establishing availability of support network and providing support to the natural support systems, if necessary.

3.3.2.2 Middle stage

During the middle stage, the therapeutic process is extended to facilitate the more intensive intrapersonal processes:

- working through internalised conflict;
- accessing traumatic memories;

- exploring effects of the abuse;
- making new meaning of trauma;
- moving towards positive resolution of trauma, that is, moving to a higher level of functioning which includes the development of a new sense of self.

3.3.2.3 Termination stage

The focus of the last stage is to move the client towards termination and hence it involves:

- working on related issues such as relational difficulties or sexuality;
- lifestyle changes;
- assertiveness training;
- moving towards termination of therapy and gaining therapeutic autonomy.

3.4 Treatment modalities

Therapists have the choice of three different treatment modalities, used either in isolation or concurrently (Hall et al., 1986; Hecht et al., 2002). They include therapeutic work with the individual survivor on a one-to-one basis, within her family context or within a group therapy setting. Depending on the age of the victim, the practitioner will change the structure of the particular modality. Thus, a therapeutic plan is developed that not only caters for the unique needs of the individual, but also takes into account her developmental ability to participate in specific forms of therapy and the context in which she lives.

The three primary modes, namely family, individual and group therapy for victims of CSA, will be introduced here, albeit only superficially (see Figure 3.1).

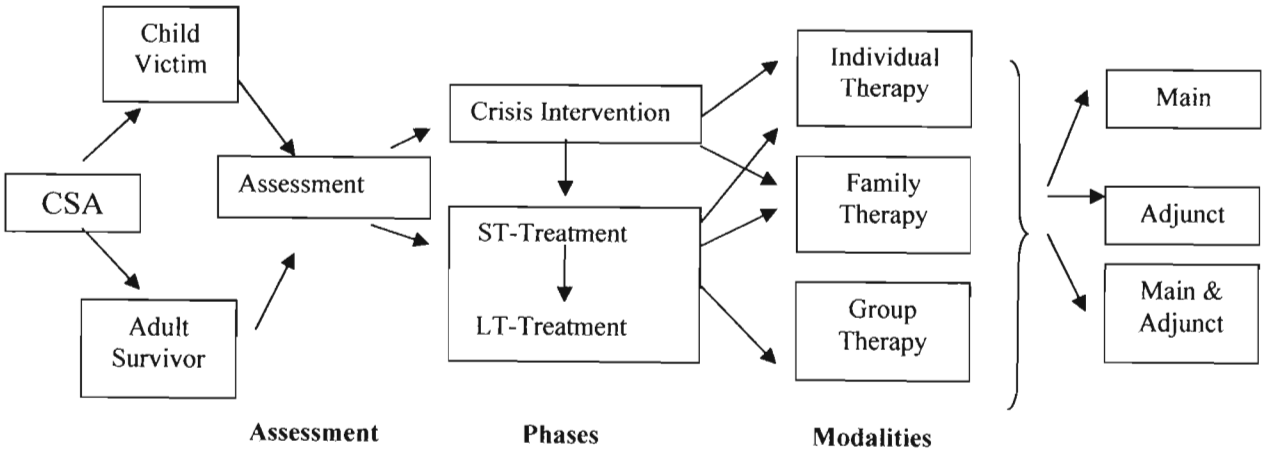

Figure 3.1 Treatment modalities

3.4.1 Family therapy

"Older articles" (Briere, 1989, p. 137) propagate family therapy as the cardinal modality for working with sexually abused children (Porter et al., 1982). The question whether to include the abuser or not has not been unequivocally answered. Furniss (1991), for example, supports the inclusion of the perpetrator, while Briere (1989) describes it as "unlikely to be helpful" (p. 139). Agreement however prevails that the non-offending parent and/or siblings should be invited to join the therapeutic process (Berliner & Elliott, 2002; Briere, 1989; Deblinger, Lippman & Steer, 1996). Two reasons are offered in support of this latter position. Firstly, Cohen and Mannarino (1997) argue that the way the parents deal with their own emotional distress in response to the CSA incident is an important element in the healing process of the child victim. Secondly, the family can thereby deal with the issues that need to be addressed. These include, among others, inappropriate use of power in the family, conflicts about authority, the reliance on denial as a coping mechanism and the emotional unavailability of family members (Sgroi, 1982). It also provides the victim with a platform to verbalise her anger towards family members who are perceived to have abandoned her in times of need. Voicing repressed emotions, related to the sexual abuse within a family therapy setting, might also benefit an adult survivor, be it with the focus on the family-of-origin, or the family by marriage.

Family therapy can work. Yet because of its poor success record practitioners turned to individual and group therapy treatment as the preferred modalities of intervention (Briere, 1989).

3.4.2 Individual therapy

One-to-one therapy has been advocated for both child victims and adult survivors of CSA, and also for their parents. Studies comparing group with individual and family therapy highlight that individual therapeutic approaches are more effective (Hyde, Bentovin & Monck, 1995, in Berliner & Elliott, 2002).

Bagley and King (1990) state that individual therapy with the sexually abused child is a high priority in order to facilitate the removal of the burden of trauma. This type of therapy varies in duration and format. It might entail structured short-term work (Deblinger et al., 1990; Sturkie, 1983), or a long-term and less structured approach (Lanktree, 1994, in Hecht et al., 2002). Often it takes the form of play therapy, as young children lack the verbal skills for traditional 'talk therapy' (Killian & Brakarsh, 2004). Similar individual approaches have been advocated for the

mother of a sexually abused child with the purpose of bringing about healing and the re-establishment of a supportive bond between mother and child (Bagley & King, 1990). Furthermore, such work can help parents to reduce their distress and teach them behaviour management strategies, thereby improving parental support and perceptions of the positive impact on the child victim (Berliner & Elliott, 2002; Deblinger et al., 1996).

Cruz and Essen (1994) contend that individual therapy is equally "the keystone of an adult victim's recovery" (p. 147). Manuals for such work exist (e.g., Hall & Lloyd 1989; Herman, 1992; Jehu, 1988). These approaches outline strategies that have proven to be effective when dealing with the long-term consequences experienced by WS of CSA (Herman, 1981; Joy, 1987; Rose, 1991).

Contributions to therapeutic work with the sexually abused individual, be it child or adult victim, have been made by all major psychological schools (Cruz & Essen, 1994). Hence, psychoanalytical (e.g., Rose, 1991), as well as cognitive and behaviour strategies (e.g., Cohen, Mannarino, Berlinger, & Deblinger, 2000; Deblinger et al., 1996), have been introduced, used and empirically evaluated (Finkelhor & Berliner 1995; Saywitz et al., 2000). Research suggests that abuse-focused treatment is a dominant and effective way of treating the sexually traumatised person (Berliner & Elliott, 2002). Hecht et al. (2002) clarify that this approach

> is not affiliated with any particular theoretical perspective on the larger issues of human psychology. Neither is it wedded to any particular set of techniques or approaches. Indeed, abuse-focused treatment borrows from a wide variety of behavioural, cognitive, systemic, and reconstructive or dynamic therapy techniques (p. 166).

Therapists have developed eclectic psychotherapeutic treatment programmes (Cruz & Essen, 1994; Hall & Lloyd, 1989; Ratican, 1992) that might include:

- relaxation and desensitisation with the aim to assume control over one's own symptoms (e.g., Briere, 1989; Lipovsky, 1991, in Hecht et al., 2002);
- journal writing with the aim of providing opportunities of expression for the 'overly verbal' and those 'silenced' (e.g., Blume, 2000; Courtois, 1988);
- psychodrama with the aim of dealing with memories and feelings (e.g., Hall & Lloyd, 1989);
- empty-chair technique with the aim of facilitating the expression of the victim's feelings about the sexual abuse (e.g.; Joy, 1987);

- reunion therapy with the focus on the finding, aligning with and healing of the child within, who has been silenced (e.g., Blume,1990);
- dance therapeutic techniques with the aim of altering the distorted body image (e.g., Mills & Daniluck, 2002);
- educative approaches focusing on CSA and sex education (e.g., Meiselman, 1990, in Hecht et al., 2002).

3.4.3 Group therapy

The benefits of individual and family work cannot be denied. Although not all would agree (Berliner & Elliott, 2002), many experts claim that group therapy is the most effective way of offering therapeutic help for victims of CSA (Briere, 1989; Darongkamas & Madden, 1995; Einhorn, 2000; Goodman & Nowak-Scibelli, 1985; Hall et al., 1986; Herman, 1981; Jehu, 1988; Mrazek, 1981; Steward, Farquhar, Dicharry, Glick & Martin, 1986). Individual treatment with children could be complicated by fear of separation from the family, a distrust of adults and authority figures, and high defensiveness (Steward et al., 1986). Herman (1981) contends that individual therapy with adult survivors might not offer a platform to address the issue of secrecy, but could possibly exacerbate the humiliation of the survivor who is forced into the role of a patient. There is also the consensus that shame, guilt, isolation and stigmatisation are better dealt with in a group setting (Hall et al., 1986; Herman & Schatzow, 1984).

Group therapy has been utilised for children (Sturkie, 1983), and adolescents (Cohen et al., 2000), and adult survivors of incest and other forms of sexual abuse (Courtois, 1988; Einhorn, 2000) and parents of sexually abused children (Schoonberg, 1990, in Itzhaky & York, 2001, in Killian & Brakarsh, 2004).

3.4.4 Approach as main or adjunct

A combination of individual and group therapy is often seen as one of the optimal approaches to treating victims who have been sexually abused. There is literature that purports to clarify when a given approach is best utilised in specific therapeutic contexts. Thus, for example, Bagley and King (1990) assert that a sexually abused child, as well as the non-offending parent, should only enter group therapy after individual therapy has been concluded. Equally, Cruz and Essen (1994) and others (Hall et al., 1986; Sprei, 1987) recommend that group therapy should only be seen as

a potent adjunctive component of a more complex therapy treatment programme, or at times be used as such (Hecht et al., 2002). Others concur, but advocate a combination of group and individual therapy, both with equal value, running concurrently (Abbot, 1995; Ratican, 1992). When for example group therapy becomes stressful, individual therapy can help the victim to explore the dynamics at work, be they anxiety, anger or flashbacks (Briere, 1989).

Yet, the statement that "[t]here is no universal model for making decisions. Nor are there empirical data to drive decisions" (Hecht et al., 2002, p. 167) does not only hold true for adolescent victims. There is no clear-cut decision-tree that can assist a clinician in choosing the preferred treatment modality in a given abuse context. The utilisation of a multimodal approach might be indicated (Cruz & Essen, 1994), and actually be the most comprehensive and effective method of intervention for survivors. However, what treatment mode is ultimately chosen as the main therapeutic approach and which one as an adjunct, will largely depend on the client, the unique needs she brings to the therapeutic relationship, and the professional bias that the therapist brings to his/her choice of therapeutic intervention (Berliner & Elliott, 2002; Hecht et al., 2002).

3.5 Two distinct group treatment modalities for WS of CSA

Different group therapy interventions exist. They can be differentiated according to structure (Tsai & Wagner, 1978, in Darongkamas & Madden, 1995; Yalom, 1985), the degree of openness to new members (Briere, 1989; Darongkamas & Madden, 1995; Hall & Lloyd, 1989) and the number of sessions involved (Courtois, 1988). The group treatment modalities presented here are both conceptualised as unstructured, closed and short-term group interventions. Closed groups promote more cohesiveness and trust than open groups (Darongkamas & Madden, 1995), while the time limit placed on the existence of the group forces participants to concentrate on current problems (Einhorn, 2000) and fosters bonding between the participants (Herman & Schatzow, 1984). The unstructured frame is process-oriented, and allows the members of the group to set their own pace and move in the required direction as a group or as individuals.

Jehu (1988) has outlined typical goals that traditional therapeutic groups for WS of CSA propose to address. Broadly speaking they entail building self-esteem, alleviating guilt, building trust, dealing with anger, changing interpersonal relationships and taking control of one's life and

behaviour. The dynamics at play during group sessions and the interpersonal reality of the group are seen as the main catalysts of goal achievement (Yalom, 1985).

Using group therapy is said to have several benefits (Briere, 1989; Jehu, 1988; Leehan & Wilson, 1985; Sprei, 1987):

- The group experience can lessen the survivor's feeling of isolation and alienation. Appreciation of, and identification with, the other members might lead to a shared resolution of the abuse experience and thereby enhance the members' self-respect.
- By participating in the group, the individual WS of CSA has the opportunity to realise that she is not alone in her experience. Through this concept of universalism, the members can learn that the long-term effects are not related to their imperfections, but are the result of the abuse.
- The supportive and understanding group environment may invite individual participants to address the issue of secrecy, and thus facilitate disclosure of the sexual abuse experience.
- The group as an interpersonal system can offer trust. Being of assistance to others in the group has the potential to increase the individual's self-confidence, while the group might create a forum that promotes a healthy resolution of conflict, devoid of rejection or victimisation.
- The disclosure of details of the abuse by one group member might activate memories in other participants.
- As the group process is unfolding and each participant gains new insight and understanding about her negative self-concepts and distorted views of others, the group as a whole may start to identify these distortions and cognitively and emotionally reframe them.

3.5.1 A traditional time-limited group for WS of CSA

Before any group for WS of CSA can commence, a number of structural and procedural issues require attention. Thus, the facilitator of the group will need to make decisions with regard to several issues.

3.5.1.1 Number of sessions

The literature does not recommend a specific number of sessions for a time-limited group for WS of CSA. The number of reported sessions ranges from four to twenty-four sessions (Briere,

1989; Goodman & Nowack-Scibelli, 1985; Herman & Schatzow, 1984; Sprei, 1987) with an average intervention period running from six to twenty sessions (Finkelhor & Berliner, 1995). Agreement exists, however, on the length of each session, which ranges from 1.5 to 2 hours (e.g., Goodman & Nowack-Scibelli, 1985; Herman & Schatzow, 1984; Sprei, 1987).

3.5.1.2 Membership

The recommendation when working with WS of CSA is that participants be at least 20 years of age (Sprei, 1987). The argument is that homogenous groups, for example in terms of 'abuse-category' or symptomatology, are the most beneficial (Abbot, 1995). Herman and Schatzow (1984) add that the motivation and positive expectations that a person brings to the group for victims of sexual abuse may overcome issues such as age, ethnic group, educational level, and sexuality.

On average, a group can be made up of four to six members (Sprei, 1987), although others will work with groups of up to eight participants (Goodman & Nowak-Scibelli, 1985). A group with less than the minimum number runs the danger of becoming too intense a forum, while an oversized group prevents certain members from processing their issues within the group context.

3.5.1.3 Therapist(s) or facilitator(s)

Research data about the impact that the number, gender and/or traits of the group facilitator might have on the effectiveness of the group therapy process is lacking (Jehu, 1988). In the choice of therapists for groups of WS of CSA, preference has been given to a female facilitator or facilitator dyad (Sprei, 1987; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1985), since they are believed to engender more trust in female abuse victims than their male counterparts. Hall and Lloyd (1989) suggest that male therapists may be perceived as potential abusers and reactivate the sense of disempowerment in the participants. Yet, a counter-argument has been brought forward, stating that a male co-therapist "in a nonexploitive role could be beneficial to the members" (Goodman & Nowak-Scibelli, 1985, p. 542) by serving as a positive male behaviour role-model (Abbot, 1995; Hall & Lloyd, 1989).

Therapists engaging in co-facilitation need to establish a work alliance based on trust and collaboration as well as clearly delineated roles and responsibilities (Hall & Lloyd, 1989; Sprei, 1987).

3.5.1.4 Inclusion criteria

Careful selection of participants for a group therapy modality is imperative (Abbot, 1995; Cole & Barney, 1987; Goodman & Nowak-Scibelli, 1985; Harvey & Harney, 1995; Hecht et al., 2002; Herman & Schatzow, 1984; Sprei, 1987). WS of CSA wishing to participate are usually expected (a) to have a history of intrafamilial and/or extrafamilial sexual abuse, and (b) be willing and prepared to commit themselves to the process (Goodman & Nowak-Scibelli, 1985). In the case of a time-limited group experience, the person needs to have "sufficient tolerance to deal both with the painful feelings that may arise, and the intimacy of the group, a sufficient level of interpersonal skills, and sufficient energy to focus on the abuse" (Sprei, 1987, p. 203). Through a pre-intervention screening process, the facilitator(s) will ascertain those who might not benefit from a group. Exclusion criteria have been formulated (e.g., Courtois, 1999; Goodman & Nowak-Scibelli, 1985; Hecht et al., 2002; Herman & Schatzow, 1984). However, in some cases they exclude nearly every sexually abused person since these criteria are analogous with typical long-term sequelae of CSA (Briere, 1989). Expressed in positive terms, criteria for inclusion comprise (a) no chronic crisis of major magnitude, (b) no current or recent substance abuse, and (c) a reasonable social support structure (Cole & Barney, 1987) that often includes individual therapy (Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984).

3.5.1.5 Ground rules

In order for the group to function effectively, ground rules need to be established. These generally cover issues such as confidentiality, conditions that permit termination, emotional expression and the procedures regarding discussions and unplanned meetings outside of the group (Briere, 1989; Hall & Lloyd, 1989; Sprei, 1987).

3.5.1.6 Structure of sessions

Traditional group models can be likened to unstructured or "non-programmatic groups" (Briere, 1989, p. 150). Although a basic format is followed consistently, the structure of the session is kept to a minimum, thereby giving participants the opportunity to determine the themes to be processed collectively. The group commences with a brief review of the past week, focusing on significant feelings and events. Thereafter, the group interacts on the basis of the members' initial presentations, affording every participant time and space to explore her unique issues. At the end of the session, the process is summarised and the members are asked to reflect on their perceptions and feelings in response to the intrapersonal and interpersonal dynamics during the

session. These elements make up an essential part of the therapeutic frame of the group that provides predictability and counteracts anxious reactions in group members.

3.5.2 Wilderness therapy as a therapeutic programme for WS of CSA

Wilderness therapy has been used for WS of CSA (Asher et al, 1994; Copland, 1994; Courtois, 1988, Herman, 1992; Levine, 1994; Powch, 1994), for victims of rape (Asher et al., 1994; Pfirman, 1988, in Hyer et al., 1994) and for domestic violence victims (Smith, 2002).

No general outlines or manuals for wilderness interventions with WS of CSA could be located. On the contrary, it has been stressed that new variations of wilderness therapy need to constantly be developed in response to the different personal histories and attributes of the participants (Powch, 1994). Yet, as a therapeutic intervention for WS of CSA that shares characteristics both with other adventure-type therapy modalities and traditional group therapy models, it has distinct features, making it a unique approach. Before outlining these features it is important to introduce its origins in theory, as well as in practice, and to discuss issues of definition and efficacy.

3.5.2.1 Roots of wilderness therapy

People throughout the world and throughout time have withdrawn into nature for a period of reflective time. Religious figures such as Jesus and Buddha are recorded to have found insight into their life's mission by spending time alone in unique wilderness settings (Copland, 1994). Vision quests, that is, initiation rites of young men among the 'First Nations' (formerly: native Indians) of the American continent, similarly have been viewed as mechanisms to help the initiatees to discover their 'calling' in life (Ramsay, 1987). African traditional rites of passage, conducted in isolated settings away from the community, are equally viewed as preparation time of an individual before assuming an adult role within society (Morris & Levitas, 1987).

In the 1960's and 1970's, wilderness therapy developed as a form of psychological intervention, in response to the increasing demand for rehabilitation programmes for youths with problems (Brandoroff & Scherer, 1994). Based on the ideas of Kurt Hahn, a model of experiential education had evolved in the early 1930's that aimed to develop young people holistically (ibid., 1994; Fletcher & Hinkel, 2002; Powch, 1994). Hahn claimed that a challenging wilderness experience would bring individuals to learn more about themselves and to develop moral character, pride and dignity (Zwart, 1988, in Brandoroff & Scherer, 1994). This theory was later

translated into the Outward-Bound Experience, a programme initially used for British seamen destined to fight in World War II. In 1962 it was taken to the United States of America and introduced as an educational tool for adolescents (Asher et al., 1994; Fletcher & Hinkle, 2002; Powch, 1994).

During the 1970's and 1980's, wilderness therapy entered the therapeutic counselling arena (Fletcher & Hinkle, 2002; Scull, 1999) as a psychotherapeutic medium, perceived to hold restorative effects contributing to health and general well-being (Kelley, Coursey, & Selby, 1997). Since then, it has been used for people with long-term mental illnesses such as depression (Ramsay, 1989) and schizophrenia (Kelley et al., 1997), as well as for substance abusers (Bandoroff & Scherer, 1994; Hyer et al., 1996). Wilderness therapy, with its emphasis on male-oriented physically challenging tasks, was initially offered to male clients only (Asher et al, 1994; Cumes, 1998; Powch, 1994). However, it is today available to both men and women, and has been found to appeal and help children and adolescents (Hyer et al., 1994), many of whom have been victims of abuse, trauma and mental or physical 'dis-ease' (Fletcher & Hinkle, 2002).

3.5.2.2 Definitional issues

In tune with the worldwide recognition of the important role ecological environments play in humanity's survival, psychology has started to explore the relationship and interdependence between the natural environment and a person's well-being (Clinebell, 1996; Greenway, 1995). One outgrowth of this phenomenon was the academic study of human-environment relationships that came to be known as environmental psychology (Reser, 1995, in Scull, 1999). A paradigm called 'ecopsychology' (Nussbaum, undated; Roszak, 1994), which "attempts to understand the psychodynamics of our relationship to the environment" followed suite (Williams, 1997, in Scull, 1999, p. 14). It is a fusion of ecology and psychology (Hill, 1999, in Scull, 1999; Nussbaum, undated) and puts forward as one of its basic assumptions that people experience an innate need to interact with the living world of which everyone is a part (Carin, 2001). Steeped in that human-nature relationship, so Scull (1999) argues, ecopsychology is "spanning a range of questions from ecology through religion, anthropology, sociology and political economy, to the psychology of individuals" (p. 15). Ecotherapy (Banning, 1989; Clinebell, 1996) is the practical application of ecopsychology. It aims to implement programmes that address any of the four foci associated with the paradigm. These include evolving ecologically significant behaviour, healing the relationship between person and planet, developing a concept of self which is relational and

inclusive, as well as learning experientially how people can form spiritual and emotional connections to the ecological systems of which they are a part (Scull, 1999).

Wilderness therapy as a psychological modality differs from ecotherapy. It is a growth-oriented therapeutic approach that moves beyond the aim of re-establishing an ecological balance. It also takes place in a wilderness setting, which according to the Wilderness Act of North America "is an area where earth and its community of life are untrammeled *(sic)* by man; where man himself is a visitor who does not remain" (Cumes, 1998, p. 96). Any temporary exposure to this natural region, which usually is uninhibited (Robertson & van der Heyden, 2001) and free of distractions (Cumes, 1998; Kaplan & Talbot, 1983, in Taylor, 2001) is believed to facilitate personal growth in an individual. It might also focus on rehabilitation, education, leadership skills or organisational development (van der Heyden, 2003). At times wilderness therapy has been called "adventure based therapy" (Fletcher & Hinkle, 2001) or "outdoor adventure program" (Kelley et al., 1997); yet Hyer et al. (1998) claim that these terms describe one type and experience of therapy. These interventions have in common that they, besides being outdoor experiences aimed at learning skills, are standardised programs of structured experiences to facilitate personal and interpersonal change and to challenge people in a novel setting, usually wilderness, to grow beyond themselves. The activities have been carefully planned, prescribed and managed to accommodate the participants' specific needs and include various skills (Herbert, 1998) and challenges, designed to develop capability and success to counteract low self-worth, learned helplessness, and dependency (Kimbell & Bacon, 1993, in ibid.).

3.5.2.3 Evaluative studies

With such an array of programmes, the search for a successful wilderness experience has commenced. As yet, there are no conclusive results (Kelly et al., 1997; Russell, 2001). Research into the benefits of adventure-type therapeutic interventions suggests that there are therapeutic effects (e.g., Hyer et al., 1994; Kelley et al., 1997; Ramsay, 1987; Russell, 2001). However, it has been argued that it is one of the least developed and understood bodies of knowledge about wilderness (Duncan, 1998).

Studies have reported benefits such as the development of skills and general physical well-being (ibid.). Benefits have also been related to changed self-perceptions (Kaplan & Talbot, 1983, in Taylor, 2001). Participants report improved self-concept, self-esteem, or self-confidence

(Bandoroff & Scherer, 1994; Cumes, 1998; Herbert, 1998; Kelley et al., 1997; Powch, 1994; Priest & Gass, 1997, in Fletcher & Hinkle, 2002; Ramsay, 1989; Robertson & van der Heyden, 2001), a sense of empowerment and self-sufficiency (Cumes, 1998; Robertson & van der Heyden, 2001), as well as a renewed connection to one's spiritual self (Fletcher & Hinkle, 2002; Fredericksen & Anderson, 1999; Rossman & Ulehla, 1977)

Kelley et al. (1997) summarise these findings:

> [e]ffects of outdoor adventure programs demonstrated in empirical studies have included improvements in multiple dimensions of self-concept, self-acceptance and more realistic self-perceptions, enhanced self-actualisation through "flow" experiences and encountering the spiritual aspects of wilderness, reduced racial conflict, reduced substance abuse, reduced recidivism, and improved academic achievement. (p. 62)

Criticism has however been levelled against many of these studies. Ramsay (1989) argues that what is successful is often related to elusive and uncontrollable factors. She further stresses that the responses to the wilderness experience are extremely complex, and subjective, with internal processes often biasing participants' responses. While some researchers report consistent and positive findings (Bandoroff & Scherer, 1994; Kelley et al, 1997; Powch, 1994; Priest & Gass, 1997, in Fletcher & Hinkle, 2002), others are cautious. In one study, several follow-up contacts with participants over a period of fourteen months, produced inconsistent results among participants. Some reported that the effects were maintained, while others pointed to an increase; and again others admitted that the effects had worn off (Bandorff & Scherer, 1994).

There is general consensus that therapy in a natural setting can have positive therapeutic effects, but that methodological problems mar the reliability of these findings (Kelley et al., 1997). These problems include lack of well-designed replicable studies (Herbert, 998), poorly defined non-random sampling, lack of control groups and generally unreliable measures (Hyer et al., 1994), as well as difficulties with operationalising certain concepts (Kelley et al., 1997).

3.5.2.4 Objective and structure of wilderness therapy for WS of CSA

Wilderness therapy for WS of CSA, as any other therapeutic intervention, requires clear objectives and a delineated "psychological road map" (Powch, 1994, p. 16) reflecting how these objectives will be achieved. On the broadest level it offers elements of both individual and group processing (e.g., Powch, 1994), it is however steeped in a group counselling model (Luckner &

Nadler, 1992, in Fletcher & Hinkle, 2002). On a more specific level, wilderness therapy uses a "combination of experiential education and traditional therapeutic group processing" (Levine, 1994, p. 176) with an emphasis on intrapersonal exploration (Fletcher & Hinkle, 2002).

Participation in the process is said to help WS "master [fear and powerlessness] and regain some of their personal efficacy and self-respect" (Courtois, 1988, p. 210) and to lead to decreased fear levels and increased self-esteem (Pfirman, 1988, in Hyer et al, 1994; Powch, 1994). According to Herman (1992) it puts WS "in a position to reconstruct the normal physiological responses to danger, to rebuild the 'action system' that was shattered and fragmented by the trauma" (p. 198). This provides for the re-establishment of a degree of control over their own bodily and emotional responses and reaffirms their personal sense of power.

Many wilderness therapy programmes, including those for victims of child sexual abuse, are a blend of activities that demand the use of so-called soft and hard skills, which aim to create optimum levels of stress in the participants and thereby to induce change (Cumes, 1998; Levine, 1994; Powch, 1994). Hard skills involve structured risk-taking intended to induce fear and encourage the participant to build confidence and strength as they succeed in doing something they were sure they could not (Copland, 1994; Fletcher & Hinkle, 2002; Herbert, 1998; Kelley et al., 1997; Levine, 1994). Examples of these skills are canoeing, abseiling or caving, but also include the actual experience of hiking. WS of CSA for example thus are challenged to experience their bodies as allies rather than enemies (Copland, 1994). Soft skills, on the other hand, direct the participant's attention inwardly, and aim to induce mental relaxation that could be perceived as restorative (Cumes, 1998). These skills are non-directive in nature and include activities such as solo experiences, use of metaphors, group processing, and reflection times. Solo experiences involve the participant spending time on her own, in the natural setting experiencing the unfolding of the transformative process (Angell, 1994). Metaphors are intentionally introduced, but are also created by the participants during activities (Fletcher & Hinkle, 2002). For example, the facilitator might present the idea that the wilderness hike is a metaphor for the psychological journey of the participant, while the participant perceives her heavy backpack as a symbol of her daily burdens. These metaphors usually mirror life circumstances of the participant, and can, if mastered or processed properly, lead to a positive transfer of the learning to personal life contexts (Cumes, 1998; Gass 1995, in Fletcher & Hinkle, 2002; van der Heyden, 2003). Much time is consequently spent in debriefing and group

processing (Asher et al., 1994; Copland, 1994, because "[it] is not helpful to provide a major transformative event for someone and then send her back to her life without adequate processing" (Levine, 1994, p. 181). Processing after the experiences is meant to reinforce positive behaviour changes, reframe potentially negative interpretations of the experience and focus on the integration of functional changes of a participant's lifestyle (Fletcher & Hinkle, 2002).

Thus, wilderness therapy for WS of CSA differs from other endurance-like adventure experiences (Asher et al., 1994; Copland, 1994; Levine, 1994; Powch, 1994). It calls for minimal goal orientation and time restraints, as well as a lack of social pressure to copy others' behaviour. The aim of the process is not 'to make it' but rather it needs to be slow-moving, to facilitate transformative processing and subsequent growth, and enable the participants to make their own choices and define their own limits and boundaries (Levine, 1994).

3.5.2.5 Therapeutic frame: Length and setting

Wilderness therapy for WS of CSA is usually conceptualised as a one to three-day programme (Asher et al., 1994; Levine, 1994; Pfirman, 1988, in Copland, 1994) taking place in a wilderness setting (Powch, 1994). For victims of childhood sexual abuse, the wilderness setting is perceived as a "supportive environment that is separate from their daily lives, yet carries constant references to their abusive situations" (Levine, 1994, p. 176) and is psychologically safe (Powch, 1994). Risks of any sort need to be avoided (Fletcher & Hinkle, 2002) although an invitation to take risks in activities that might appear beyond the capacity of certain members is a key element of wilderness therapy.

3.5.2.6 Therapist(s) or facilitator(s)

Therapists directing the wilderness experience have the task to "facilitate the process by which a person engages in *(sic)* wilderness alone, or with others, and derives healing from that interaction" (Powch, 1994, p. 14). Their key role is to assist the participants to understand their experience, and thus enable them to transfer their learning from and within the natural setting to their everyday lives (Asher et al., 1994; Levine, 1994; Ramsay, 1989). Each participant is encouraged to formulate specific therapeutic goals in advance of the therapeutic experience (Powch, 1994). This requires the facilitator to be familiar with the needs of each of the participants (Fletcher & Hinkle, 2002; Powch, 1994), and based on those insights, to develop the

programme so as to ensure individualised goals are attained. For women who have a distorted body image because of CSA, Copland (1994) for example contends that a "[g]roup process in an all-women's group, increased body awareness through skilled movement in risk-taking activities, and the wilderness setting are all necessary for a transformative experience" (p. 47).

3.5.2.7 Participants

Many programmes suggest a group size of 6 to 12 members (Fletcher & Hinkle, 2002; Kelley et al., 1997; Russell, 2001), although no indicators could be established for women groups dealing with issues of sexual abuse. It is however strongly advocated that wilderness therapy with WS of CSA should occur in a purely female group (Copland, 1994). A women-only experience is perceived to be devoid of imposed gender roles and thereby able to provide a safe and intimate environment for personal growth and transformation as well as for processing effects typically associated with CSA through frank and consensual validation (ibid.; Levine, 1994).

3.5.3 Primary or adjunct therapy

Fletcher and Hinkle (2002) report that wilderness therapy has been propagated as a primary therapeutic tool (e.g., Gass, 1995, in ibid.) as well as an adjunct to more traditional models of therapeutic interventions (Hyer et al., 1993; Levine, 1994). One study indicates that adventure interventions only show long-term benefits when integrated with on-going individual therapy (Parker & Stoltenberg, 1995). As an adjunct, wilderness therapy can afford the WS the opportunity to deal with specific survivor issues such as body image or self-imposed limits.

3.6 Rationale, aims, and goals of the study

3.6.1 Rationale

Violence against women and girls in South Africa has been described as 'endemic' (Vogelman & Eagle, 1991). Considering what might contribute to the high prevalence of CSA in this country, Townsend and Dawes (2004) have proposed an ecological, multi-level model of risk factors with the following elements: (a) individual characteristics (b) a mircosystemic interpersonal context and (c) macrosystemic socio-cultural and economic contexts. This framework is indeed a valuable contribution to the attempt of explaining the high occurrence of CSA in South Africa.

However, not all children who have experienced sexual victimisation will exhibit initial effects or develop long-term sequelae later in life. Current research indeed attempts to discover which intercorrelated variables reinforce resilience in children and contribute to their asymptomatic state. Similarly, early treatment responses can assist a child to deal successfully with the effects and hence prevent longer-term problems.

Yet, for many women struggling with the after-effects of CSA becomes a reality. Typically when they are between the ages of 32 and 38 and enter a phase of more mature self-reflection, these women seek therapeutic assistance for achieving identity tasks which their psychologically tortured childhood and adolescence denied them (Cole & Putnam, 1992). Various treatment modalities exist to assist them at this point in their lives. Whether individual therapy, family therapy or group therapy is used, and whether in isolation, sequentially or concurrently, the choice is largely dependent on the unique treatment issues the individual WS of CSA brings to the therapy process.

Among the array of therapeutic frameworks, wilderness therapy is a relatively new and unique form of treatment intervention for WS of CSA. For the South African context it holds two benefits. Firstly, as a group-based intervention, it appears to be able to assist a wider group of previously traumatised women in a shorter span of time (Levine, 1994; Powch, 1994). Secondly, its group structure reflects a more African approach to healing, that is, dealing with problems and seeking assistance while interacting with others and the environment.

WS of CSA often feel disempowered and live a life of secrecy, since disclosure of the abuse experience and related feeling responses was typically not an option. It is these women, therefore, who need to be given a voice about what works for them and empowers them in their quest for healing (Levett, 1989; NPAT, 2001; Simonds, 1994). Their experiences will provide insights that might prove valuable in terms of continuous efforts to refine and modify therapeutic modalities (Dale, 1999). Hence, this study proposes to be clinically significant, in that it holds the potential of examining the therapeutic processes of wilderness therapy for WS of CSA.

3.6.2 Aims and goals

This study is a response to the lack of literature available with regard to the usefulness of wilderness therapy for WS of CSA, especially within the South African context. Its main

assumption is that wilderness therapy has elements of therapeutic importance, differentiating it from other group modalities, and that when used for WS of CSA, initiates a unique change process.

Thus, the primary aim of this study is to explore the way in which a group of WS of CSA subjectively experienced and perceived the therapeutic change as a result of such an intervention to determine what makes it a unique treatment modality in relation to more traditional group models. Indirectly, it also explores the women's personal experiences of their CSA and their understandings of the effects of such abuse.

It is hoped that this study will provide a foundation upon which further research into the possible factors that are experienced as impacting on the therapeutic change within may be conducted. By making these factors more salient, they might assist in the development of more refined therapeutic tools within wilderness therapy.

CHAPTER FOUR

METHODOLOGY

4.1 Introduction

Alternative strategies to mainstream clinical research have evolved over the years (Schneider, 1999). These place the emphasis on 'experience-near' research and aim to elucidate clients' lived or subjective realities. This study was positioned within this evolving research field, since it proposed to explore the way in which WS of CSA subjectively experience and perceive therapeutic change, as result of a therapeutic intervention in a wilderness setting. The assumptions underlying this research were (a) that change indeed occurs and (b) that it would best be described by the WS themselves, who often have been without a voice for too long. In itself, such an approach may be considered therapeutic, but it is furthermore a way of accessing descriptive and exploratory information. Hence, research of this nature suited a qualitative method of data collection and analysis. Individual interviews were conducted after the intervention focusing on the participants' unique change experience. These were transcribed and the text analysed qualitatively, using a phenomenological framework, which is considered an 'experience-near' modality (ibid.).

4.2 Phenomenological research approach

4.2.1 Philosophical roots

Phenomenological research has its roots in a philosophical discipline commonly associated with Edmund Husserl (Polkinghorne, 1989). He developed a methodologically rigorous approach to the study of 'things' as they appear or are subjectively experienced by the subjects of the study. In response to the empiric approach to knowledge prevalent in his time, he felt the need to return *zu den Sachen selbst* ('to the things themselves'). This was to be achieved by virtue of cutting through the layers of assumptions and presuppositions surrounding experience. This lead to the birth of phenomenological reduction that sets aside a natural tendency and everyday belief in the existence of realities independent of the person (Halling & Nill, 1995).

4.2.2 Phenomenological psychology

Polkinghorne (1989) highlights that phenomenological philosophy has to be differentiated from phenomenological psychology. The former's fundamental and valuable insight served as a basis

for "a concrete program of psychological scientific research" (Giorgi, 1985, p. 45).

Phenomenological psychologists see themselves rooted in natural science. They claim to expand what everyone already does in their "everyday experience by making it explicit" (Keen, 1975, p. 27). He asserts that ultimately every thinker, in whatever discipline or field, relies on a similar approach when pursuing an inquiry into phenomena such as behaviour. One might call it intuition or "prereflective sensing of meaning" (Valle, 1978, p. 11), which speaks of an informal and non-systematic way of making sense of a phenomenon. As a phenomenological psychologist, Keen (1975) extends this to be a more disciplined method that does not yield new information, but "seeks to articulate explicitly the implicit structure and meaning of human experiences", by virtue of descriptive techniques which ask the question 'what' rather than 'why' (Valle, 1978). The goal of understanding becomes then the data of an individual's immediate consciousness as it is experienced. This goal acknowledges the reality of the realm of meaningful experience as the fundamental locus of knowledge (Halling & Nill, 1995; Polkinghorne, 1989). It chooses for research purposes, those phenomena that are relevant to psychology, and investigates these "in a methodological, systematic, and rigorous way" (ibid., p 43).

Hence phenomenological psychology is interested in, and seeks to systematically investigate 'phenomena', which might be things, images, and/or feelings, experienced by an individual (Giorgi, 1994). These experiences however cannot be objectified. The argument is that no person, his/her perception and/or behavioural actions can be taken as isolated and separate objects of study. Perception, action, person and world are essentially parts of an interactive, wider system (Osborne, 1990; Valle, 1978) that defies separation in a reductionist way. For a phenomenological researcher, the aim of any investigation is the description of the 'what-ness' (Keen, 1975) of a given phenomenon and not the interpretation of a causal reality based on some technical interpretative framework (Bolton, 1990). Hence, the key issue is the experience of a person as it is, and not as it is supposed to be experienced, judged by some external standard. This consequently demands descriptions from research participants (Giorgi, 1985), rather than from researchers' self-reports. The aim is to produce clear and accurate descriptions as the result of an examination of the conscious experience and the subjective understanding of phenomena, as individuals perceive them (Peterson, 1994).

One type of phenomenologically based inquiry asks how meaning presents itself in experience. Colaizzi (1978) states that in experience events appear as meaningful, that is, in terms of the appearance of objects and happenings as well as the accompanying thoughts and feelings. The purpose of phenomenological research is to produce a precise and systematic description of meaning that constitutes the activity of consciousness (Polkinghorne, 1989).

Polkinghorne (ibid.) however warns that such study can be problematic, since

- consciousness, unlike natural objects, is in continuous flux, and hence cannot easily be grasped;
- consciousness is complex with several interacting strata, be it levels of abstraction, awareness, or control, and while access is gained to the finished work of the conscious processes, operations at work to create it, are not always available;
- accessing consciousness is problematic, as the researcher collects data that is several times removed from the actual flow of experience;
- the researcher him/herself has only direct awareness to his/her own consciousness and hence must take care in the way the reports from others describing their experiences are interpreted.

In order to counteract these problem areas, a three-step procedure is normally used (ibid.):

1. The first step involves gathering descriptions from people who are having or have had the experience under investigation.
2. In the second step these descriptions are analysed so that the researcher comes to grasp the common elements that create the experience.
3. The final step consists of finalising a research report that gives an accurate, clear and articulate description of the experience in question.

During the second step three further procedural strategies are employed (Keen, 1975). Through the technique called phenomenological reduction, the researcher listens to the phenomenon as described by the subject from all different perspectives, trying to incorporate into the description all levels of meaning, and thus, gradually to unfold what shows itself in order to provide clarity. One will not be able to get in touch with all meanings, but can attend to some of them, thus making meaning explicit. This is the "first-order" description (ibid., p. 43) completed by the subject, which is followed by a second-order description of the experience by the therapist. This

is called reflection. Here the appearance of the phenomenon is imagined, so to speak, against the backdrop of various factors in an attempt to see what it means in its albeit relative totality, since it cannot be captured as it is 'in itself' (Giorgi, 1995). Since some form of interpretation is inevitable, it is important to restrict it as far as possible by virtue of acknowledging prevailing active presuppositions and their influence on the meaning formation. Equally, the researcher will have to be conscious of his/her own overarching complexity of meanings that guides him/her, and therefore needs to be careful not to bring other than phenomenological aspects to the process (Giorgi, 1994). That means, for example, that he/she adheres to "facts as they are happening" (Keen, 1975, p. 44) and not to underlying subjective interpretations that the researcher might bring to the information. In a final stage, the researcher communicates his/her understanding of the phenomenon to the individual. During a subsequent dyadic interaction, both the researcher and the subject continue to refine the meaning (Peterson, 1994; Valle, 1978).

4.2.3 Applications of phenomenological inquiry

Such phenomenological inquiry has been applied to different themes, closely related to the focus of this research. In 1999, Dale (1999) used it as a research framework for his study about the experience of counselling and psychotherapy by survivors of CSA. Ogilvie (1995) applied it to her investigation of mother-daughter incest. It has also been utilised to explore dance therapy as an intervention for WS of CSA (Mills & Daniluk, 2002), while in his doctoral thesis, Taylor (2001) explored the experience of wilderness therapy phenomenologically.

4. 3 Research question

In qualitative research, questions and problems for research tend to come from observations of real-world phenomena and dilemmas (Robson, 1993). They are not phrased as 'if-then' hypotheses developed from a specific theory. Rather, they take the form of wide-ranging enquiries, and aim to describe a phenomenon in depth rather than proving something about it (Silverman, 2000). The research question of this study may be stated as follows: How do WS of CSA experience and perceive therapeutic change as a result of wilderness therapy?

4.4 Research design

A phenomenological approach is descriptive and qualitative in nature (Colaizzi, 1978; Osborne, 1990; Polkinghorne, 1989). Qualitative description as an investigation and interpretation of psychological phenomena through words, symbols, or gestures (Schneider, 1999) uses natural

language descriptions for its data, and usually presents the results in natural languages (Polkinghorne, 1989). The goal is to gain depth and breadth of understanding. It is for that reason that the research design was conceptualised to include both an experimental and a comparison therapeutic group, both of which were to proceed along predetermined steps. Due to circumstances, a non-participant group evolved. The outline for the research design is given in Table 4.1:

Table 4.1 Research design for study

	EXPERIMENTAL GROUP	NON-PARTICIPANT GROUP	COMPARISON GROUP
Step 1	Initial telephonic contact		
Step 2	Pre-interview & questionnaire		
Step 3	Allocation to groups based on geographical considerations ↙ wilderness therapy ↘ group therapy		
Step 4	Pre-meeting		Pre-meeting
Step 5	Wilderness therapy (Four days in Drakensberg Mountains)	No therapy (Self-selected)	Time-limited group therapy (Six sessions)
Step 6	Post-interview	Post-interview	Post-interview
Step 7	Follow-up meeting	N/A	Follow-up meeting
Step 8	Validation	N/A	Validation

This process was chosen in order to allow the researcher to gather in-depth information from the female participants (a) about their personal experience of CSA and their understanding of the effects thereof on their lives; and (b) about their subjective reflections on the respective therapeutic processes and the experience of change. The members of the participant group added insights about the reasons for their non-participation.

4.5 Data gathering

Phenomenological research holds that the unique characteristics of consciousness require a distinct kind of science, utilising data-gathering procedures and processes designed specifically for developing general descriptions of experiential processes (Osborne, 1990; Polkinghorne, 1989). Researchers using phenomenological principles often conduct open-ended interviews. Working from long interview transcripts, they search for meaning units (Polkinghorne, 1989). Their products are general descriptions of the features and structures common to interview examples. Hence, while being descriptive and qualitative, the study has another realm of inquiry, namely the structures that produce meaning in consciousness. It differs from other qualitative or descriptive approaches because of its focus on the participants' experienced meaning instead of a description of their overt actions or behaviour. Phenomenology maintains the critical distinction between what presents itself as part of a person's awareness, and what might exist as a reality 'outside' of people's experience (Halling & Nill, 1995; Osborne, 1990).

4.5.1 Research participants

Polkinghorne (1989) elaborates that there has been a move in phenomenological research to call participants 'co-researchers' (e.g., Friere, 1970, in Colaizzi, 1978; Osborne, 1990). This label developed in response to the unique understanding of the person, as someone sharing their experiences with the researcher, and not being an experimental object for utilitarian purposes. He maintains, however, that 'subject' is an acceptable designation, since firstly the researcher is still the one who plans, implements and writes up the study, and secondly the participants are "human subjects – that is, they are actors (the subjects of sentences); they are not objects (passive recipients of stimuli)" (ibid., p. 47).

4.5.1.1 Selection

In line with the qualitative research approach, emphasis was placed on an information-rich sample that would provide the researcher with the desired data. Polkinghorne (1989) highlights that when using a phenomenological research frame, "[t]he point of subject selection is to obtain richly varied descriptions, not to achieve statistical generalization (...) The researcher needs to choose an array of individuals who provide a variety of specific experiences of the topic being explored" (p. 48), thereby producing a wide range of descriptions. Hence, the study used a non-probability purposive sample elicited through criterion sampling. The researcher chose

participants who had experienced either intrafamilial or extrafamilial sexual victimisation at the hands of perpetrators either known or unknown to them, and thus were WS of CSA.

Consistent with general rules for verbal methods of data collection, participants have to be able to describe their experience in a way that will uncover the nature and essence of the phenomenon being investigated (Osborne, 1990). It has therefore been argued that merely having had an experience with the topic under investigation and articulateness are sufficient as criteria for selection as participant for the study (Colaizzi, 1978; Polkinghorne, 1989). However, in terms of the present research, these criteria were extended to include:

- a history of childhood sexual victimisation;
- minimum age of 21 years;
- of female sex;
- previous therapy;
- absence of chronic or current crisis.

Research participants can be accessed in various ways (Dale, 1999). Firstly, therapist researchers can use their own clients or request support from colleagues. Secondly, relevant agencies may be approached, and, to provide permission for their clients, to be informed of the research with an opportunity to participate. Thirdly, clients can be invited to respond to notices or articles in media requesting volunteers. All three options were considered, but for practical reasons, the researcher opted to invite the involvement of two counselling agencies, both of which chose to publish notices.

4.5.1.2 Formation of the two groups

Once the researcher had obtained the names and addresses of potentially interested women, practical considerations led to the decision that the participants for each group would be allocated to the experimental or comparison group based on their geographical location.

4.5.1.3 Description of research participants

Overall, it proved to be difficult to obtain women survivors, who were prepared to participate in the research study. Research in the field of sensitive topics, that is, areas that are traditionally considered private, secret, or controversial, have described the difficulties in gaining access to

appropriate respondents (Lee, 1993). These difficulties might be related to issues of stigma, years of silence, shame or self-blame. In such cases, statistically representative samples of relevant populations are not feasible for practical and ethical reasons (Dale, 1999). In total, twelve responses were received. The sample was varied in terms of age, geographical location, ethnic background, types and extent of abuse, as well as types and episodes of prior therapy. Ultimately, the number of respondents was adequate for the creation of two groups with four members each. It reflected the recommended minimum number of four for group therapy (Sprei, 1987).

The participants (the names are their self-selected pseudonyms) had the demographic characteristics as set out in Tables 4.2 and 4.3 respectively:

Table 4.2 *Wilderness group*

	Age	**Educational level**	**Ethnic group**	**Marital status**	**Type of sexual abuse – perpetrator**	**Duration of abuse**
Camilla	31 - 40	tertiary	White	married	IF – brother	unspecified
Nonhlanhla	31 - 40	tertiary	Zulu	single	IF – step-brother	unspecified
Mariann	50+	tertiary	White	married	IF – father	4 years
Jennifer	31 - 40	tertiary	White	married	IF – brother	unspecified

(IF – intrafamilial EF – extrafamilial)

Table 4.3 *Group therapy group*

	Age	**Educational level**	**Ethnic group**	**Marital status**	**Type of sexual abuse – perpetrator**	**Duration of abuse**
Anna	41 - 49	tertiary	White	divorced	EF brother-in-law	unspecified
Gail	41 - 49	pre-Matric	White	divorced	IF & EF father, stranger	unspecified
Ruthie	50+	tertiary	White	single	EF acquaintances	1 year
Mary	41 - 49	tertiary	White	single	EF acquaintances	4 years

(IF – intrafamilial EF – extrafamilial)

The information on the non-participants is set out in Table 4.4:

Table 4.4 *Non-participant group*

	Age	**Educational level**	**Ethnic group**	**Marital status**	**Type of sexual abuse – perpetrator**	**Duration of abuse**
Barbara	31 - 40	pre-Matric	White	divorced	IF stepfather	unspecified
Desirée	21 - 30	tertiary	Coloured	single	EF acquaintances	2 ½ years
Lee	21 - 30	tertiary	White	single	EF acquaintance	7 years
Kim	21 - 30	Matric	White	single	IF cousin	unspecified

(IF – intrafamilial EF – extrafamilial)

The participants, who formed the experimental and comparison group respectively, came with the exception of a Zulu woman from a white ethnic background. They were all 31 years of age or older, spreading equally over three age dimensions. Seven of the eight women reached tertiary education levels, while one participant with pre-Matric advanced to an equivalent standing in her professional field. The two groups differed in terms of two categories. All but one of the women in the wilderness group were married, while none of the females in the traditional group was. They indicated 'divorced' or 'single' as marital status. Equally, the type of sexual abuse that the women suffered as children differed. The participants of the experimental group consistently reported intrafamilial CSA, while all women in the comparison group experienced extrafamilial abuse, although one was additionally abused by her father. In terms of the duration of sexual victimisation, the women were predominantly uncertain. Only one participant indicated that it persisted for one year, and two others for four years. It is noteworthy that four of the subjects worked in counselling related fields.

The non-participant group showed similar variations along the different demographic and CSA-related dimensions. They were on average younger than the participants of the other two groups; that is, three women in the '21 - 30 age' group and only one in the '31 - 40 age' group, and like the comparison group with one exception, unmarried; that is, one female was divorced or three were single. Except for one coloured women the non-participants were white females, of whom two had engaged in tertiary education, while the other two had reached pre-Matric and Matric levels, respectively. Half of the members of the non-participant group had experienced intrafamilial abuse, while the other half were victimised by acquaintances. Although two women could not specify the duration of the abuse, the other two reported that it persisted for 2 ½ and 7 years respectively.

It needs to be taken into consideration why these women responded, that is, what specific experiences influenced them to volunteer as participants in the research study. Self-selected participants are often the 'elite' members of a group with tendencies towards high levels of education, articulateness and well-developed opinions (Lee, 1993). In the case of the WS of CSA who participated in this research, this observation was borne out, as most respondents had obtained higher educational qualifications.

4.5.2 Interviews

Dale (1999) outlines different strategies for gathering original data in phenomenological research. Written statements and interviews are most commonly used, with the latter being the preferred method of data collection. The face-to-face interaction of an interview has proven to be beneficial as it allows the researcher to help the subject move towards non-theoretical descriptions that accurately reflect the experience (Osborne, 1990; Polkinghorne, 1989). Interviews have the advantage as they can elicit more direct and focused answers than written responses. They are also less likely to fall prey to the predicament often associated with written answers, that is, the pre-structuring of the phenomenon for the subjects through set questions (Stevick, 1971, in Polkinghorne, 1989).

4.5.2.1 Interview schedules

Two interview schedules were developed: one for the pre-interview and one for the post-interview (see Appendix A & B). Both followed a semi-structured format that began with a 'grand-tour' question (Spradley, 1989, in Dale 1999) that aimed to facilitate free descriptions of the experiences under investigation. Other questions were only used to invite the subject to clarify, or describe in more detail, the phenomenon under investigation.

The thematic focus for each interview however differed. The pre-interview had the aim to obtain a narrative account of the sexual victimisation and its impact on the life of the WS of CSA. The post-interview proposed to explore the subjective experience of the particular therapy intervention, and in particular the experience of change as a result of the treatment.

4.5.2.2 Development of questions

In accordance with the phenomenological perspective, a researcher must initiate the inquiry afresh, without preconceived notions about what one will find in the investigation (Polkinghorne, 1989). Thus, he/she must examine his/her own prevailing preconceptions about the investigated phenomenon (Colazzi, 1978; Osborne, 1990; Peterson, 1994). This is necessary in order to prevent an imposition of the researcher's expectations on the study (Polkinghorne, 1989), for example, through the biased selection of certain data (Keen, 1975; Osborne, 1990; Valle, 1978; Valentine, 1982). Hence, a cardinal feature of phenomenological research is that throughout the process the researcher attempts to suspend or bracket his/her beliefs, hypotheses, attitudes and hunches that predominate and possibly might influence the overall research (Ashworth, 1996;

Osborne, 1990). Bracketing has the added advantage of assisting with the formulation of research questions that can be used in a pilot study and subsequently refined for the actual sample of subjects (Colaizzi, 1978).

In line with this principle, the researcher initially engaged in self-reflection on the topic with the aim to uncover dimensions for exploration (ibid.; Polkinghorne, 1989), but also to understand her own preconceptions. Based on these, she developed an initial set of eight questions (see Appendix C). During the piloting of the interview schedule, four participants of previously held wilderness therapy experiences were approached to respond to these questions by providing descriptions (see Appendix D) of their experience of personal change as a result of a four day exposure to wilderness. Three responses were returned, examined and used to develop the set of questions for the post-interview of the WS of CSA (see Appendix B).

4.5.2.3 Setting up the interviews

In April and May 2003, the researcher contacted the women who had expressed interest in the study. During the telephone conversation she promoted the research project by providing a brief summary of the study and invited each WS to a meeting with the researcher and co-therapist. At these two and separate pre-meetings, an informal routine was followed. After the initial introduction of both therapists, a detailed presentation of the research was provided that highlighted the aim and objectives of the project (see Appendix E). The particular treatment modality was outlined and the interview, as well as the data analysis process were explained. Questions were answered and the anxieties and questions of potential participants addressed, at the end of which commitment from each of them to the research process was invited.

4.5.2.4 Pre- and post-interview

The researcher interviewed each subject personally before and after each treatment intervention. The appointments were set at a time convenient to each participant and took place in a safe and quiet place, where confidentiality could be upheld.

Before the individual pre-interviews commenced, the 'research bargain' (Hammersley & Atkinson, 1983, in Dale, 1999) was finalised with each participant by ensuring:

- completion of questionnaire (see Appendix F);
- signature of the research participant's informed consent form;

- reminder of the focal areas of the interview;
- assurance of confidentiality;
- guaranteed permission to withdraw from the process or withhold information at any time;
- establishment of pseudonyms to be used for transcripts and published material;
- offers of follow-up support, for which arrangements had been made through the two agencies involved.

The format ensured that the researcher presented the context of the study in a consistent manner to each woman.

Literature on group therapy in general (e.g., Briere, 1989; Courtois, 1997, 1999), and on wilderness therapy specifically (Russell & Hendee, 1999), speaks about the necessity (a) to ascertain whether those interested have the psychological ego-strength and interpersonal skills to work effectively in a group setting, and (b) to establish the unique therapeutic needs that each participant brings to the group process. The pre-interview and the questionnaire assisted the researcher in obtaining essential demographic and CSA-related information. These were not used for quantitative comparison purposes, but helped with gauging the suitability of each volunteer as a member of one of the two therapy groups, and with formulating their particular treatment goals.

For the actual interviewing process, the guidelines for qualitative research interviews as outlined by Kvale (1996) were used. As such, the interviews concentrated on the *Lebenswelt* of each WS of CSA, with the aim to obtain descriptions of the experience itself without the subject's interpretation (Kvale, 1983, in Polkinghorne, 1989). The researcher tried to establish an atmosphere in which each participant felt safe enough to talk freely about her experiences, to share her thoughts and emotions without fear of judgment, and to engage in clarifying descriptions when statements were ambiguous (Colaizzi, 1978).

Interviewing WS of CSA calls for extra sensitivity and empathy (Dale, 1999; Kvale, 1996), since these women may make themselves vulnerable through revealing personal and emotionally intense material to a stranger. Each interview was time-limited to 1.5 hours to set clear parameters for the pacing of the interview, and to allow the researcher to monitor and respond to

any emotional distress in a participant, and provide an opportunity to ground her by the end of the conversation (Dale, 1999).

Both narrative interviews were largely unstructured, in that they focused on the subjective experiences of the co-researchers. The interviewer attempted to facilitate an in-depth exploration of each participant's lived experience of the respective foci, at a level that allowed for the explication of meaning. Open-ended questioning, paraphrasing, and reflecting empathetically helped deepen the exploration of issues raised by each WS, and elicited rich, detailed descriptions (Polkinghorne, 1989). The interviewer endeavoured to conduct interviews in a sensitive manner, conveying an attitude of interest, openness, trust and respect (Dale, 1999; Osborne, 1990). She kept detailed process notes highlighting her own reactions to, and experience of, the data collection and analysis process. In phenomenological research, meaning formation is co-constructed between the researcher and subject, and the result of the Mitsein during an open-minded and thoughtful process (Osborne, 1990; Valle, 1978).

Overall, twelve pre-interviews and eleven post-interviews were held. In terms of the post-interviews only seven participants of the group interventions were interviewed, two to three weeks after the completion of the respective therapy, while one subject opted for a written response, as she was unavailable, because of her life circumstances.

Of the seven WS of CSA, three opted not to participate in the research project for reasons other than unavailability. Hence, the researcher decided to hold an interview exploring the reason for their withdrawal. Included in the study were ultimately only those interviews directly related to the research question at hand. The psychodynamic reasons for non-participation in the study will be explored in a subsequent study.

4.6 The two group interventions

The focus of the research study was the group therapy frame 'Wilderness Therapy', and how WS of CSA experience it as a change-inducing treatment modality. As stated previously, little research has been done in terms of this relatively new therapeutic approach of wilderness therapy. This study aimed to capture how participants, who were sexually victimised, would subjectively describe their experience of a therapeutic wilderness exposure. It was felt that

comparing their subjective descriptions with those of participants with similar pre-conditions who partook in a more traditional group therapy experience would allow the researcher:

- to access the unique change experience of the members of each therapeutic group intervention;
- to describe their perception of change in terms of CSA-related effects;
- to establish how the change experience differs in terms of belonging to a specific therapeutic group modality;
- to theorise about what promotes the change in the participants of the respective groups; and based on these insights,
- to draw conclusions in terms of the future use of wilderness therapy as a treatment modality for WS of CSA.

In order to be able to compare the descriptive and qualitative responses of the participant groups, two group therapy treatment modes were developed with similar group structure, the same therapist dyad, an equal time spent in a therapeutic context and a comparable process. They however differed in terms of where the respective groups met, and what activities were used as part of the group process.

4.6.1 Programme

For the Wilderness Therapy Group, both the programme and structure were developed by a wilderness therapy facilitator who was working for the NPAT at that point in time (see Appendix G). It was conceptualised as process-oriented in nature and hence no concrete activities or treatment details could be provided in advance. It involved a four-day hike in the Central Drakensberg with prescribed activities such as solo-time, silence and group processing. The actual wilderness experience took place from 7 to 10 August 2003.

In preparation for a comparable traditional group therapy modality, the researcher created a synopsis of three different time-limited approaches (Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Sprei, 1987 – see Appendix H). Based on the literature review, a Yalom-inspired group process was developed that covered six sessions (see Appendix I). A short-term approach was chosen for two reasons. Firstly, it was felt that it would be consistent with the time spent on the wilderness hike in group processes. Secondly, short-term work has shown to

minimise regression, to keep the focus on the abuse experience, and often, to remind the members that they are nearing the completion of the process (Goodman & Nowak-Scibelli, 1985). Five three-hour sessions took place on consecutive Monday evenings starting on 28 July 2003, and were concluded with an all-morning meeting on a Saturday.

4.6.2 Therapist and co-therapist

Literature indicates that facilitators tend to run groups for WS of CSA with two female therapists (Briere, 1989; Darongkamas & Madden, 1995; Goodman & Nowak-Scibelli, 1985). Hall and Lloyd (1989) maintain that this enables trust to be more easily established in a group, while a male therapist could possibly reactivate a sense of disempowerment. Consequently, two female therapists, namely, the facilitator of the wilderness experience as qualified educational psychologist and the researcher as a Masters student in clinical psychology facilitated both groups. The former received supervision through her supervisory structure, while she in turn served as supervisor to the researcher.

4.6.3 Process

Both therapists brought their unique experience and expertise to the therapeutic process and the frequent supervisory and planning meetings that took place throughout the time of the interventions. In preparation for the two groups, the two facilitators discussed and finalised the structure and process, addressed issues around their working alliance, and both participated in the introductory meetings, thereby availing themselves to participants for any queries and questions.

Once the respective processes commenced, the therapists continued to meet regularly to prepare the next session or activity, as well as to reflect on sessions and activities that had passed. Both therapists developed their own process notes, which formed the basis for their evaluative dialog sessions. This mechanism helped to unearth inconsistencies and discord within the therapeutic dyad, to which the therapists responded by putting corrective measures in place. Thereby, the co-facilitation process was monitored and a good working relationship upheld (Hall & Lloyd, 1989).

4.7 Ethical considerations

An informed consent form (see Appendix J) was given to each participant to sign, indicating their willingness to participate, and their understanding of the purpose of the study and how the

results would be used. The representative of the two organisations, as well as the researcher, assured the participants that confidentiality would be maintained and that they would be free to withdraw from the process at any time if they wished to do so. Since the interviews were audiotaped, it was necessary to assure the members of the two groups that only the researcher, the supervisor, the co-facilitator and the transcriber would have access to the tapes. Furthermore, in order to protect their identity, each participant was invited to choose a pseudonym, which was used during the interviews as well as in the write-up of the research study. The participants were not offered a choice in terms of which group they wished to participate in, since geographical realities dictated this. At the end of each interview, a short de-briefing took place. This was seen as essential; each participant had shared sensitive material and her dignity and autonomy deserved recognition (Durrheim &Wassenaar, 1999).

Special ethical considerations that Fletcher and Hinkle (2002) outline for wilderness therapy work were addressed for both modalities. Since both were adjunct therapeutic interventions, the integrity of other therapeutic relationships was upheld through the invitation of participants to discuss their involvement in the research with their own respective therapists where applicable (Sprei, 1987). Both facilitators were competent (a) to facilitate this process and (b) to deal with potentially traumatic responses of WS of CSA. Supervision was also sought when necessary. For both groups, ground rules were formulated that included the emphasis on upholding confidentiality. All steps were followed to safeguard the well-being of the participants. Working therapeutically in a wilderness setting required the facilitator to attend to two further aspects. Firstly, a route, familiar to both facilitators, was chosen that led through a safe area and which required hiking skills that were within the capability of each participant. Secondly, keeping professional boundaries in wilderness therapy is difficult, since the prolonged time spent together can create the perception of friendship (Bandoroff & Scherer, 1994; Fletcher & Hinkle, 2002). It was attempted to prevent the development of dual or ambiguous relationships through the debriefing meetings of the facilitators.

4.8 Data analysis

Common themes in the experiences of the four WS of CSA in each of the treatment groups were extracted using Colaizzi's (1978) method of phenomenological analysis. The analysis involved reviewing the transcripts extensively and repeatedly, highlighting significant phrases that reflected the meaning of the participants' experiences, and using insight and perception to move

beyond the words to identify the underlying phenomenological meaning of the women's experiences in the form of significant common themes. The themes were reviewed by each of the participants, and based on their input, further refined.

4.8.1 Transcribing the interviews

Transcribing the interviews is an important facet of the data creation stage (Polkinghorne, 1989). It is in the process of transcription that a written record of the interviews is developed, and the raw data is transformed into a data set for further in-depth analysis. Transcriptions are however limited, in that they only reflect what was said in the interview, without including non-verbal communication or emotional expressivity.

The woman who was enlisted to transcribe the audiotapes signed a confidentiality pledge (see Appendix K). With her permission, the researcher enquired with the participants whether they were related to the transcriber or knew her. No acquaintance was established. She consequently created word-by-word transcripts of each interview, each averaging being fifteen to seventeen pages. The researcher who had facilitated the interviews was able to decipher the few inaudible sections.

4.8.2 Analysis of 'talk'

The actual description, by virtue of which the phenomena are to be clarified, needs to cut through the different layers of meaning and, without trying to establish any causal link, to elicit what is appearing and what the researcher is present to (Osborne, 1990). Hence, the analysis of 'talk', as present in the transcript protocols, is a gradual, dialectical process towards clarity, which will however never bring to the fore an absolute truth or objectivity. What the outcome is going to be, can only be called 'reality' (Valle, 1978), that is, the individual's experience of the world, and thus the meaning she is giving to her own 'being-in-the world'.

This process involved the following steps (Colaizzi, 1978):

1. reading of the protocols to "acquire a feeling for them" (p. 59);
2. extracting the phrases or sentences that directly pertain to the experience;
3. transforming the phrases as they appear in the protocol into the words of the researcher resulting in a list of meaning or "significant" (p. 59) statements that reflect the essential point of each original statement;

4. clustering the individual themes to produce a further reduction into general themes, called theme clusters, that are common to all the subjects' protocols, by moving back and forth between the meaning statements and a successively revised hypothetical "exhaustive" list, until the themes are accurately reflected in the clusters;
5. formulating the essential structural description of the phenomenon in question.

This process was applied to the protocols that were generated by the interviews. In line with Colaizzi's (ibid.) method, the end-product was returned to the subjects who were asked to communicate how the descriptive results compared with their own experiences. Any relevant further data that emerged from this exercise was worked into a revised, final description.

Polkinghorne (1989) clarifies that the phenomenological researcher faces two challenges. He/she needs (a) to work towards the transformation of each meaning unit, given in everyday language, into statements that use psychological terms, and that adequately describe the phenomenon under investigation and (b) to reach a synthesis of those transformed meaning units by integrating them into consistent and systematic general descriptions. In order to do justice to this task, the researcher used the following strategies. Firstly, she reflected on what each meaning unit was truly describing. The insights gained through the initial exercise were tested using mental experimentation, that is, she "altered, through imagination, various aspects of the experience, either subtracting from, or adding, to the proposed transformation" (ibid., p. 55), thereby enabling her to produce meaning transformation on which there is consistent intersubjective agreement. In the final step, she used "eidetic reduction' which involves an intuitive 'grasping' of the essential psychological elements that incorporate the redescribed psychological meanings" (ibid., p. 56). At this stage, the researcher again applied reflection and thought experimentations as key tools.

4.8.3 Reliability and validity

One measure of a good research study is its reliability and validity. These are conceptualised differently in qualitative as opposed to quantitative research designs. In qualitative research "reliability refers to the trustworthiness of observations or data", whereas "validity refers to the trustworthiness of interpretations or conclusions" (Stiles, 1993, p. 601). Phenomenological research is based on different metatheoretical assumptions to those used in other natural sciences

(Wertz, 1986, in Osborne, 1990). It is descriptive, and not explanatory (Giorgi, 1985), and hence uses specific strategies to safeguard these key elements of research.

4.8.3.1 Safeguarding reliability

For research results to be considered valid they must be reliable. In order to test reliability, some form of consistency and accuracy is necessary. Few, if any, qualitative research projects are exactly replicable. Therefore, Stile's (1993) good practice recommendations were taken into consideration for the design and execution of this study. That entailed the following:

1. The researcher disclosed her expectations of her research, summarised her preconceptions and assumptions about the findings, and documented in some detail the process of the research as it unfolded, in response to emerging data and other events (Lincoln & Guba, 1985, in Dale, 1999; Kirk & Miller, 1986, in Osborne, 1990; Silverman, 2000). By providing such detailed outline the researcher offered a methodological description that allows a reader to follow the thought processes that have led to the conclusions, and thereby affords the opportunity to examine the decision critically that has been taken during the study. Thereby, the meaning ascribed to the observations by the researcher can be inferred by others (Stiles, 1993).
2. Internal processes while conducting the research and engaging in the process of analysis were presented, thereby illuminating the context of the interpretations as far as these were accessible to the researcher herself (ibid.).
3. The researcher engaged with the material (a) by immersing herself in the texts, thus developing close familiarity with the descriptions, and (b) by discussing and checking evolving themes with the participants and the fellow therapist (Guba & Lincoln, 1989, in Stiles,1993). The repeated encounter with the text as well as the replaying of the audiotapes assisted with connecting and negotiating the meaning of the phenomena under investigation. Important in this context, is the degree of consistency with which instances are assigned to the same category by different observers, or by the same observer on different occasions (Silverman, 2000). After a first analysis, the researcher set the results aside and proceeded to examine the texts of the interview anew. She furthermore invited the co-facilitator of the therapeutic processes to work through two transcripts of each group in order to gauge the degree of consistency between their descriptions of the women's *Lebenswelt*.

4. Key selected texts, salient to the research, were integrated into the research paper, thereby showing the link between the underlying, more abstract insights and the initial subjective descriptions of the WS of CSA (Stiles, 1993).

4.8.3.2 Assessing validity

With qualitative research, there is always the concern whether the findings are valid, that is, whether they can be trusted and used as the basis for actions, and whether the key ideas are well-grounded and well-supported (Silverman, 2000; Stiles, 1993). According to Stiles (1993) validity is about "whether an interpretation is internally consistent, useful, robust, generalisable, or fruitful" (p. 607). Thus, validity is based on a judgment about the credibility of the description, analysis, and theoretical discussion of the research project, that is, the extent to which the account accurately represents the phenomenon to which it refers (Silverman, 2000).

In phenomenological research, validity is about questioning whether the conclusions from the research inspire confidence, because the argument in support of them has been persuasive (Polkinghorne, 1989) and that the findings are indeed accurate. Certain doubts about the accuracy of the report, and possibly the process, can arise. For example, it might be asserted that the researcher influenced the contents of the participants' descriptions in such a manner that they are not reflecting their actual experience, that the transcription is not accurate, or that after the analysis, conclusions were drawn that are not reflected in the texts. Safeguarding validity then requires two forms of inference:

1. transformation of raw data into phenomenological, informed psychological expressions;
2. synthesis of transformed meaning units into general structural descriptions (ibid.).

This was achieved by applying several validity strategies. Firstly, triangulation was utilised (Silverman, 2000; Colaizzi, 1978). It is defined as obtaining a number of varied perspectives in relation to similar phenomena, where convergence across several perspectives represents a stronger validity claim than does any one alone (Stiles, 1993). In the case of the present study, this variety of perspectives was firstly achieved by using the transcripts of the respective post-interviews, as well as data gathered through the process notes and a post-questionnaire for the NPAT (see Appendix L). Secondly, the researcher employed 'respondent validation', which involves asking for feedback from participants (Silverman, 2000; Osborne, 1990; Polkinghorne, 1989). At various stages of the process of analysis, the WS of CSA were asked to respond to the

summaries of the interview transcripts as well as the evolving description of the phenomena. Their input served as corrective responses to the evolving themes and psychological formulation. Thirdly, "peer debriefing" (Stiles, 1993) was utilised. The rationale for such debriefing was to obtain consensus with other researchers through trying out interpretations on other investigators (Guba & Lincoln, 1989, in ibid.). In the case of this study, the researcher invited the co-therapist of the two therapeutic modalities to become part of a research team, thereby (a) creating a work environment where, as a dyad, interpretations were developed and (b) allowing points of agreement and disagreement to be addressed. In the final stage of summarising the results of the research study, the researcher also endeavoured to present coherent and convincing arguments in the presentation of the interpretations of the phenomenological data. She in particular tried to indicate how the structure resonates with the experiences of other people, not in the study, who have experienced the phenomenon (Shapiro, 1986, in Osborne, 1990) such as Taylor (2001).

CHAPTER FIVE

RESULTS

5.1 Introduction

Underlying the practice of psychotherapy is the assumption that therapy can induce change in clients and thereby lead to growth, healing and/or reconstruction of one's being and life. Measuring therapeutic change, process and outcomes is however problematic (Sonnanburg, 1996). Factors such as the difficulty to describe and verify the implementation of programmes, to control for other conditions but those established through the therapeutic frame, and to define aspects such as techniques or populations consistently, are not easily overcome. Theoretical research frameworks have evolved that outline effective empirically-based research approaches to the process of therapy and its outcomes (ibid.; Toukmanian & Rennie, 1992). The qualitative, phenomenological research framework was considered better suited to procure descriptive data from WS of CSA about their experience and perception of therapeutic change as a result of the exposure to wilderness therapy.

As indicated in the previous chapter (see Table 4.1), the participants moved through a process that in its totality, influenced the results of the research. The experiences and perceptions as captured in the post-interviews reflected indeed the therapeutic change process, as it started with the early contact and was affected by the pre-interview and the treatment intervention. Further, the follow-up meeting and the validation exercise contributed by confirming or disconfirming subthemes that had evolved from the data analysis. Equally, observations that the researcher and the co-facilitator captured in their process notes further validated and substantiated evolving themes.

The analysis of the various sources of available data then resulted in rich descriptions of the participants' subjective experience of the respective group modalities, as well as their perception of how the intervention facilitated change in them and the results of that change. This chapter will not be able to do justice to the uniqueness and the complexity of the transformative process each participant underwent. It can only aim to fulfil two objectives. Firstly, it will provide a summary of the WS's descriptions of therapeutic change as captured in Figure 5.1 for group therapy and Figure 5.2 for wilderness therapy. Secondly, it will outline commonalities and

differences that were established as result of comparing the data of the two therapeutic group modalities, with the aim of eliciting unique facets of the wilderness experiences to be discussed in the next chapter.

Extracts from the interviews, presented in *italics*, will be used to illustrate the descriptive results. The following notation will be used in order to give an indication of the place of the quote in relation to the interviews:

- (name) will denote the pseudonym of the WS of CSA who made the statement;
- ... the use of ellipses in the middle of an extract indicates that part of the extract has been omitted in order to highlight the parts of the extract that were considered to be most relevant to illustrate a theme;
- [ ] words in square brackets refer to words that were added by the researcher for the sake of clarity.

5.2 Group therapy experience: A summary of its change process

All of the women who partook in the traditional group therapy process acknowledged that the experience had induced change. They attributed the experience of transformation to the dynamics within the group that resulted in cognitive and emotional processes, which while they could not dismantle all defense mechanisms, nevertheless led to outcomes that the women summarised as 'empowering' (see Fig. 5.1 for graphic overview of process).

5.2.1 Pre-group experience

The WS in this modality acknowledged that their predominant feeling before the group experience was anticipation in the form of raised anxiety levels, which began soon after the pre-interview and meeting.

> *"I was probably feeling quite apprehensive. Not sure what to expect in terms of this particular group. Because the group dynamics in every single group that I have been in have always been different."* (Anna)

> *"The fear of talking... And the fear... of meeting new people that I didn't know."* (Gail)

> *"I suppose I was a little bit apprehensive, but I was also quite excited about [the group]... It was just the fact that it was with people that I didn't know... You don't know if people are gonna respect [confidentiality]. I think that is it mainly. The confidentiality and the trust."* (Mary)

Figure 5.1

EXPERIENCE & PERCEPTION OF THERAPEUTIC CHANGE - GROUP THERAPY

Pre - Group

Exit (N=0♀)

Enter (N=4♀)

a) CSA - related
b) Group - related
c) Process - related

Heightened Stress Levels

Cognitive Dissonance

Increased Anticipatory Anxiety

Pre - Meeting (N=4♀) & Pre - Interview (N=4♀)

Group Experience

Commitment but Defensiveness

brought to

Group

INTENTIONAL ELEMENTS
1. Structured communication
2. Therapeutic frame
3. Safety as ground rule

Disclosure

A) feeds

or

INTRAPERSONAL PROCESSING
★ Cognitive
★ Emotional

B) leads to

INTERPERSONAL IDENTIFICATION
Universalism
Bonding
Increased trust

increases

UNINTENTIONAL ELEMENT
Emphatic listening

solidifies

a) b) } Feedback Loops

Post - Group

OUTCOMES

1. CSA - related
★ Acceptance of vulnerability
★ Reframing of CSA & effects
★ Grieving loss & reclaiming inner child

2. Self - acceptance as "normal"
★ Decrease in self-blame
★ Increase in self-confidence
★ Choice of healthy coping mechanisms

3. Interpersonal
★ Redefining boundaries
★ Social choices

Empowerment

active

Post-Interview (N=4♀)

> *"Apprehension. Nervousness. Anticipation. Slight fearfulness. Wondering whether one could meet any expectations that might be around. And wondering how I was going to cope with the other individuals in the group... And whether I could be adequate to that."* (Ruthie)

The quotes indicate that the women were concerned about their individual capacity to function within a group therapy setting as well as about interpersonal issues such as trust, compatibility and dynamics. The anticipatory anxiety remained activated during the first session. Gail noticed, *"But after the first session it was very comforting for me to realise that ... there [were] those common feelings of insecurity and mistrust."* The participants responded to it through defending against disclosure. Anna elaborated, *"...I knew the others were very tightly zipped."*

5.2.2 Change experience: Its factors and processes

With the start of the group sessions the participants felt that therapeutic processing commenced. The key factor of that change was the group and its therapeutic frame as well as its communicative structure.

> *"The minute that there are boundaries, one feels comfortable and that did that for me... I think telling my story, being part of the group, listening to the others and their experiences made me re-evaluate me... it's made me realise that I'm a survivor."* (Anna)

> *"The group itself provoked a lot of things... It's freed me to be more honest. To be more open and not so fearful to talk...."* (Gail)

> *"I would say [it = the group] was the life. The lifeblood .The life feeling. The lifestyle. The dynamism of it. You know that it became a living moving growing entity. And the trust deepened..."* (Ruthie)

> *"You know that people felt comfortable enough to share at a deep level from the beginning which meant that everyone was committed to the whole group..."* (Mary)

The structural features created a sense of safety that increased the women's willingness to disclose elements of their story, feeling responses and thinking patterns. Gail, for example, clarified, *"... the group actually enabled me to do that [to say yes I was sexually abused] because I could speak."* One key element of the group was the women's capacity to listen empathetically to each other. This observation from the facilitators' debriefing sessions was borne out by the following comment, *"You were rendered sort of speechless and just feeling these intense sorrows and so on that were going about... you had empathy with other people and that you could feel your way into them."* (Ruthie)

The participants described how self-disclosure within the empathetic context of the group initiated two processes with feedback loops, one at an interpersonal, and one at an intrapersonal level. As the individual woman communicated how CSA had impacted on her life, identification with others occurred.

> *"I realised that I wasn't alone... just that connection, I'm not being this lone ranger out on the prairie was important to me... Ja, it's almost like a traumatic[trauma connects] bonding experience where you've connected...."* (Anna)

> *"... because the discussion was so intense and seeing the mirror of myself in the others and realising that's me too, you actually really couldn't hide. You couldn't hide... because everybody was intertwined. Those things were in everybody."* (Gail)

> *"The fact that everyone else was in the same boat made it so much more a process of growth, because you could relate to the other people in the group. And that made it much easier to share and to tell, to talk about your situation...And that made me see that we are survivors and that we can survive and can move on and that there is hope after abuse."* (Mary)

> *"...everybody in the group merged together in a sense and that was quite a safe feeling to have... It made me feel much less isolated. And it... made me feel accepted. That people had compassion for me and ditto me for them. You know it created a kind of bonding that I found very fulfilling."* (Ruthie)

The universalism of CSA-related experiences, either of the past or the present, created a bond and connectedness that one participant described as *"sisterhood"* (Anna) while another stated, *"They have been integrated into me."* (Ruthie). It solidified the trust in the group. An attitude of non-judgmental listening was sustained, transforming the group into a secure therapeutic holding space, where the individual WS could face her personal needs. It was seen as a *"[w]onderful experience – [it] can only truly be experienced with same circumstance people."* (Gail).

Hearing and narrating CSA-related statements, the participants felt that internal processing, both at a cognitive and emotional level, ensued.

> *"Once I had actually got over the major wobble... then the real work began. Like I said once it felt like me being this little mole shovelling tons of dirt... and I got very, very tired... because of all the internal processing that I was actually dealing with."* (Anna)

> *"...each session brought up that thing that you realised, ja I have to deal with now. I have to deal with that now."* But also, *"we had a lot to think about."* (Gail)

> *"It went in little cycles. Hills and valleys."* (Ruthie)

> *"It was definitely a process of growth,"* since *"the intense connectedness instigated the experience of inner devastation as my past caught up with me."* (Mary)

The processing ushered in further disclosure and further intrapsychic work, but was at times defended against through decisions not to communicate or to retreat into silence. This quote from Anna *"I tried very hard to remain in control. I really did. Often waiting long beyond everybody else had finished..."* serves as just one example.

5.2.3 Outcomes

The women described the group experience as empowering. The statements, *"I think it's been empowering for me,"* (Ruthie) and *"I feel much stronger in myself. Yes. I feel much more empowered,"* (Gail) were echoed by all participants.

All participants agreed that the group process impacted on three areas of their lives and transformed them. Firstly, they accepted CSA-related aspects as constitutive parts of their lives.

> *"I realise that it's never ever going to go away. That's never going to change... the sense of inconsolable loss... It was an opportunity to recreate me, how I really wanted me to be. Nothing can ever be the same...Things would have been very different had this not happened because whether one accepts it or not, it affects absolutely every part of you. Being aware that I'm not superhuman and that I am still very, very vulnerable and very fragile. But in the vulnerability and in that fragility, there is strength that I can draw on."* (Anna)

> *"It's a thing that's done that cannot be undone... You've got to deal with it. It's not going away and you've got to now fix it. All the character defects that it produced... I would've been a different person and I would've had a childhood... Ja, it would have been a totally different life... Something happened in my life that I had no control over and now I've got to spend the rest of my life fixing it up."* (Gail)

> *"The impact that abuse can have on a person. The lifelong impact... how devastating that impact is...I am trying to get in touch with my inner child. I see sparks of my inner child coming out. I still want more of my inner child... I'd like to be able to be more carefree and more spontaneous..."* (Mary)

These excerpts indicate that the women developed an increased awareness of their vulnerability, reframed the CSA experience and its long-term effects and grieved the irreversible loss of part of their life, although three participants started to reclaim some of what they called 'their inner child'.

Intrinsically related was a change in self-perception. On a general level, the process invited self-evaluation as Anna indicated, *"I think telling my story, being part of the group, listening to the others and their experiences made me re-evaluate me."* The women were able to feel 'normal' for the first time in their lives. They felt that they were not different from other people because of their CSA experience and that their emotional and behavioural reactions were common, not only to WS of CSA, but to all people.

> *"Although our emotions come out differently and we've all responded differently to our own experiences, we all share those very very deep, intense and violent emotions. And, ja, it reaffirms to me that it's actually okay. It's okay to feel those things."* (Anna)

> *"It's definitely made me freer... almost a sense of, I'm the same as you. Even though I had this experience, I'm still a human being. I'm still the same... And as I say the common things that everybody battles with I also battle with, so I don't feel different anymore... I [don't] feel like an alien in the world [anymore]."* (Gail)

> *"I feel normal. I don't think I feel any different to the person next to you. I definitely feel more confident about who I am."* (Mary)

This insight was experienced as liberating, as a result of which self-confidence increased, as did the women's ability to be assertive, which corresponded with a third facet of change, that is, a new perspective on relationships.

> *"I am living my life more on my instincts and on what I know is true for me and not on what other people expect of me, whereas before I've always lived to please other people."* (Mary)

> *"I can be more compassionate and can also protect myself. Because when... aggression and rejection is brought towards me, I can identify where it's coming from ... and actually step back."* (Gail)

The women redefined their boundaries and asserted the need to make healthy choices within their social contexts, which entail taking *"an intelligent risk, not a stupid risk"* (Gail).

5.3 Wilderness therapy: A summary of the change process

Like the women of the traditional therapy group, the WS who were exposed to wilderness therapy felt that the intervention had elicited an experience of change in them. They stressed that the process started with the pre-interview and persisted after the end of the hike. On reflection they pointed to three therapeutic factors that induced intense intrapersonal and interpersonal processing activities, and eventually issued into changes in relation to their self and to others,

Figure 5.2

EXPERIENCE & PERCEPTION OF THERAPEUTIC CHANGE - WILDERNESS THERAPY

Pre - Group

Exit (N=4♀) | Enter (N=4♀)

a) Self - related
b) CSA - related
c) Group - related
d) Process - related

Heightened Stress Levels

Cognitive Dissonance

Increased Anticipatory Anxiety

Pre - Meeting (N=8♀) & Pre - Interview (N=8♀)

Group Experience

Commitment but Defensiveness

brought to

Nature as container — offers → THERAPEUTIC ASPECTS -Individual WS-
1. Non-judgementalism
2. No distractions
3. Safety

reinforces

offers (unintentional)

liberates

Disclosure

Silence

THERAPEUTIC PROCESSING
+v: 1. Disequilibrium, 2. Processing, 3. Insights
-ve

SHIFTS
★ Cognitive
★ Emotional

(structural) offers

liberates

reinforces

Group-in-Nature as container — offers → THERAPEUTIC ASPECTS -Individual WS-
1. Commonality WS of CSA
2. Universalism
3. Bonding
★ Non-judgementalism
★ Acceptance
★ Trust
★ Sense of safety

reinforces

Post - Group

OUTCOMES

1. Increased self-awareness
★ The view as survivor
★ Active defenses

2. Increased self-acceptance
★ As WS
★ Bodily reality

3. Interpersonal acceptance

4. Choice to continue therapy

empowerment but

★Post-hike depression
Loss of safe space for processing

active

Post-Interview (N=4♀)

leaving them with an increased sense of empowerment (see Fig. 5.2 for graphic overview of process).

5.3.1 Pre-intervention experience

The pre-interview that served as a therapeutic screening procedure initiated the therapeutic process. The participants described that initially their feelings were mixed. These included excitement and positive anticipation, but after the recounting of their abuse stories and the subsequent pre-meeting with the other members, they also reported raised levels of anticipatory anxiety.

> *"The initial interview had brought all the hurt and stress to the surface. I was feeling sensitive."* (Camilla)

> *"I had varying feelings about it. Some of the time I actually wasn't sure I was doing the right thing... I was quite anxious and tense about it. But at the same time I was also quite excited because it was something that was going to be like a new experience and I really hoped that it would help me... I was a bit worried how I would react. Whether it would open up stuff that I wasn't ready to deal with... I was a little bit worried about going with a bunch of people that I didn't know... I was just nervous about the fact that I didn't know how the other people would behave... I was a little bit concerned about the actual physical side of things, as to how hard it would be... You know one of the things that I always fear is losing control in terms of maybe crying or whatever and ja, that worried me. I don't want to be with a bunch of strangers in that situation."* (Jennifer)

> *"I was a bit concerned. I was more concerned on my fitness than the actual abuse. I had mixed feelings about going and it was constantly on my mind... "*(Mariann)

> *"Scared. Quite apprehensive... How hard it was going to be and if it would be comfortable enough to enjoy for the duration. And... not knowing what therapy involves and what I be subjected to... I was quite a bit apprehensive about that... I didn't know how it [disclosure] would come about and how I would handle whatever feelings come after that... I mean what if there was a huge big snake in my pack and what if it was so cold I really wanted to go back home to my bed... I like to feel that I can cope with the situation. I didn't know if I would cope with it... And the people that I am going with... How is everybody gonna be comfortable with each other?"* (Nonhlanhla)

The factors that impacted on their anxiety can be grouped as related to

a) their self-image (self-doubt in terms of emotional skills and outdoor skills),

b) the experience of CSA (rekindled hurt and pain),

c) the group as such (expectations and trust issues),

d) the process (uncertainty).

All participants dealt with the inner disequilibrium by calling on familiar coping skills and defense mechanisms. Three of the four women who withdrew from the programme indicated that, besides concerns about health and weather conditions, the anxiety might have contributed to their choice not to participate. Kim stated, *"Maybe we're just sissies at the end of the day,"* while Lee admitted, *"It's difficult to separate what is real and what is just defenses."*

The other four women stayed committed to their choice to participate and dealt with their concerns through rationalisation and blocking their emotional reactions.

> *"Setting out on the hike and not knowing the other women, I felt that I could get through the hike without divulging too much of my past, and not opening it all up again. I was focusing on the hiking experience rather than our common purpose for being in the Berg."* (Camilla)

> *"Let's experience this, you know? What is it going to do?... I sort of had sussed everyone else out a bit [at the pre-meeting] and I sort of thought, okay I'll probably cope with this... I had gone on this hike with the attitude that I must actually open myself up to whatever emotions I needed to."* (Jennifer)

> *"When Barbara didn't go, I felt even worse about going but once I've made a commitment I decided that's it and I'm gonna do it."* (Mariann)

> *"I committed myself to wanting to deal with this [CSA], even if only to myself. So I went out really wanting to achieve something as far as my experience is concerned."* (Nonhlanhla)

5.3.2 Change experience: Its factors and processes

Once within the wilderness setting the participants found their defensiveness challenged. The post-interviews revealed that the interplay of three main factors facilitated a process that had a midwife function and resulted in therapeutic changes within each of them.

The first factor was 'nature' as described by the participants.

> *"... how the women responded to the environment by opening up in ways I really don't think they would have in a clinical setting. We were a turbulent group of humans in a vastly calm setting. When we expressed our anger and hurt about our abuse it was absorbed by the environment and not used against us in any way."* (Camilla)

> *"For some reason beauty in nature triggers my emotions. Maybe it gives me a sense of freedom to be me. The wilderness is completely natural, no pretenses, no facades. What you see is what you get. Its main beauty is in its freedom to just 'be'... Wilderness creates a yearning in my soul and from this my emotions are more accessible."* (Jennifer)

"The beauty... but I didn't like the long grass when it was over my head, closed me in... this experience in nature triggered a memory. Nature in itself. It was painful and scary..." (Mariann)

"I would say the feeling of being safe out there away from everything that is familiar. I felt safe... I felt secure... I could have stayed there and I would have been happy... I felt it [nature] was beautiful. I felt it was peaceful. Unfamiliar, but so beautiful and so peaceful... No demands. No pressure, you know, to be something or to be somebody... it allowed for the focus because there are no distractions so you could actually complete the task... You know everything was perfect and so you're not trying to fix anything outside but inside." (Nonhlanhla)

The WS experienced nature as a stable, non-changing space. It offered a safe space that was calming and non-judgmental. It removed all distractions and preoccupations and turned the women's focus inward. Thereby, the women experienced that their defenses against processing CSA-related issues broke down. This was experienced as liberating. Thus, it can be said that nature was seen as an overarching therapeutic container, able to hold the individual and her reality, but also the group, while offering silence as a beneficial therapeutic tool.

The WS appropriately named the group the 'group-in-nature" as the second factor in their subjective change experience. Jennifer remarked, "*In fact, there was this little group of us in the midst of the wilderness. It does make it a more safe place.*" What made the group therapeutically significant for the participant can be summarised as a 'holding context' that was strong and safe enough to become the deposit of the WS's stories about their abuse experience and the effects as well as to hold the emotional processing of related pain. This holding capacity developed gradually through sharing the therapeutic 'adventure' with its inherent reality of interdependency, and was reinforced through self-disclosure and communal group processing. Important in the context were two elements. Firstly, the WS described an intimate bonding experience that was fostered by a non-judgmental attitude, mutual acceptance, and empathetic 'withness'.

"I enjoyed the hike very much. The way the group gelled... It was good not to be the only person releasing all the emotion... I felt very angry against the other women's abusers. I felt the huge injustice of their experiences. I have not ever felt really angry for myself. I felt very sorry for them, both empathy and sympathy." (Camilla)

"I could trust them... It was much easier to be open because I felt that I was with people that at least could understand some of what I was feeling... [Hearing their stories] I think it made me quite sad... I felt sad for them. Maybe that's what's good about a group

experience, is that not everything's focused on me. You actually have to listen to other people and actually think about, okay this is what they feel." (Jennifer)

"I could feel that, you know,... there was a closeness in the group. That everybody was there to help me... [Although not having joined in one activity] it was okay because I was still able to speak to them and they were still able to speak... there was connecting... They were there, they encouraged me, no one was cross with me, I was a nuisance but it was okay... There was time for each of us, a time of understanding, we were all individuals but we had something in common and could find comfort in it. Also it was a time to share how we coped and a time to normalise our experiences. It felt okay, it was safe." (Mariann)

"We all, I mean, were battling with our own demons and I think everybody wasn't like looking at another person... You were one of the group... we're women and that is platform enough and we're going through an experience together... I felt that the group allowed for that. Just be [myself]. And there was no pressure... But it sort of wasn't just my journey. It was about these... people that I've been grouped with and you know you feel their pain... It [disclosure] happened. And I think it sort of like brought us closer and having shared pain and felt each other's pain it sort of like helped." (Nonhlanhla)

For Nonhlanhla, it also extended to the facilitators: "*You two had not necessarily gone through that experience, but I felt you just gelled as just one of the people who had gone through that."*

Secondly, the participants highlighted that their bond was further strengthened through comparing their experiences, which developed in them a sense of commonality with regard to being a woman, a WS of CSA, a victim carrying much pain and adhering to a predictable behaviour pattern.

"I found it a relief to hear the other survivors doubt their thought processes/themselves as much as I do... There was almost a sense of relief for me in being able to identify with these women on issues that are deeply buried and not often brought to the surface, certainly never in a calm, open way..." (Camilla)

"... the feeling of being with another few people that had been through similar kinds of experiences to me. I think that was actually very good... In fact as we talked we did discover that there were certain things that we all felt... which was nice because I've never met another person that had actually advanced enough to tell me what they went through... Like it opened a door to talking and being more open." (Jennifer)

"[Being with other WS] was good... It is unusual that you would get a group of women going together like that. And um ja, everybody was totally relaxed with each other... I think almost from the beginning there was a kind connection... you could see that other people also had the struggles... The anger, the ambivalence, the internalised anger leading to depression... Sexual problems, family problems, the others all had them too.

And yet they are all fully functioning people appearing to cope but underneath like a fragile egg..." (Mariann)

"I knew that I wasn't the only person that's gone through something like that but being able to share some of it with people who have gone through similar experiences sort of like took away this feeling of you're different, you're weird... we were all the same and human beings with all this. And I felt that we accepted each other as women, as human beings, and [with] whatever other differences... I felt that the people were mature in that sense [meaning here: non-racial]." (Nonhlanhla)

Again this group-bonding process was felt to have been liberating, contributing to the breaking through defenses, in particular, since the group provided a sense of safety.

The participants highlighted that both nature and the 'group-in-nature' offered periods of silence. Nature was experienced as the *"calm setting"* (Camilla) that naturally lacked the noise of urban and normal living and offered quietude instead.

"I didn't like it because then you start to think things. My mind starts to work overtime. I start to worry about things... I don't like silence. I'm a talking person. I felt alone. Even though everybody was there and everybody was helpful, I felt very alone." (Mariann)

"Nature doesn't talk to you, you know. It's there... and when you walk, you have to concentrate on the path and all there is, is your mind and we didn't have any distractions. So it's all in you, inside. I think it just got too much... I think it made me see another world... amongst nature... That you can escape and be there and be yourself and really feel in tune with the inner person." (Nonhlanhla)

Silence was a mechanistic element of the programme, since hiking in the terrain required that attention was focused on the path and away from social interactions, while on the third day silence was also factored into the process as an activity.

"After spending the morning in silence I had to speak about my experience of abuse even though I had planned not to open up fully... When we did break the silence it was almost a kind of purging. We all spoke in great detail of our experience but more importantly of the effects of the abuse on our psyche. I found it a relief..." (Camilla)

"I don't have a problem with silence, but I definitely got very reflective... sort of was dwelling on a whole lot of stuff... I didn't find it threatening but as we've said it definitely tends to get one into a self-reflective mood. And for me it became more a self-destructive kind of feeling. It wasn't good... I think it's actually connected with anxiety... And then at one point... it was getting too heavy... We were all getting a little bit too deep. Ja, anyway, so then we shared and that was good." (Jennifer)

> *"I woke up... the silence thing... I don't like that. It was quite creepy quiet. It's like you're scared and you can't say. It's like a secret. Everybody's there, but you can't talk to them. You can't ask them for any help. You are on your own."* (Mariann)

> *"I think we often kept quiet because you don't know how people are gonna react... Unconsciously something important starts happening inside and you feel the need to stifle it, and it's easy when you can talk. And then you can talk about any non-issue... But when you are faced with silence... you can sort of like shift it in your mind but there is nothing else to do... It just felt like it was piling up and piling up and piling up and piling up or like coming up... you know there's just no way that I'm gonna leave this inside... just thoughts that I didn't know where they came from... stuff is just slowly getting ready to come out."* (Nonhlanhla)

The participants experienced this silence as both negative and positive. A self-reflection process started that was inwardly focused and that involved active cognitive and emotional work, while also increasing a sense of loneliness. Eventually, it created such an intense degree of inner disequilibrium and disorientation in the WS that disclosure became a necessity. This repeated itself in a cyclical pattern, reinforcing the containing quality of the experience, and in turn the processing capacity of the participants.

5.3.3 Outcomes

When asked about the outcome of the therapeutic process, the participants of the wilderness therapy group highlighted empowerment as a key outcome, as they felt *"strengthened"* (Camilla) or *"filled with courage"* (Nonhlanhla). Mariann added, *"I think it said to me that yes you know you've done this, and if you can do this, there's lots more that you can do."* Jennifer stressed, *"A bunch of women can actually go out into the Berg and survive and we don't need men"* because of the ability to use their own capacity to control life. They felt that empowerment was linked to shifts in self-awareness, self-acceptance, and interpersonal acceptance. However, these shifts differed in their degree and constellation according to the participants' unique stage of growth.

All WS developed a new sense of self that included holding a positive view as survivor and being more aware of their unique coping skills and defense mechanisms.

> *"I will never be free of it. I saw that on the hike, we all carry it with us no matter how hard we work to clear it or understand it, forgive it, forget it... That both frightened and strengthened me... I felt like I have coped well with the effects to a degree. I am not whole and will never be but I am doing what I can to overcome the effects and hold*

myself together... The hike, meeting other women survivors, showed me how damaged we all are through no fault of our own." (Camilla)

"I don't know that anything new was opened up. I have been aware of my reactions and emotions all along but... the big thing was just being able to actually be honest about what I felt... 100% honest about my feelings and things." (Jennifer)

"It's very special because it's very, very hard for women who have been abused to come together and speak about their experiences with someone else. And I felt that was very important for me... [What started was] the talking about what had happened and maybe the accepting of what had happened... There was catharsis..." (Mariann)

"I became aware of my coping mechanisms and why they were there and where they come from... I had never had any reason to question why I handled situations in that way before... I felt personally that I've just begun on a journey and I have to walk this through and get to a point where I feel I've dealt with issues...." (Nonhlanhla)

Related was an increased self-acceptance (a) of being a WS and (b) of their bodily image.

"I came away with all that hidden emotion exposed to a degree but also a sense of being part of a group of survivors. We have experienced these abuses of ourselves in every way but we are all busy surviving those abuses." (Camilla)

"My body image is really bad. I look in the mirror and I really hate what I see... So for me to [bathe] with a whole bunch of other people was really hard. I sort of felt embarrassed because I'm not perfect. But I mean the nice thing about being with women too was the sort of feeling of freedom... I just thought, Oh bugger this. Just be free for once... You don't like your experience. You don't like your body. And yet when you exposed both of these, there was no attack. There was just like being together. I suppose it's like a feeling of acceptance... [Before] I've always felt like I'm different..." (Jennifer)

"After I accepted myself as a valuable individual who's gone through an experience and there's no expectations that I ... should be something else. The hike I think for me really allowed me to focus. This is something that happened to me, that is real and there's no trying to call it anything else but what it was. There was physical abuse. I was sexually abused... It's just not being comfortable with certain parts of my body... one of the thoughts about my experience is feeling dirty. And feeling dirty in my body... I think whilst we discussed it as a group and things came out, I thought, Oh so that's how people feel about it. Okay. And a certain freedom came about that I could actually experience... with the group being comfortable with my body. I felt it. I thought I achieved something." (Nonhlanhla)

There were also changes in the interpersonal view held by the participants that are best summarised in this excerpt from Nonhlanhla.

"My faith in people as human beings... they are not bad as such... I mean as counsellor I should know that, but it took five women stuck with them for three days to make me think, ja, people... act in certain ways because of certain things. Just because I don't know

those things, doesn't give me the right to judge or to be so offended by how they are not in line with how I think things should be done or people should act and behave around other people, you know."

The WS participants described the onset of post-hike depression. This emotional reaction was connected to the loss of the group and the safe space for processing. They also felt that there was unfinished business from the wilderness experience that in turn influenced the decision of three women to continue with therapy.

"One of the things I experienced at the end of the hike was just a sadness... Especially with two of the ladies I got very close to them where I'd actually really like to keep contact... Maybe part of it was just this feeling of that we'd experienced this together but now this is finished and what the heck is the good of this group anyway. You know, I've now got to go back and deal with my life... I'm not 100% sure whether this is a good thing but I've decided to continue with therapy... I'm aware of the fact that there's a lot of stuff in my life that's not right because of what I experienced and I need to sort it out otherwise I'm only living half a life." (Jennifer)

"I felt that I'd started something and I wasn't quite able to finish it off... There was just some unfinished business... it was too short... I was a bit shocked. I was quite shocked by that because I felt I should feel more exhilarated... " (Mariann)

"And I've learnt to face a lot of who I am from this and the time has come for me to change that... That opening up is the start of the journey for me to find closure in what happened and not keep allowing what happened to define what I think of myself or who I am as a person." (Nonhlanhla)

5.4 Commonalities

5.4.1 Anticipatory anxiety

The participants of both groups described heightened degrees of anticipatory anxiety before the beginning of the therapeutic process. The pre-interview with its focus on the CSA-experience created these heightened stress levels in the WS, but most participants stayed committed to the therapeutic process and the need to face CSA.

5.4.2 Group and its therapeutic aspects

The descriptions of all eight participants supported Yalom's (1985) list of advantages of a group modality. Thus, for example, they experienced the group as instilling hope, offering a sense of universality, imparting information, opening opportunities for altruistic responses and inviting cognitive reflections and corrective emotional experiences. Thereby the group became a

containing space, where the women felt safe to speak about their traumatic experience of sexual victimisation and process some of the related issues.

5.4.3 Outcomes

The outcomes as highlighted by the WS of CSA at the time of the post-interview, and during other interactions indicated that the participants' perceived changes in self-concept and interpersonal reality were sustained. They also agreed that increased self-confidence and empowerment were the key outcomes.

5.5 Differences

Despite commonalities the data suggests that both modalities have aspects of therapeutic value that are unique to that specific intervention. Thus, wilderness therapy as a new modality used for WS of CSA has distinct features that sets it apart from the traditional group model, and vice versa.

5.5.1 Anticipatory anxiety

Before the beginning of therapy, the participants of both groups developed raised anxiety and stress levels in response to CSA-related, group-related and process-related issues. The WS of the wilderness experience also described self-related concerns about their physical competence, level of self-confidence, and coping ability in an unknown environment as impinging on their emotional state.

5.5.2 Nature as a therapeutic aspect

Wilderness therapy offered two containing realities; the group as such, and nature. The WS of CSA experienced it as a safe space since it was non-judgmental and had the capacity to listen, descriptors normally used for therapists. The natural setting in the Berg was experienced as being without distractions but also without safety nets. Mariann, for example, stressed that the hike gave her the sense of *"going away from civilisation... too far for somebody to assist when needed"*. The latter initially caused some degree of anxiety, but was readily perceived as a catalyst for the surrender of defenses and for dealing with the issues that arose in the participants.

*5.5.3 **Silence as a therapeutic aspect***

Consistently, the participants in the wilderness experience elaborated on the positive and negative aspects of silence that were part of the therapy. Both as a natural phenomenon within an environment without the familiar noise and as a result of a structured 'silence' activity, it turned the individual WS's attention inward. The women described intense self-reflection experiences, which made them face emotional pain, and cognitive defense mechanisms that had initially resulted in inner dissonance and tension. Only self-disclosure within the safe and containing space offered by both nature and the group-in-nature facilitated release from depressive reactions and issued in a systemic self-perpetuating therapeutic process.

5.5.4 Unique outcomes

Although the descriptions by the members of both groups suggest that the interventions were able to facilitate similar outcomes, there were differences. The traditional time-limited group put the participants in touch with their 'inner child' while the wilderness therapy group, that by definition demanded the completion of physically challenging tasks, invited the women to deal with their body image.

5.5.5 Post-intervention experiences

Although the participants in both groups expressed sadness about the shortness of the intervention and a sense of loss at the time of termination, it was the WS who participated in wilderness therapy who showed signs of post-intervention depression that persisted for some time after termination.

CHAPTER SIX

DISCUSSION

6.1 Introduction

The cardinal aim of this research was to outline how WS of CSA, who participated in a wilderness therapy programme, experienced and perceived therapeutic change as result of the intervention. Fredericksen and Anderson (1999) stress that the way in which individuals experience wilderness, and the meaning they associate with it, is highly subjective. Therefore, the research was conceptualised as an explorative study and neither sought to explore any causal links between aspects such as CSA, wilderness and change components nor to establish quantifiable results such as measurable degrees or intensities of therapeutic outcomes. On the contrary, the findings of the study highlighted the subjective experience of the participants in terms of (a) the process of therapeutic change, (b) unique factors that contributed to this change, and (c) the perceived outcomes with regard to CSA-related effects. The results of the traditional group therapy served as comparative data that helped to isolate what wilderness therapy uniquely has to offer to WS of CSA and thus can give direction to further research.

The analysis of the subjective descriptions of how the WS' experienced and perceived therapeutic change resulted in a vast amount of valuable information about the two group intervention modalities that highlighted the uniqueness of wilderness therapy as a therapeutic modality for WS of CSA. It is beyond the scope of this thesis to discuss all the issues that were raised even if they are interesting and significant. A few salient themes have been chosen for discussion since they indicate that wilderness therapy offers unique features and potentially powerful mechanisms for change that make this modality a valuable therapeutic tool for WS of CSA.

6.2 Discussion of the findings

The formulation of the research question implied that the WS would undergo therapeutic change as a result of the wilderness experience and that the change could be subjectively described. The women participants did indeed report that the wilderness experience initiated a dynamic process of change that helped them deal with CSA-related issues and led to shifts at an intrapsychic and an interpersonal level.

6.2.1 Wilderness therapy: A phasic process

A process is normally assumed to follow certain steps or move through specific phases. Literature in general describes the multiphasic character of wilderness experiences (Fletcher & Hinkle, 2002; Greenway, 1995). For example, Borrie and Roggenbuck (2001) claim that people visiting a wilderness setting move from an entry stage, through an immersion stage, to an exit stage, and develop unique responses to nature in each given stage. Thus, at the time of entry they are described as gradually discarding their concerns and refocusing towards the requirements and the opportunities inherent in nature. With less external distractions, they can then immerse themselves into the setting and attend more to what is immediately at hand. As they move again towards exiting the wilderness, they prepare for their return mentally, physically and emotionally, shifting gradually to civilisation and the "readoption of an outside identity" (ibid., p. 209). This general pattern is reflected in the process that the WS described as having unfolded in response to their therapeutic wilderness experience. At the beginning of the hike, they felt their focus shift from daily affairs to what was at hand. In their case, it meant attending to the therapeutic processing of CSA-related issues. This intrapersonal activity persisted until the group started its return journey, at which point the participants shifted their focus back to the requirements of their roles within their normal social environment.

A phasic conceptualisation of wilderness experiences does not provide any insight into the complex and dynamic change process within a person. Such inner process is highly individual and can possibly not be reduced to a common template. However, the women of the wilderness group agreed that for change to occur, a person must be able to shift her focus towards her inner self. She can only do so in a setting that frees her from outside preoccupations, while offering an environment in which she can engage with personal issues.

An observation deserves mention. At the beginning of the study, the participants were invited to choose a pseudonym that would protect their identity. In certain settings where new names are bestowed in rituals such as confirmation or entering sisterhood, people start moving towards embracing this new identity. Thus, one could argue that the WS, in their pseudonym role, engaged in the transformative growth process or narrated perceptions and experiences in the interviews. However, two points speak against such identity confusion or pseudo-role assumption. Firstly, despite their pseudonyms, the women experienced high levels of anxiety and intense inner dissonance. Secondly, throughout the wilderness experience the participants used

their real names with each other, thereby acknowledging their true identity to themselves and to those present.

6.2.2 Nature as therapeutic 'container'

The members of both treatment modalities perceived the therapeutic group as a safe place with the therapeutic capacity to hold the intrapersonal and interpersonal change processes. Yet, within the wilderness context, the group had a specially defining characteristic, that is, of being perceived by the participants as a 'group-in-nature'.

The WS experienced nature as a safe environment that provided a necessary emotional container for their therapeutic processing. They described nature as "fair" and "non-judgmental", and stressed the importance of the immediacy and concreteness of the feedback they felt they received from wilderness. Because they did not feel prejudiced against by nature, they could be honest with themselves, which included dealing with painful memories, expressing strong emotions, and addressing unhealthy coping styles. These experiences correspond with those presented in literature (e.g., Powch, 1994).

The wilderness setting offered the WS what a therapist is invited to bring to a therapeutic relationship, that is, the capacity to hold the person and her inner process. Nature thus took on the role, and thus the qualities of a therapist. As Rush (1997) put it

> ... the natural environment is experienced as a nurturing matrix, close to and perhaps identical with the Kleinian 'good breast'. The boundaries of the ego are relaxed and we have a sense of 'taking in' the richness and beauty of our surroundings. Precisely because the environment is not human (does not judge us or place any demands on us), it also acts as an unresisting receptacle into which we can project unwanted feelings and parts of ourselves and so 'takes us in'. This powerfully relieves our anxieties and confers a sense of release and liberation (p. 4, in Taylor 2001).

Yet, not everyone experiences wilderness as a safe space (Asher et al., 1994). One participant, for example, stressed that being in nature evoked in her the feeling of claustrophobia, which kept her anxiety levels and defenses up. Unlike the other WS, she needed to draw much more on inner reserves, such as her commitment to this therapy experience, to persevere (a) in the intense intrapsychic process and (b) in completing the physically demanding hike. However, she processed issues within the wilderness setting that she admitted never having attended to before.

It could therefore be argued that, despite her concerns for her emotional, mental and physical safety, nature offered her enough security to hold her when dealing with her unique CSA-related issues.

Although the findings highlight that nature was experienced as a therapeutic 'container' and that certain factors contributed to this quality, the totality of this holding capacity remains an enigma. It can only be hypothesised that multiple factors are at play that are complex and intrinsically connected, cyclically impacting on each other. The WS indicated that one such factor is the silence found in nature.

6.2.3 The therapeutic midwife function of silence

Consistently, the WS described silence as a powerful tool that reinforced their intrapsychic reflection processes and led to the need for disclosure.

A literature search on silence as a therapeutic tool did not elicit any references to research studies, except to sections of books on counselling and therapy practice, highlighting the significance and usefulness of silence within a therapy session. As in one-to-one work, silence can enhance but also block transformative growth within a person. Thus, two questions deserve attention: (a) what makes silence such a powerful therapeutic tool and (b) when does it lose this midwife function.

Jung once stated, "... noise protects us from painful reflection; it scatters our anxious dreams" (Sabini, 1995, p. 13, in Taylor, 2001). Being within a natural setting with its inherent moments of silence therefore can "bring us to ourselves, (...) can connect us to the ancient roots of the self " (Clinebell, 1996, p. 46). Silence therefore brings an individual into contact with her inner self, while compulsive speaking detracts from it. These comments suggest that silence can indeed be beneficial (Larson, 1990). When alone, people are more likely to engage in more primary process thinking. Their attention is freed from social participation and thus creates the opportunity for deep absorption (ibid.). It offers room for emotional and spiritual development (Hoeritzauer-Willem, 1986) and can organise thoughts and effect reflection on past actions and future plans (Altman, 1975, in Burger, 1995; Storr, 1988, in Buchholz, 1999).

These benefits were part of the participants' experience; however, not without stirring unpleasant feelings. Research suggests that time spent alone typically is less pleasant than time spent with others (Larson, 1990). It can create a sense of loneliness as in one participant, and thereby increase passivity and depression. It can further bring to a person's attention her "immediate subjective state." (ibid., p. 176). In the case of the participants, this subjective state was about intrapersonal pain caused by the sensitive and often traumatic CSA-related themes of their lives. As these themes surfaced, the women's levels of anxiety rose pushing them to seek contact with the other participants (Buchholz, 1999). It seems that once an inner threshold was crossed, emotional baggage came up and needed to be expressed and thereby defused (Cumes, 1998). Thus, silence was a precondition for the reception of unspoken intrapersonal stirrings just as it was for interpersonal sensitive listening, both elements found in the group of WS (Hoeritzauer-Wilhelm, 1986). Interpersonally, silence created an intersubjective space from which the women could recognise their unique otherness and engage in disclosure. This describes a positive scenario. Because of silence, the WS allowed issues to surface and used nature and the group to process these.

But silence can also lead to negative experiences. Thus, it can be argued that a person might be so overwhelmed by the intensity of her cognitive and emotional dissonance created by silence that she moves towards fragmentation of self rather than integration. Similarly, a person who avoids silence and escapes into social chatter may thereby defend against her own processing and prevent others from pursuing their therapeutic goals. As with individual therapy, the facilitator of a wilderness therapy experience needs to be in tune with the processes unfolding in each of the participants and intervene with individuals according to their needs. Hence, silence needs to be properly structured, since only then can it be used to heal a person, and become a springboard for health and growth (Peplau & Perlman, 1982, in Buchholz, 1999). What this proper structure looks like and what an optimal balance between time in silence and social interaction is, are important questions yet to be answered. These answers would guide the therapist in ways to effectively contain the processing within an individual.

6.2.4 Anticipatory anxiety

The WS reported that silence increased their levels of anxiety. Similarly, they indicated that after the pre-interview, a state of disequilibrium developed in them that was characterised by heightened levels of anticipatory anxiety and stress.

Clawson and Knetsch (1966, in Borrie & Roggenbuck, 2001) argue that as a person prepares for a wilderness experience, she will experience anticipation, associated with increasing joy and satisfaction. This emotional response, so the argument goes, will facilitate the necessary attunement to the natural environment, before the person can benefit from its healing powers (Cumes, 1998). Taylor (2001) argues that only through such an attuning process can the person discard her many concerns and adjust to what therapeutic elements wilderness has to offer. One would therefore assume that the heightened levels of anticipatory anxiety impede such process through blocking receptivity. Yet, the descriptions of the WS suggest that their emotional state of an inner disequilibrium assisted their attuning and therapeutic process, since as indicated by literature, it creates an openness within a person that has been described as a crucial ingredient in processes of change (Gass, 1993, in Herbert, 1998). When an individual is taken out of her comfort zone and, as coping mechanisms do not work anymore, she is forced to learn new skills or develop new behavioural patterns (Fletcher & Hinkle, 2002; Gass, 1993, in Herbert, 1998) and thereby increase her sense of competence, of mastery and inner self-esteem.

It remains unclear what the optimal level of anticipatory anxiety, stress, or cognitive dissonance for initiating change is. Or, expressed differently, what does placing a person "just beyond [her] comfort zone" (Asher et al., 1994, p. 163) mean in relation to therapeutic change and the role of anticipatory anxiety. One woman experienced stress symptoms resembling panic attacks after the first meters of the hike that persisted throughout the four-day programme. Another participant described low levels of stress as she proceeded with ease. Although an optimal degree of stress in wilderness can uncover core patterns of behaviour that can be modified for the better, excess in stress can be harmful and inhibit growth (Cumes, 1998). Greenway (1995) goes so far as to assert that the less stress is created, the more the person will be able to interact with wilderness at the level where it will be transforming. Hence, the unique anxiety levels a person brings to and experiences during wilderness therapy need to be monitored and can impact on therapeutic decisions such as the suitability of a person to participate in a wilderness therapy experience, or the termination of therapeutic interventions that may hinder rather than induce growth. It might also mean that a WS, like Mariann, is allowed to separate from the group and, with assistance from a facilitator, process her unique CSA-related issues at her own speed.

Unlike the four participants of the wilderness group, four women chose not to join the experience. One woman had professional commitments that she could not change, while the

other three alluded to concerns about weather and health as well as to raised anxiety levels as reasons for non-participation. In comparison to those who participated, these women were younger. They were not concerned about the physical demands the wilderness hike would have placed on them, but succumbed to increasing levels of anxiety. One possible explanation for this phenomenon might be that as their age bracket placed them outside the time in life when WS are normally assumed to deal with CSA-related issues, that is, typically between ages 32 and 38 (Cole & Putnam, 1992), they might have (a) lacked the urgency to engage in therapeutic processes and (b) been more skilled in keeping their defenses up.

6.2.5 Metaphors and spiritual themes

Literature speaks about the therapeutic value of metaphors, both unintentionally present or intentionally introduced in wilderness experiences (e.g., Cumes, 1998; Ramsay, 1989; van der Heyden, 2003). The participants of the wilderness group, except for Mariann and Jennifer who made some references of a metaphorical nature, did not mention metaphors as an essential aspect of their therapeutic change experience. This divergence from general findings could be related

- to individual differences in terms of responsiveness to metaphorical work, or metaphor-mindedness;
- to the subtle rather than direct processing and use of metaphors by the facilitators during the therapy experience; or
- to the interview questions that purposely lacked such directedness in order to invite subjective descriptions from the participants.

Similarly, spiritual themes were not consistently raised. Being within wilderness is often described as inducing spiritually uplifting experiences (Asher et al., 1994; Rossman & Ulehla, 1977; Springer & McAvoy, 1992, in Frederickson & Anderson, 1999) and as creating the feeling of being one with a force that embraces the person as well as nature (Fletcher & Hinkle, 2002). Both Jennifer and Nonhlanhla spoke about connecting to God during the hike, although they did not offer details as to how these spiritual experiences arose. Yet in line with the literature, they hinted that the expansiveness of the landscape and an awareness of sheer power of nature created in them a sense of connectedness with the divine (Frederickson & Anderson, 1999). A question remains as to whether the fact that the researcher is a religious sister influenced the women's reference to spiritual themes. The other two WS did not speak about spiritual themes at all; one

woman admitting that she had to stay focused on her inner struggles so that she *"could not pay attention...."* to anything else (Mariann). It remains therefore unclear what facilitates spiritual responsiveness or the experience of the 'ineffable' within a natural setting (Greenway, 1995) and how it relates to therapeutic change in a person.

6.2.6 Outcomes

Outcomes are often measured quantitatively since these measures are perceived to be valid evidence for change to have taken place as result of a therapeutic intervention. Although not pursuing such empirical activity, the researcher obtained descriptions of the WS's experience that included references to outcomes that consistently focused on personal and social issues. The psychological benefits that the women described were broad. Each person had a different set of outcomes (Russell, 2001), but all agreed, in line with literature, that being in wilderness has restorative powers (Clinebell, 1996; Cumes, 1998). In their experience, wilderness therapy invites change in a person's self-concept and her interpersonal relating (Hendee & Pistick, 1993).

Since this therapy experience focused on WS of CSA, it is of interest, whether CSA-related outcomes were reported. Overall, none of the WS made reference to processing long-term effects such as nosological disorders, but all reported an increase in self-acceptance, a sense of empowerment, and a changed view of their body image. As these were still described at later interactions with the researcher, it can be assumed that change occurred at a deep level and thus reflects a significant and permanent shift within the WS. Thus, wilderness therapy holds the promise of being a valuable therapeutic tool.

The perceived outcomes of the two groups showed commonalities, as was indicated in the previous chapter. Several conclusions can be drawn from this in terms of wilderness therapy. Firstly, the shortness of the wilderness experience did not block but intensified the change process. Unlike with the other group that had time to engage in 'in-between session work' as well as possibly to solidify defenses, in the wilderness, the WS were not able to avoid confrontation with both the process and challenges by the group. Secondly, the shortness of the experience might have forced the participants to be focused therapeutically (Herman & Schatzow, 1987). Thirdly, the four WS had to deal with more factors influencing their anticipatory anxiety than the group therapy participants. Not withdrawing although having a guaranteed permission to do so, demanded an inner struggle and possibly enhanced their

commitment not only to the hike, but also to their own therapeutic process. Lastly, both group interventions invited psychological benefits that seem to complement each other. Thus, the two types of group therapy could ideally be used together in order to assist WS.

6.2.7 Post-hike depression

All WS described what is said to be a frequent occurrence after a wilderness experience, that is, post-hike depression (Greenway, 1995; Cumes, 1998). They described this as characterised by the dissatisfaction and sadness of seeing the experience coming to an end.

Post-hike depression is seen as part of the re-integration into society and has been connected to the contrast between the balance and harmony experienced in nature with the dismal prospect of returning to those catastrophes of life that were left behind (Cumes, 1998). Hence, it is apparently linked to a fundamental loss experience. Yet, the question is what the WS felt they had lost: the group, the safe space, or simply the opportunity to process their inner pain. That raises the further question of what an optimal or appropriate length for such intense wilderness process is. The WS expressed dismay that the "time was too short", preventing them from concluding their therapeutic process. Greenway (1995) however warns that there is a correlation between the intimacy of emotional response to wilderness with the depth of depression and that if a person stays too long within nature, adjustment problems could be too intense for a person to bear.

6.3 Summary of findings

The findings indicate that wilderness therapy can be a beneficial therapeutic modality for WS of CSA. Like other group interventions, it offers the female client the opportunity to process her issues in a group setting with women who had similar experiences. This can dissipate her sense of isolation and normalise her CSA-related emotional responses and behavioural styles, facilitating a therapeutic change leading to increased self-acceptance, a changed self-concept and new relational pattern. The fact that therapy occurs within a natural setting, free of the noise and usual distractions of everyday life, can intensify the change dynamics. Nature offers containment of the person and her painful transformative experience. An important therapeutic tool that wilderness therapy extends to WS who are often women without a voice, is silence. It motivates WS to embrace their need to deal with issues therapeutically and to cathart and disclose what often has been a secret in their lives. The last point suggests that wilderness therapy might be

particularly suitable for WS who hesitate to engage with CSA-relate issues or find it difficult to speak about its traumatic and life-changing impact. Thus, wilderness therapy promises to be a valuable introductory therapy experience that, like in the case of the participants, is followed up through long-term individual or group therapy, or as an adjunct, complementing other therapeutic work undertaken by WS.

6.4 Implications of the findings of this research

As much as the study has been able to describe and explore factors involved in the change process facilitated through wilderness therapy, many questions remain unanswered and call for more research.

While this study was able to outline the dynamic change process that the WS underwent, the question remains about how various change mechanisms like nature, group, or silence interact with each other to produce such therapeutic change. More investigations into the pathways and the possible interdependency of the mechanisms might assist in gaining a clearer theoretical understanding of what underpins the dynamics of the change experience.

Nature has been described as an overarching therapeutic container, yet this exploratory study did not shed light on what facilitates its holding potential. Further research could, for example, focus on the mechanisms at work when metaphorical realities and spiritual themes invite a participant to place her projections within nature and thereby express her feelings. Investigating how these and other features make a setting safe, or not, for therapeutic processing, might allow for the refinement of wilderness therapy programmes. In this context, comparing the responses of WS with different affinity to being in nature might add insights as to what makes a wilderness environment such a unique therapy setting.

The participants experienced a high degree of emotional and cognitive dissonance. It would be interesting to try and isolate factors that contribute to the rise in anxiety and then attempt to control and monitor these therapeutically. As with all interventions, therapeutic work is not to harm a client but to benefit her. Thus, to work towards finding clarity about proper balances and optimum levels could be an important insight ensuring better ethical practice of therapeutic work. Comparing the experiences of the participants and the non-participants might be one way of contributing to achieving this goal.

The wilderness therapy programme, used in this study, was conceptualised as a time-limited experience that aimed to invite intense therapeutic work. Processing at such a depth might, however, not occur if, as Greenway (1995) asserts, too little time is given for the attunement to nature. He also warns that being too long in wilderness can cause adjustment problems on return (ibid.). His concerns invite more research into the optimal duration of a wilderness experience, which suggests to be highly individual and possibly influenced by aspects, such as, previous exposure to nature or the level of defensiveness a person brings to the setting.

Silence evolved as a promising therapeutic tool. The paucity of research into its qualities calls for investigations. That could, for example, entail exploring how introvert WS respond to silence in comparison to extrovert WS, or whether people engaging in meditative practices experience less anxiety than people who do not. Equally, it might be of interest to compare the effects of silence as used in an individual therapy session with those found in certain religious practices and/or in nature, as it might shed light on what factors contribute to the change quality of silence.

It might also be worthwhile to inquire how male survivors of CSA experience wilderness therapy and whether their perception of change corroborates the findings of this study or differs. In either case, the results of such inquiry can further the understanding of how male and female WS uniquely respond to wilderness, to therapy in wilderness and to its unique therapeutic tools.

6.5 Limitations of this study

This study, like all research, has limits that need to be acknowledged. It focused on a broad topic and elicited an amount of data that could not be integrated in its totality into the limited frame of this thesis. Although not lost, valuable information and related insights had to be excluded and possibly lead to a conceptualisation of the therapeutic process excluding some of the experiences described by the WS participants. However, the researcher believes that the framework that evolved is a valuable first step towards further investigations around wilderness therapy for WS of CSA.

Another critical issue is that the sample size for each group consisted of only four participants each. A sample of this size means that the results cannot be generalised to the rest of the population of WS of CSA, since a different picture might have arisen from a different segment of the same population. In terms of this, Silverman (2000) points out the importance of carefully

documenting the method that the study followed so that the study may be replicated by another researcher. The researcher followed this advice as closely as possible, despite the inherent difficulties of clearly describing therapeutic processes that develop within nature and group interaction.

One key element of phenomenological research is the validation through the participants in a study. That proved to be difficult at times. One woman had left South Africa and trying to contact her was in vain. Another WS struggled with the psychological language used in the thematic summary, and only talking her through the text made it possible for her to confirm the findings as reflecting her experience. Some women also struggled to find the language that allowed them to describe their experience of the therapeutic change process. It is possible that, despite probing, valuable insights of some WS were therefore lost to the research.

The analysis of the interview texts ushered into the conceptualisation of the two therapeutic change processes, that is, of the wilderness group and the traditional therapy group. Working sequentially on the texts held the danger of confounding the results. It could potentially have increased the researcher's bias, in particular influencing what she attended to in the text and what she extracted as meaning. The researcher offset the bias by inviting the input from participants, by using various data sources besides the interviews, by stepping back from the evolving insights repeatedly, and by going through the process several times.

Another possible limit could be participant bias, that is, the WS' need to give the researcher what they perceived she was looking for. Thus, the question arises whether the fact that the researcher is a religious sister, invited, for example, comments of spiritual nature from the women. Also some participants struggled during the interview, largely staying at a cognitive level, rather than engaging more emotionally. Because of their intellectualisation, it was difficult to access their subjective experiences and perceptions, which is the cardinal feature of phenomenological research. As a result, the researcher found it difficult to stay engaged with these WS during the interview, which may have negatively influenced the data obtained.

CHAPTER SEVEN

CONCLUSION

Many a times, WS of CSA experience that they are on their own when it comes to dealing with the long-term effects of the childhood trauma that was often meted out by trusted adults. Starting therapy is not always a path that these women pursue, especially when guilt and shame, fear and insecurity have kept them silent for many years. Those, who seek therapeutic assistance, are faced with having to make a decision, namely, which of the various treatment modalities to choose. Wilderness therapy is but one such modality that has been used for survivors of sexual abuse (Powch, 1994). Studies have investigated aspects of this therapeutic intervention (Flechter & Hinkle, 2002), however little structured research has been undertaken in terms of wilderness therapy experiences for WS of CSA and in South Africa. This study was a response to this reality. It proposed to explore the way in which a group of WS subjectively experienced and perceived therapeutic change as a result of a wilderness therapy intervention to determine what makes it a unique treatment modality when compared to a more traditional group model.

Twelve women responded to the invitation to participate in this research study. Taking geographical realities into account, they were placed in one of two group modalities. This meant that four WS participated in a traditional, time-limited therapy group, while four other women were exposed to a four-day wilderness therapy programme within the Drakensberg Mountains. The other four women withdrew from the study for personal reasons. In the case of three of these WS, it appears that raised anxiety levels contributed to the decision not to participate.

The study used a phenomenological research framework for gathering and analysing its research data (e.g., Colaizzi, 1978; Polkinghorne, 1989; Giorgi, 1994). It entailed that the researcher interviewed each participant after the interventions and subsequently used the transcribed material for an in-depth analysis of the data that included validation processes through the WS. The diagrams that captured the reality of therapeutic change, as it was experienced and perceived by the women, highlighted themes, common to both modalities, but more importantly so, unique to wilderness therapy. These themes included therapeutic change in terms of CSA-related issues, nature as a container for therapeutic processes, and silence as a midwife function, inviting disclosure and catharsis. Other elements that evolved as significant features of therapy conducted

in a wilderness setting were the post-hike depression as well as the anticipatory anxiety that contributed to initiating change.

At the end of this study, many questions remain and much more research is needed. But valuable insights have been gained. Greenway (1995) upholds that there is no unified single psychological event or process, which can be described as happening with all people when they enter a wilderness setting, since it is a complex and deep experience that cannot easily be put into words. Kaplan and Talbot (1983, in Taylor, 2001) concur that there is no unitary emotional response, but rather it is possible that distinct and identifiable processes are involved in the individual's encounter with wilderness.

This research ventured into exploring such identifiable processes and has shown that wilderness offers a unique opportunity for growth. Whether visiting a wilderness setting, or working therapeutically in it, as the WS did, a different self is indeed discovered there, a self less conflicted, more integrated and more desirable (Scott, 1974, ibid.). Nature then is a valuable resource in more than one way. In South Africa, wilderness settings exist, and will continue to exist, as they have been declared protected areas. Also in South Africa, women live who were sexually victimised as children, and through undergoing this trauma, had their life change permanently. Taking these women as groups into the existing wilderness areas gives them a chance to move therapeutically to a new intrapersonal and interpersonal level in their lives.

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APPENDIX A:

Pre-interview schedule

Pre-amble

Before we engage in the interview, please allow me to assure you once again that whatever we will be talking about is confidential. That means that only those who have been mentioned on the consent form will have access to the content of the interview – be it in the form of audiotapes or in written form, and that any future publications about the study will protect your identity by way of changing demographic details and providing a pseudonym.

This interview is the first part of the study for which you volunteered. An intervention and a post-interview will follow. You are free at any time to revoke your consent and discontinue your participation without prejudice from the research team.

Interview

The focus of this interview is your experience of the trauma of child sexual abuse. I am aware that you have shared your stories repeatedly and that doing so once again is possibly a painful process. Thank you therefore for being prepared to be part of this process.

Possible questions to facilitate further information gathering

a) In your recollection, what effect(s) did the abuse have on you – immediately, longer-term but also today – in terms of your social relationships, your emotional state, your psychological and/or overall functioning?

b) In your understanding, what contributed to the onset of the abuse?

c) When did you disclose the abuse for the first time?
To whom did you disclose?
What was the response that you received?
How did you feel after you had spoken out about the abuse?

d) You have engaged in therapy. What worked for you? What did not work for you?

APPENDIX B:

Post-interview questions

Objective: To invite participants to describe in detail, examples of their experience of the topic under investigation, here: impact of wilderness/group therapy on women survivors of child sexual abuse.

Important: To get descriptions, not interpretations or theoretical explanations.

1. Before you set out into the wilderness – how did you feel (in particular in terms of the abuse that you experienced as a child)?

2. What stands out for you in your wilderness experience? What did you experience – what was it like for you? Try to describe the impressions that it made on you, i.e., in which way did it affect and/or influence you.

3. What was your internal process like? That is, what thoughts and/or emotions did you have and feel respectively?

4. What evidence is there that allows you to feel sure that it made an impression on you?

5. How did your experience affect you afterwards?

6. Were there any changes in your perception or thinking around the issue of the abuse? Explain.

7. In terms of the effects of the abuse on your life that you described in the pre-interview – what has happened to you during the wilderness experience?

APPENDIX C:

Questions for participants of wilderness therapy experiences

I would be grateful if you could reflect on the following questions pertaining to your WILDERNESS EXPERIENCE. Thank you!

1. What do you feel like when you are in nature for an extended period (3-5 days or more)?

2. What stands out for you in your wilderness/natural environment experience?

3. How did you feel beforehand?

4. How did you experience affect you afterwards?

5. What was your internal process like? That is, what thoughts and/or emotions did you feel?

6. Were the effects, if any, lasting - did they persist over time?

7. Were there any changes in your perception or thinking?

8. In response to any of the above possible answers I may ask: why do you think you felt that?

[Three responses were received. The unabridged version of each response has been added to this document.]

Respondent A (female, divorced)

ECOTHERAPY – A PERSONAL EXPERIENCE

I experienced many unexpected and remarkable things on my trip into the mountains with the ecotherapist and her partner. An extraordinary sense of community began to emerge between the group members within a short space of time. Not many of these people were known to me at the beginning of the expedition, but by the end, I felt as comfortable with them as if I had known them all my life. I also felt a deep sense of care for this disparate group, which is with me still. This phenomenon may have come about initially because we were forced to share living conditions of unusual sparseness, discomfort and intimacy. Stripped of the normal material niceties of comfortable living, we were perhaps forced to look inwards to our own, untapped resources in order to survive. Also necessary to this survival would be a co-ordinated and co-operative communal sharing of tasks, and a honed sensitivity to the needs of others. Immediately we were pressured to know, support and depend on each other. The conditioned emotional and mental barriers that exit between people in the outside world also seemed to disappear. Cramped together into a cave, miles from the civilised whirl of our habitual lives, we became merely a group of humans performing together the basic rituals of physical survival. We were forced to look beyond the external and into the essence of group living. This was a very powerful experience for me of a kind of primal, human bonding which reached beyond my customary restraints of caution and reserve.

The group and individual exercises we performed promoted a sense of emotional sharing and trust, and all of this within an atmosphere of mutual support, understanding and empathy. Even the most reserved of the group members appeared to relax and find comfort in this experience of listening and disclosure. This was particularly powerful as we sat one evening, in a circle in the encroaching dark, all of us bound by a strange, invisible thread, sharing in strangely symbolic, essential, meaningful ways. These exercises and the uniqueness of our physical reality combined, for me, in a way that released very deep, possibly unconscious dynamics. Standing in the Eland Cave, a place of ancient spirituality, we were asked to let go of two things and to symbolise this letting go with two stones which we would throw down a waterfall cascading down from a vast, overhanging shelf. I found myself clutching those stones to my chest, unable to let go of what I knew I must, stunned that I was still clinging to things I thought I had relinquished years ago. I let go of the stones, eventually, sobbing from some deep, unreachable place. This realisation, for me, was the beginning of real change and a profound inner shift and release and the beginnings of new growth, the effects of which I can still feel today.

There was an intense spirituality to some of these exercises in which we were invited to develop an awareness of, and gratitude for, the immense beauty and grandeur of our surroundings. I was graced with a powerful awareness of God's immensity and mystery, and this most particularly on the solo exercise. Alone in the vastness of the mountains, I felt very small and young, with all the simplicity, innocence and joy of a child at play. This extra-sensory awareness seemed to increase by day. Each time we stood in a circle holding hands, I felt a surge of energy pass between us all, uniting us in a surreal, yet intensely physical sort of way. As we parted, I felt a deep love for those people which I'm sure will remain with me always.

Respondent B (female, single)

My experience in the wilderness

My trip to the mountains had quite an effect on me. I think perhaps it was in part due to being in such a powerful environment. It's quite hard to hide from things in such an environment. I almost felt like it encouraged honesty with oneself and with others, which may sound strange, but it was almost as though everything was so open and pure in this natural space of the mountains that it was difficult to deny one's own personal 'stuff'! I was not able to lie to myself, of bluff myself as I may have done in the Varsity environment, or even that of home for that matter. Instead, I felt like I had to confront certain things. The space around me didn't permit me to be distracted by noise, other people, work, or any of the other clutter that fills our lives. I feel as though space literally had an effect on me.

I can remember thinking when I returned from the trip, how strange it was that I had not seen my reflection for four days. In an urbanised environment, one sees one's reflection, or at least images of oneself, everyday. This might be literally through mirrors or shop windows or even through others, by their reactions to you. I think sometimes one can feel constantly 'watched', and even judged. I think this is a second point that made the mountains so special for me personally. I felt as though I could be anything. Ugly, dirty, sad, depressed, happy, moody, selfish, kind, everything and anything was just simply okay! I think this helped the process of being honest with myself because I felt as though, whatever came out of me, would be respected and safe.

I think my trip to the mountains was essentially a very positive experience. I would recommend it to many people; in fact, I think I would encourage it. I think one leaves such a trip feeling refreshed and drained at the same time, but I think that is perhaps why the wilderness has the potential to heal people.

Respondent C (female, single)

My experience with wilderness therapy

Emotional Response

- I found the process extremely emotionally stirring. I'm not sure why but part of the process or a combination of the physical exercise, silence and surroundings was able to bring up strong and powerful memories of my childhood. Things I hadn't thought of or weren't in my conscious mind at the time. It filled me with a deep longing for the past/people in the past. I have never experienced anything like it.
- The emotional response I believe in deeply connected to the spiritual aspects of the process. I felt a deeper awareness of God as well as a more intimate connection with him. I was able to meditate and pray with deeper meaning and conviction as well as develop a new insight and emotional connection to the truth.

- I must admit, I felt a little uncomfortable or uncertain at times. Possibly a little bit of tension within me, which actually made it difficult for me to deeply connect with some of the people on the trail. However, I experienced a powerful breakthrough with two people that I had not expected and this breakthrough has fused me permanently to them and I seem to have very strong feelings of love and connectedness to them, even when I don't see them.
- I was also able to put things into perspective somehow. I realised my 'littleness'. So in fact, it was a very humbling experience. This is also why it was so spiritually powerful because I believe that pride disconnects us from God. I was able to appreciate the 'bigness' of things.

Changes or shifts

- deeper friendship/intimacy with two people
- slight emotional dislocation, confusion for a few days
- desire for meaning and purpose in life as well as an energy to pursue it
- breaking down of barriers – internally (self) and externally (with others)
- sense of physical competency and physical strength => usefulness of the body
- lack of fear – physical danger => more able to take risks.

APPENDIX D:

Researcher's presuppositions

(based on reading and the experiences of three participants from other trails)

Being in the wilderness and engaging in therapeutic activities there I am forced to look inside and get in touch with my 'self'. The outer journey becomes symbolic for an 'inner journey' taking place. Nature is a space where no distraction by noise, work, or other forms of clutter can occur. De-masking can happen as I am facing my inner barriers and am pushed to my limits, which I can extend by letting go of control. I can gain inner freedom by connecting to painful memories, confronting them and putting them into perspective. As the natural environment touches me I am emotionally stirred, get in touch with my body, and am reenergised and empowered. But I also become aware of my soul where God resides in His immensity and mystery and a deep bond that connects me with other participants, a bond of trust and love.

APPENDIX E:

Presentation of study to participants
-Pre-meeting-

Thank you for coming to this meeting. My name is Sr Ulrike Diekmann and, as I mentioned to you on the phone, I am a Master's student in Clinical Psychology at the University of Pietermaritzburg.

An essential part of the requirements for the course is the submission of a thesis. Through my work with children in school settings and with women at a Crisis Care Centre, my professional interest in child sexual abuse, its effects and possible interventions was kindled. For that reason I chose a topic for my thesis that focuses (a) on WS of CSA and (b) on a unique therapeutic format, that of wilderness therapy. Wilderness therapy is a new type of therapeutic intervention that has been used for trauma victims here in South Africa, and I believe that it holds promise for work with women who try to deal with the after-effects of early sexual traumatisation.

The aim of the study is to explore how women survivors who participate in wilderness therapy experience and perceive therapeutic change as a result of the intervention. Related are the questions about what makes the therapeutic modality unique, and how and when it could be best used for effective future interventions with WS.

The format of the study therefore entails the formation of two therapy groups for WS of CSA. The first group will experience a traditional time-limited group therapy process, while the second group will participate in a wilderness therapy experience in the Drakensberg Mountains. The members of both groups will spend approximately the same time in group processing, will engage in similar process-oriented activities, and will be interviewed before and after the intervention. The initial interview is for therapeutic purposes. A comparison of the results of the respective post-interviews will allow (a) for the formulation of common themes among the participants, (b) for conclusions in terms of the change process, and (c) for isolating therapeutic features uniquely connected to wilderness therapy.

I would like to assure you, the potential participants, that confidentiality will be upheld at all time. You are invited to choose pseudonyms that will be used during the interviews and in any publications. You are also free to discontinue your participation in the study without prejudice from the researcher. After the analysis of the data, I will approach you with preliminary findings inviting you to provide me with feedback about its accuracy.

Would you like to ask me any questions?

APPENDIX F:

Questionnaire for participants

Demographic details
(Please, tick where applicable)

Name: _____

Age: ☐ 21-30 ☐ 31-40 ☐ 41-49 ☐ 50+

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Cultural background: ☐ Zulu ☐ Xhosa ☐ Coloured ☐ Muslim ☐ Hindu ☐ Other

Religious background: **Which of the following best describes your practice of religious meditation?**

- ☐ **Prayer is a regular part of my daily life.**
- ☐ **I usually pray in times of stress or need but not often at other times.**
- ☐ **I pray only at formal ceremonies.**
- ☐ **Prayer has little importance in my daily life.**
- ☐ **I never pray.**

Educational background: ☐ Pre-Matric ☐ Matric ☐ Tertiary

Stated occupation: _____

Social support network:

When you are experiencing problems or struggle with yourself, others, the world… to whom do you turn and what type of help do you experience?

PERSON/GROUP THAT SUPPORTS ME	TYPE OF HELP RECEIVED				
Family member(s):					
☐ Husband/Partner	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
☐ Parent(s)	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
☐ Child(ren)	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
☐ Relative	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
Friend(s):					
☐ Female Friend	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
☐ Male Friend	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
☐ Circle of Friends	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
Religious Support:					
☐ Church Group	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
☐ Minister/Priest/ Rel Sister	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
☐ Religious Relative	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
Other Support:					
☐ Work colleague(s)	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
☐ Neighbour(s)	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
☐ Social Worker	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
☐ Community Project	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other
☐ Psychologist/ Counsellor	☐ Listening	☐ Advice	☐ Understanding	☐ Problem Solving	☐ Other

(This proved not to be helpful.)

Information related to the abuse
(Choose if you wish to answer)

Nature of abuse: _____

Duration of abuse: _____

Relationship to abuser: _____

Age range at time of abuse: _____

Time in abuse-related therapy: _____

Number of therapist(s): _____

Residual problems: _____

_____

_____

Information about relationship to nature

Please, explain what nature means to you.

What story of a significant event in relationship to nature can you share?

APPENDIX G:

Wilderness therapy: Schedule of activities

(as provided by NPAT wilderness therapy facilitator)

Wilderness therapy trail

Venue:
Dates:
Meeting time:
Meeting place:

Programme:

Day 1:
On the **first** day of the hike the participants and facilitators met early in order to prepare the backpacks and to move together to the departure point in the Berg. At the start of the hike an introductory ritual, aimed at initiating the personal growth process, was used. It emphasised to the participants that the outer journey was to become an inner one and that feelings needed to be noticed and attended to. On the first day the group walked five kilometres, following a slightly undulating path and pacing itself according to the slowest participant. Setting up camp and preparing food are tasks done as a group. During a group session at night, the participants spoke about the therapeutic significance of physical tasks such as walking and of being removed from one's ordinary environment. Other foci were the role the individual took on within the group, emotional triggers and the importance of attending to issues arising on the trail. A brief introduction to the programme of the next day followed. The day closed with a ritual that allowed each participant to express what she felt at that point of time.

Day 2:
A lengthy and physically challenging hike of 4 km was the highlight of this day. Whenever a participant was faced with feelings that arose in response to inner or outer experiences, the group spent time together to reflect and explore those. After reaching the second campsite, that is, Leopard Cave, the group was introduced to the concept of an over-night silence. The time in quietude was meant to offer to the WS of CSA, a mechanism by which they could get in touch with the process unfolding within them. A debriefing activity provided the group with time and space for sharing, reflecting on and processing issues from the day. The activities of the next day were also prepared at that stage.

Day 3:
On this day the group left the campsite in order to walk to a sacred San cave called Eland's Cave. During breaks to and from the cave, the participants openly shared their respective abuse stories and related past and present emotions. One key aspect of the group-sharing was dreams of

various members of the group that reflected unconscious processes but also contained real life references. At the cave, the women participated in a "Letting go and Receiving" ritual conceptualised as a change-inducing tool. This activity entailed that after a time of reflection the participants let go of pains in their life and received healing from nature, expressed through symbolic gestures. On return to the cave and as closure to an intense day, the participants were engaged in a group processing activity called 'cycle of life'. Through its symbolic language and character, it afforded the WS of CSA an opportunity to come to understand their psychological changes and develop an awareness of self in relation to others and the environment. It also provided space for processing and integrating the experiences of the day and the issues that arose.

Day 4:
On the **last** day the group retraced its steps and returned the nine kilometres back to the starting point. Common experiences and moments of sharing about feelings continued to facilitate processing. Through two ritual activities, entailing symbolic thanksgiving to the environment and the group for allowing and holding the overall therapeutic process of the individual and the group, the participants moved towards closure. On return to Pietermaritzburg, the whole group packed away the camping utensils before setting out for home.

The facilitator added the following general comments:

"It is difficult to articulate a defined programme other than the detailed sketch above as the work is process-oriented and so dependent on the group, their interactions and what happens on the trail. Our experience is that deep levels of personal reflection happen, positive moments for change in one's life are initiated, deep connections are made with other participants, and a perspective on one's life back home is gained. Participants are usually rejuvenated by this deep process and time-out. The work and environment provides an opportunity to re-evaluate and re-establish one's connection to self, to others and to the environment – relationships that are usually disrupted through stress, trauma, and our modern life-styles. Space is provided for connecting while also providing personal time-out throughout the time on trail. Follow-up interaction is a part of the commitment of the facilitator to the participants on the trail, and this takes the form agreed upon by the group or individuals in the group."

APPENDIX H:

Three examples of time-limited group therapy

-Women survivors of child sexual abuse-

1. Goodman, B., & Nowak-Scibelli (1985). Group Treatment for women incestuously abused as children. International Journal of Group Therapy, 35(4), 531-544.

PHASE	AIM(S)	DETAILED GROUP ACTIVITIES/DYNAMICS
Beginning	Introductions Ground rules Goal definition	▪ introduction of person, name, reason for joining ▪ possible expression of anxiety about what to talk about/what not able to say ▪ pointing out common feelings and experiences ▪ ground rules (attending meetings, confidentiality ▪ homework: defining a goal to be accomplished by the last session ▪ goals needs to be narrowed down/precise ▪ involves revealing much about herself, family of origin
Middle	Focus on details of abuse	▪ telling abuse story (story-telling session can be intense) ▪ exploration of material offered (allows connecting with underlying effects) ▪ emergence of strong feelings (for example, around loss, anger, fear) and expression ▪ also cognitive shifts ▪ encouragement to deal more concretely with abuse (for example, confrontation)
End	Termination	▪ renewed sense of abandonment and loss ▪ also: re-emergence of guilt and anger towards leaders ▪ emphasis to be placed on the changes that have been initiated (in self and as observed in others) ▪ move to acknowledge potential to take control/use own strength

2. Herman, J.L., & Schatzow, E. (1984). Time-limited group therapy for women with a history of incest. International Journal of Group Psychotherapy, 34(4), 605-616.

STAGE/ SESSION	AIM(S)	DETAILED GROUP ACTIVITIES
ONE	Introductions & ground rules	▪ introduction of person, name, reason for joining ▪ ground rules (attending meetings, confidentiality) ▪ homework: defining a goal to be accomplished by the last session
TWO – FIVE	Goal definition & story-telling	▪ sharing of personal goals (1) recovery of memories or (2) improved relationships or (3) improved self-esteem or *(4) sharing the 'secret' with a close acquaintance/ family member* ▪ goals need to be narrowed down/precise ▪ involves revealing much about herself, family of origin ▪ around fourth session telling abuse story (story-telling session can be intense)
SIX– NINE	Achievement of goals	▪ [reminder of midpoint] ▪ clarification of goals ▪ move towards taking action (for example, disclosure, feed-back, preparing for such action) ▪ could be time for 'group mourning' (that is, dealing with the abuse) ▪ possibly shared fantasies of revenge ▪ [reminded that last session will happen]
TEN	Termination	▪ organised as a ceremonial occasion ▪ members prepare feed-back for others and for evaluation (clear directions) ▪ formulate description of gains and remaining problems ▪ instruction regarding future sources of support (for example, temper or feelings of sadness)

3. Sprei, J.E. (1987). Group treatment of adult women incest survivors. In C.M. Brody (Ed.). Women's therapy groups: Paradigms of feminist treatment (pp. 98-216). New York: Springer Publishing Company.

STAGE/ SESSION	AIM(S)	DETAILED GROUP ACTIVITIES
ONE	Getting to know each other & ground rules	▪ provide commonalities between members ▪ provide safe and supportive environment ▪ introduction of all participants (as much as comfortable with) and building cohesion ▪ ground rules ▪ during last half hour (review ground rules and give homework) ▪ warn: experience of increased distress (flashbacks, memories) ▪ homework: to do something good for oneself (self-nurturing) ▪ (in later weeks: depends on topics discussed – ask members to devise these for themselves)
TWO – FIVE	Focus on the Past	▪ (pre-group: invite members to move immediately to the room) ▪ group go-around: 1) events that happened during the week 2) reactions to or unfinished business from previous session 3) topics to be addressed about during the session provides air-time for every member and offers opportunity for resolution [facilitator to examine issues, feelings, defenses, behaviour patterns] ▪ focus on past: (disclosure is not forced) 1) members describe their family patterns 2) faulty childhood messages 3) abuse itself 4) explore possible reactions to revealing 'secret' (for example, self-punishment) 5) emphasize common feelings and experiences
FOUR, FIVE or SIX	Putting the wall back up	▪ members of group may block the process at times ▪ result: fear of intimacy and intensity of the group ▪ facilitator to be supportive, non-punitive, respectful of right to maintain own boundaries
SIX– EIGHT	Focus on the present	▪ explore members' present lives (for example, current relationships, problems, behavioural patterns) ▪ move towards action (for example, confrontation of perpetrator, developing support networks) ▪ also: start taking better care of themselves
NINE & TEN	Termination	▪ evaluation of progress ▪ point out that last session represents an ending of the group

APPENDIX I:

Group therapy: Schedule of activities

The two aims of the **first** session were to provide space for the group members to get acquainted and to delineate the goal and structure of the therapeutic process. The participants introduced themselves through creating their own name-tags and explaining their symbolic meanings to each other. Thereafter each participant formulated her expectations of the group and the therapeutic group process and described how she felt at the onset of the intervention. As a group, the participating women also discussed and decided on a set of ground rules.

Sessions **two** to **five** followed a similar process-oriented format. Opening and closing rituals were used to highlight the significance of the group and its process. The facilitators then provided a short summary of the previous meeting with the aim to reconnect every WS of CSA to the unfolding process. The participants were also asked to describe how they felt and how the group process had affected them throughout the week. The four sessions afforded the women the opportunity to tell their stories and together reflect on the contents and the feelings they evoked. Group processes included exploring patterns, encouraging more concrete interaction with the effects of the abuse, and supporting each other in times of increased distress. During session **four** the facilitators reminded the women of the termination at the end of the sixth session.

The **closing** session was an extended meeting that included both the usual group therapy process as well as an art therapy activity. The participants created a doll and engaged in a guided communication exercise that focused on the symbolic meaning the doll held for the woman concerned.

After each group meeting the two facilitators met in order to reflect on and discuss the overall process. Foci were the dynamics among the participants and the facilitators as well as the individual and the group process. At that meeting the next session was prepared.

APPENDIX J:

Informed consent form

By virtue of this consent form the signatory confirms that she has been informed about the process and the aims of the research study conducted by Ulrike Diekmann in partial fulfilment of a Master's Degree in Clinical Psychology at the University of Natal, Pietermaritzburg.

She also confirms that she volunteered to be participant in the _____ group and that she consents to being interviewed both before and after the proposed intervention. She also consents to the audio taping of these interviews for the purpose of later transcription and analysis.

She further confirms that she has been made aware that confidentiality will be upheld at all times. Both the researcher U. Diekmann and the co-facilitator A. Hough as well as the supervisor B. Killian will have partial and/or total access to all information. For the sake of transcribing and future publication of this study, the participant's identity will be protected by the use of pseudonyms and changes to the biographical data in order to ensure complete confidentiality.

She finally confirms that she has been informed that should she wish to withdraw her consent and to discontinue her participation she is free to do so at any time without prejudice from the researcher.

Pietermaritzburg/Pinetown

Participant: _____ **Date:** _____

Witness: _____ **Date:** _____

APPENDIX K:

Confidentiality pledge of transcriber

I, _____ , hereby declare that I will be committed to keep confidential all the information that I have access to while transcribing the material from the audiotapes give to me by Sr Ulrike Diekmann. This means that I will not speak to family members, friends, or other people about anything on the tapes, that is, the details about the women and/or their stories. I am aware that the data is sensitive and that violating confidentiality could lead to renewed hurt of the women involved in the study that the Master's student is undertaking. I have permitted Sr Ulrike to inquire with the participants whether they know me personally so as to avoid that I type texts for people that I might recognise on the tapes.

Should I at any time feel that I am affected by the stories, I will seek assistance through Sr Ulrike.

Place: Date:

_____ _____

(Transcriber) (Researcher)

APPENDIX L:

NPAT Post-questionnaire

Name:

Post-trail questions:

1. Stories about the trail:

(a) Draw or write a story about your journey on trail.
(b) Describe your drawing or tell your story.

2. What was the most meaningful thing for you on trail?

3. What changes have taken place in your life since the trail? (For example, in your family relationships, the way you solve problems, your behaviours, etc.)

4. What would you like to say to the guides? (For example: Are there things you would have changed about the trail? What was good for you and what was not so good?)