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A GROUP INTERVENTION PROGRAMME FOR ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE

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This study reports on the core components of the Survivor to Thriver strengths-based group intervention programme for women who experienced childhood sexual abuse. It advocates a balanced approach and draws on an eclectic mix of theories, and has been field tested with two groups of women. An exposition of the philosophical and theoretical underpinnings, a description of the context, the role of the expert companion, outcomes and activities of the programme, evaluation methods and standard of care is provided. Finally, critical reflections on the intervention are discussed as well as limitations and the way forward.

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INTRODUCTION

Childhood sexual abuse (CSA) is a global epidemic which can have detrimental health outcomes (Amado, Arce & Herraiz, 2015). Two meta-analyses reporting the prevalence of CSA in 22 countries (Pereda, Guilera, Forns & Gomez-Benito, 2009) and 217 publications between 1980 and 2008 (Stoltenborgh, Van Ijzendoorn, Euser & Bakermans-Kranenburg, 2011) concur that the worldwide prevalence of CSA is between 18-19.7% for females and 7.6-7.9% for males and that this may be even higher in Africa. Correspondingly, a recent study in the Eastern Cape Province of South Africa found that 39.1% of women and 16.7% of men reported cases of CSA (Jewkes, Dunkle, Nduna, Jama & Puren, 2010). Some researchers, however, strongly argue that retrospective studies of CSA are not reliable, since one has to rely on adult memory (Jewkes & Abrahams, 2002); consequently, we count on the official statistics provided by the South African Police Service (SAPS) to appreciate the prevalence of CSA in South Africa. According to the SAPS, 22 781 cases of sexual offences against children were reported for the year 2013/2014 (SAPS, 2014). This figure is estimated to be even higher, since it is predicted that only one out of nine cases of CSA is reported to the SAPS (Mathews, Jamieson, Lake & Smith, 2014). It could thus be assumed that disclosure among CSA survivors is uncommon (Sorenson & Snow, 1991) and consequently many survivors go untreated and face various long-term negative outcomes in adulthood (Alaggia, 2005).

A body of research found that CSA is a risk factor for the development of a wide range of long-term negative outcomes such as mental health (e.g. depression, anxiety and personality disorders), sexual (e.g. intimacy and trust issues), and intra- (e.g. self-esteem issues) and interpersonal (e.g. relationship problems) difficulties (Dolan & Whitworth, 2013; Fergusson, Boden & Horwood, 2008; Hodges & Myers, 2010; Mathews, Abrahams & Jewkes, 2013; Singh, Parsekar & Nair, 2014). Consequently, CSA is described as a complex trauma, with unique trauma-causing factors (Ullman, Peter-Hagane & Relyea, 2014).

Finklehor and Browne (1985) describe four trauma-causing factors, called traumagenic dynamics, present in CSA, which makes the trauma unique and different from other childhood traumas. These factors are identified as (a) traumatic sexualisation (sexuality is shaped in developmentally inappropriate and dysfunctional ways); (b) stigmatisation (shame, guilt and self-blame surrounding the abuse); (c) betrayal (trust and vulnerability manipulated); and (d) powerlessness (child feels unable to protect self and halt the abuse). Furthermore, Finkelhor and Browne (1985) explain how a child's affective state and cognitive approach to the world becomes distorted when CSA alters the child's self-concept and worldview to the extent of causing long-term trauma into adulthood (Finkelhor & Browne, 1985). It is thus imperative that these so-called trauma messages

are addressed in treatment interventions as they distinguish sexual abuse from other traumas in childhood and can have detrimental consequences for the healing process of survivors.

There appears to be no consensus regarding how women cope with and heal from the detrimental consequences of CSA. One school of thought argues that some women resile and have a natural ability to recover from adversities and so may not require any intervention (Bonanno, Westphal & Mancini, 2011). A more traditional approach strongly advocates that women will require some form of intervention to survive and cope with the aftermath (Knight, 2009). Another, the strengths-based approach, emphasises that some women exposed to trauma can recover and even surpass their pre-morbid level of functioning and grow from their struggle to cope with the aftermath (Hassim & Herbst, 2016; Tedeschi, 2010; Vilenica & Shakespeare-Finch, 2012).

To date documented treatment studies have mainly focused on the traditional approaches, which include individual or group therapy within a pathogenic (deficit) paradigm (Kessler, White & Nelson, 2003; Taylor & Harvey, 2010). The theory of change behind these traditional approaches focuses on reducing symptoms and improving functioning by altering cognitive distortions and dysfunctional behavioural patterns in adulthood such as substance abuse, mental health difficulties and the subsequent reduction of symptoms (Kessler *et al*., 2003; Taylor & Harvey, 2010). Two recent South African studies, an empirical and an outcome study, surprisingly indicate that some women can indeed display strengths born from their struggle to overcome the adversity of the CSA (Walker-Williams, 2012; Walker-Williams, Van Eeden & Van der Merwe, 2012; 2013; Walker-Williams & Fouché, 2015). Thus, the person's strengths become the resources for change that enable them to move towards growth, mastery and wellbeing, while also remedying the dysfunctional behaviours (Cummins, Sevel & Pedrick, 2012). This is known as the strengths-based perspective. If we can understand the strengths born from these women's CSA struggle, then we might enable other women through interventions to also engage in a process of growth following their CSA trauma. Hodges and Myers (2010) have highlighted the need for such strengths-based interventions which specifically incorporate empirical studies focusing on women survivors of CSA who report growth following their struggle with CSA adversity.

Internationally, few scholars have developed and evaluated a strengths-based intervention for women who have experienced CSA (Draucker, Martsolf, Roller, Knapik, Ross & Stidham, 2011). In South Africa Walker-Williams and Fouché (2015) developed and evaluated such a strengths-based group intervention, namely S2T, an acronym denoting from Survivor to Thriver, which was empirically tested with two groups of South African CSA survivors (Walker-Williams & Fouché, 2015). It is thus the purpose of this study to report on the development and implementation of, and critical reflections on, the S2T strengths-based group intervention. In the sections to follow we contextualise the pathogenic (deficit) and salutogenic (strengths) paradigms in the context of the treatment of CSA. Below, we discuss one of the strengths-based models, namely the posttraumatic growth model. Then we motivate for group therapy as the modality of choice. This will be followed by a discussion of the core components of

the intervention, namely the philosophical and theoretical underpinnings, description of the context, role of the expert companion, outcomes and activities of the programme, evaluation methods and standard of care. Finally, critical reflections on the programme intervention will be discussed as well as the limitations and the way forward.

PATHOGENIC (DEFICIT) AND SALUTOGENIC (STRENGTHS) PARADIGMS IN THE CONTEXT OF THE TREATMENT OF CSA

Table 1 provides a comparison between the pathogenic (deficit) and salutogenic (strengths) perspectives in the context of the treatment of CSA. In the deficit approach the focus is on the psychological impact and behavioural manifestations of the CSA. CSA survivors are seen as "problem ridden, powerless and in need of repair" (Cummins *et al*., 2012:52). Consequently, the focus is on the CSA trauma and not on the opportunities or resources available to these victims intrinsically or extrinsically. Furthermore, little attention is given to the likelihood of some women achieving positive outcomes as a result of their struggle with adversity (Cummins *et al*., 2012). The strengths perspective, on the other hand focuses not only on recovery, but also on the resources and assets inherent to the individual, which can translate into experiences of growth, as a result of the struggle with adversity (Grych, Hamby & Barnyard, 2015; Hamby, Banyard & Grych, 2016; Hodges & Myers, 2010; Tedeschi, 2010; Vilenica & Shakespeare-Finch, 2012). The deficit approach is thus based on the medical model and attempts to fix what is broken (Cummins *et al*., 2012), while in the strengths perspective the focus is not on what is wrong, but instead on what is strong (Walker-Williams & Fouché, 2015).

TABLE 1
DEFICIT VERSUS STRENGTHS PERSPECTIVES IN THE TREATMENT OF CSA

Deficit Perspective	**Strengths Perspective**
Negative symptomatology caused by the impact of CSA	Strengths and resources borne from the struggle to cope with the impact and negative outcomes of CSA
Intervention focuses on identifying and assessing the negative symptoms and the impact on social functioning	Interventions focus on reframing the outcomes of the CSA into opportunities for growth
Therapist takes on a hierarchical expert role	Therapist takes on the role of an expert companion where the client is regarded as the expert on his or her life
Strong emphasis on long-term impact developmentally	Strong emphasis on having a future perspective
Clients prognosis is determined by the severity of negative symptoms	Clients recovery is determined by the utilisation of personal strengths and resources
Therapist is the prominent resource for change to occur	The client's ecology (family, community, etc.) contributes to change
Therapy focuses on reducing symptoms and negative outcomes	Therapy focuses on identifying a new life narrative based on strengths and resources, which includes a future perspective

Adapted from Saleebey's (1996) comparison of pathology and strengths

GROUP TREATMENT

Although some researchers found little evidence regarding the effectiveness of individual versus group therapy (Martsolf & Draucker, 2005), there is a strong body of research supporting group therapy in the treatment paradigm of adult survivors of CSA, specifically given its potential to reduce stigma and its cost-effectiveness (Brown, Reyes, Brown & Gonzenbach, 2013, Callahan, Price & Hilsenroth, 2004; Lundqvist, Svedin & Hansson, 2004).

According to Hébert and Bergeron (2007), group intervention is often the preferred treatment modality for women who experienced CSA as it is best suited to fit the population, process of healing and the unique trauma-causing factors (CSA is underpinned by secrecy, isolation and stigmatisation) (Finkelhor & Browne, 1986). These factors make imperative the need for an environment conducive to healing and normalising, as found in group treatment. Group therapy affords members the opportunity to share their victimisation experiences with other survivors in a secure setting, reducing isolation and stigmatisation, and creating a supportive network. This directly counteracts the lonely experience of CSA and contributes to a reframing of personal identity from lone victim-child to collective powerful survivor-adult (Callahan *et al*., 2004; Lundqvist *et al*., 2004). Meekums (2000:71) refers to this element of group therapy as "witnessing", a sense of being benevolently seen, heard and understood in the presence of others.

In the S2T strengths-based group intervention programme, group work was adopted as the preferred mode of delivery, as Calhoun and Tedeschi (1999:67) state that "group settings also provide unique and helpful means for the development of posttraumatic growth". The reports by other survivors can be an impetus that allows group members to consider their own growth possibilities. Furthermore, group therapeutic interventions become fertile ground for the revision of personal schemas essential for the experience of growth.

CORE COMPONENTS OF OUR MODEL: S2T STRENGTHS-BASED GROUP INTERVENTION PROGRAMME

The S2T strengths-based group intervention programme advocates a balanced approach and draws on:

- South African-based empirical research exploring the coping behaviours, posttraumatic growth and psychological wellbeing of a sample of women who had experienced CSA (Walker-Williams, 2012; Walker-Williams, Van Eeden & Van der Merwe, 2012; 2013);
- an eclectic mix of therapeutic theories (e.g. psychodynamic, cognitive-behavioural and psycho-education) (Callahan *et al*., 2004; Lord, 2008; Ullman *et al*., 2014; Van Rooyen, 2016);
- a South African trauma treatment model (the Wits trauma model) (Eagle, 2000); and
- a strengths-based model (e.g. posttraumatic growth model) (Tedeschi & Calhoun, 1996).

The S2T strengths-based group intervention programme aims to enable posttraumatic growth in women by enabling a transition from a victim to a survivor and ultimately a "thriver" narrative. This suggests a realisation of their personal strengths born from the trauma as well as a desire to continue on a life path of growth despite the traumatic experience.

Philosophical underpinnings of the S2T

In the S2T strengths-based group intervention programme our theory of change is based upon the following premises: a) we belief that CSA survivors internalise negative trauma messages in terms of themselves, others and the world; b) these messages play out in destructive and defensive behaviour patterns; c) the goal of the S2T strengths-based group intervention programme is to reframe these cognitive distortions, teach emotional regulation, personal integration and emotion-focused adapted coping; d) from this struggle to cope with this reintegration, we focus on the strengths emerging as a post-trauma identity, where they gain a sense of empowerment by having a future perspective, while reclaiming all the parts of themselves and their experiences; e) we believe that the group is a vehicle of healing facilitated by expert companions; and f) accessing and connecting with social support strengths is imperative in this process (Walker-Williams & Fouché, 2015).

Theoretical underpinnings

We will briefly explain how the theory of change in traditional approaches informs the S2T strengths-based group intervention programme.

Psychodynamic therapy

The subjective meaning of the traumatic CSA experience for the individual may result in a disintegrated sense of self which often manifests as symptomatic distress and impaired interpersonal functioning (Price, Hilsenroth, Callahan, Petretic-Jackson & Bonge, 2004). Psychodynamic therapy focuses on facilitating insight and mediating factors relating to the person's experience of trauma, models a supportive relationship, reduces psychiatric symptoms and increases social adjustment (Callahan *et al*., 2004; Lord, 2008). The S2T group context provides a safe environment to disclose the experience of the abusive event, as well as to explore potentially harmful implicit irrational assumptions about the meaning of the trauma in relation to themselves, others and the world. It also considers their conscious and unconscious self-concepts evoked by the trauma. This all takes place in a safe contained group context where group facilitators and members model a supportive relationship assisting group members to develop insight into the abuse process (Wilen, Littell & Salanti, 2012). This is done by allowing people to relate their story, allowing catharsis. Carr (2011), describes catharsis as a functional emotion-focused coping strategy necessary in the reintegration of the CSA. Emotional expression and giving oneself up to the feelings completely is what helps survivors get through and beyond the trauma (Godbey & Hutchinson, 1996). According to Eagle (2000), this act of remembering can be cathartic and could enable the survivor to express the unexpressed feelings and experiences associated with the trauma within the safety of the therapeutic context.

Cognitive-behavioural therapy

It is well documented in the literature that because of the inherent presence of unique CSA trauma-causing factors – such as the power difference between the child and the perpetrator, the sense of betrayal and the secrecy surrounding the CSA – a number of negative trauma messages and destructive behaviours are internalised. Consequently, children tend to develop distorted self-concepts, affective capacities, and cognitive and emotional orientations to the world (Putnam, 2003; Ullman *et al*., 2014). Cognitive-behavioural therapy (CBT) approaches focus on the present conditions in the person's life and identify cognitive distortions and misconceptions that may contribute to problematic behaviours in the CSA survivor. Through restructuring how clients perceive their world and themselves in relation to the trauma, symptoms can be reduced or eliminated and future behaviours changed; this is called cognitive restructuring (Cummins *et al*., 2012). CBT thus attempts to alter and process the feelings and cognitions associated with the abuse in order to change the behaviour associated with the abuse and integrate it into the self (Kessler *et al*., 2003; Taylor & Harvey, 2010; Wilen *et al*., 2012). CBT is incorporated into the S2T strengths-based group intervention programme using cognitive restructuring techniques in order to process each group member's cognitive distortions relating to their traumatic experiences (Stockton, Hunt & Joseph, 2011). This leads the way towards emotional regulation and processing, which ultimately results in constructive coping appraisal and experimenting with new behaviours. Liem, James, O'Toole and Boudewyn (1997) report that such cognitive reappraisals are a key factor in resiling processes and can assist in developing one's internal locus of control, which aids clients in making connections between their behaviours and past events. This serves to enhance the client's level of responsibility and accountability, and also instils hope that they have control over the choices they make, making it possible to change for the better (Orbke & Smith, 2013). Furthermore, being willing to change, being flexible to experiment with new behaviours, giving up old view points and gaining new insights are all part of this process of cognitive restructuring (Godbey & Hutchinson, 1996).

Psycho-education

CSA victims did not have the cognitive structures to process the abuse as innocent children and may have grown up accepting the abnormal as normal, e.g. avoidance of sexual intimacy, feeling unsafe and insecure etc. It is thus imperative that this complex symptomatology of CSA become normalised (Orbke & Smith, 2013). In the psycho-education approach members are taught about trauma symptoms, self-care and educational aspects involved in the recovery process in order to increase knowledge and understanding about sexual abuse symptoms and effective coping strategies (Brown *et al*., 2013). In the S2T strengths-based group intervention programme treatment psycho-educational analogies and activities (Van Rooyen, 2016) are pre-planned and incorporated into the group process when appropriate to normalise symptoms and mobilise effective proactive emotional coping skills.

Integrated approach to trauma treatment

Multimodal integrative approaches to trauma counselling are regarded as the gold standard of clinical practice in the field (Lopez Levers, Ventura & Bledsoe, 2012). There are several internationally developed integrative models which include Briere's (2002) self-trauma model and Bloom's (2005) sanctuary model. In South Africa the Wits trauma model (Eagle, 2000) is used, which combines cognitive-behavioural and psychodynamic therapeutic approaches, and is used as the trauma-based framework in the S2T strengths-based group intervention programme.

Wits trauma model

The Wits Trauma model is ideally suited for the treatment of psychological trauma; it was devised by psychotherapists working with trauma in the South African context. According to Eagle (2000:301), the "ideal approach to trauma treatment appears to be in drawing on the relative strengths of both the psychodynamic and cognitive-behavioural schools" and therefore the integrative perspective of the Wits trauma model reflects elements of both these classic traditional approaches in psychology. The model includes five components, which can be introduced interchangeably within an intervention, depending on the needs of the client and the natural flow of the session(s). The five components of the model are outlined as follows: (1) telling/re-telling the story; (2) normalising the symptoms; (3) addressing self-blame or survivor guilt – restoring self-respect; (4) encouraging mastery; and (5) facilitating the creation of meaning (Eagle, 2000).

This model was, however, limited in that it was deficit orientated and precluded the search for salutary or positive factors within the therapeutic process, such as the potential for growth outcomes. In the S2T strengths-based group intervention programme this model is expanded on by including a strengths-based component.

Strengths-based perspective

In the aforementioned traditional approaches and integrated trauma model little attention is given to the possibility of some women achieving positive outcomes as a result of their struggle with the CSA. The strengths perspective provides a meaningful approach to addressing the treatment of abuse, as it enables survivors to discover and explore their internal strengths and external resources (Slabbert, 2014). Strength-based interventions thus focus on the individual's strengths and strategies to cope with the issues generated by their abuse histories (Hodges & Myers, 2010). These strengths and strategies are defined as a "wide range of practice principles, ideas, skills and techniques to promote and draw out the resources of clients and those in the environment to initiate change and energise the change process and so sustain change once it has occurred" (Cummins *et al*., 2012:51).

The client's external resources and supportive ecologies such as family, friends and community members are also fundamental in contributing to their process of growth. In the S2T strengths-based group intervention programme the women are guided to identify external resources which are purposeful and meaningful to the person's growth trajectory (Saleeby, 2002).

Within this strengths-based paradigm models such as resilience (Orbke & Smith, 2013) and posttraumatic growth (Tedeschi & Calhoun, 1996) and the like emerge.

Posttraumatic growth model

Posttraumatic growth is a term coined by Tedeschi and Calhoun (1996) and they define it as "positive psychological change experienced as a result of the struggle with highly challenging life crises" (Tedeschi & Calhoun, 2004:1). In addition, posttraumatic growth is conceptualised as a multidimensional construct that includes changes divided into three general domains, namely changes in the experience of relationships with others, changes in the perception of self and changes in one's general philosophy of life (Tedeschi & Calhoun, 1996).

In their model Tedeschi and Calhoun (1996) describe how posttraumatic growth is an outcome resulting from a very specific coping process aimed at restructuring a coherent post-trauma life narrative; it has a quality of "transformation" or a qualitative change in functioning and includes a future perspective (Tedeschi & Calhoun, 2004:4).

This coping process begins with a seismic event, for example, CSA, which results in the internalisation of a negative trauma message or cognitive belief about the self in relation to others and the world (Finkelhor & Browne, 1986; Jaffe & DiLillo, 2013). This in turn results in maladaptive core beliefs where the individual's schematic structures (which have guided understanding, decision making and meaningfulness) fail. Thus the person's ability to manage emotional distress is challenged. In attempting to reduce this emotional distress, the person engages in a process of recurrent intrusive (nonconstructive) rumination or deliberate (constructive) rumination (Taku, Cann, Tedeschi & Calhoun, 2009). Intrusive rumination occurs where the person will dwell on the event but is unable to make meaning of their assumptive world. In deliberate rumination the person will deliberately analyse the seismic event, find meaning and re-appraise until they are able to make sense and build a new assumptive world which integrates the traumatic incident (Taku *et al*., 2009). Once this cognitive processing occurs the person experiences successful coping appraisal, which results in the trauma becoming meaningful, comprehensible and manageable. Walker-Williams and Fouché (2015:13) highlight that "the individual thus has not only survived the trauma, but as a result of the successful cognitive processing, heightened emotional awareness (catharsis), and the reconstruction of a coherent life narrative (meaningful, comprehensible and manageable) can identify transformational character strengths termed the 'thriver identity'". Several authors argue that such personal strengths develop from the struggle to cope with the traumatic ordeal. However, a body of research alerts us to the fact that such posttraumatic growth is also dependent on the person's characteristics such as resilience, optimism and sense of coherence as well as environmental influences such as the availability of external supportive resources (Calhoun, Cann & Tedeschi, 2010; Oaksford & Frude, 2003; Orbke & Smith, 2013; Tedeschi & Calhoun, 2004; Tedeschi & Kilmer, 2005).

Context of the S2T group intervention

Clinicians are encouraged to use interventions that facilitate posttraumatic growth sensitively and promote awareness of the dichotomy in trauma recovery where possibilities of growth may be explored in the context of suffering (Calhoun & Tedeschi, 2004; Walker-Williams & Fouché, 2015). The treatment outcomes of the S2T strengths-based group intervention programme follow a narrative progression from victim to survivor to thriver. But the process is not linear and requires constant circular reflection.

Group members who should participate in the S2T strengths-based group intervention programme are survivors who are above the age of 18 years and have received some form of crisis intervention (as a child or adult) or disclosure therapy, but still have a need for further intervention. They should be able to function reasonably well in day-to-day life and have established some sense of control over their abuse crises and symptoms (Walker-Williams & Fouché, 2015). In the screening process women displaying psychotic symptoms or substance dependence should be excluded. These issues are excluded as they are seen to have the potential of hindering the recovery experiences of the other women in the group. The group sessions can range from six to nine. The duration of these sessions is approximately two hours and are held at a secure, central community location. Enough time is needed for reflection, introspection, catharsis and cognitive processing.

This is facilitated by two group facilitators who would ask strengths-based probing questions and use advanced empathy to do so. This is done by using Saleeby's (2002) framework of questions and probes to assess strengths, namely: survival questions (e.g. How have you managed to survive (or thrive) thus far? What have you learned about yourself and your world during your struggles? Which of these difficulties have given you strength, insight or skills?), support questions (e.g. What people have given you special understanding, support, and guidance?); exception questions (e.g. What parts of your world and your being would you like to reinvent or relive?); possibility questions (e.g. What are your hopes, visions and aspirations? How far along are you toward achieving these?) and esteem questions (e.g. How will you know when things are going well in your life and what will you be doing? When people say good things about you, what are they going to say?) (Saleeby, 2002). In the posttraumatic growth literature such facilitators are referred to as expert companions.

Role of the expert companion

In the literature there is no consensus on a universal set of "common ingredients" which need to be present in a therapeutic intervention for victims of CSA (Wilen *et al*., 2012:4). However, the following common ingredients that are included in most traditional approaches and interventions, both globally and in South Africa, were adopted in the S2T, such as providing a non-judgmental attitude and accurate empathy, demonstrating unconditional positive regard towards the client, acknowledging the diversity of clients and settings and the complexity of therapeutic change, acknowledging the uniqueness of each group member, working at the group member's pace (Van Rooyen, 2016; Wilen *et al*., 2012). Another important ingredient is a strong

therapeutic alliance which entails behaving in a warm and respectful manner, setting clear boundaries and modelling behaviours of a healthy relationship (Wilen *et al*., 2012). Such a relationship creates a safe and responsive environment which allows for accessing, reworking and integrating the traumatic material. Two group facilitators were able to take turns guiding the process and being available for any individual containment needed.

In the strengths-based perspective the incorporation of well-trained professionals, needed to create an atmosphere that could facilitate a process of personal exploration useful in developing a sense of posttraumatic growth, is imperative. This person is called an "expert companion", a unique term in the posttraumatic growth literature (Tedeschi & Calhoun, 2006:292). The expert companion encourages reflective cognitive processing of the traumatic event and helps the survivor to consider the ways in which they are reacting to the traumatic experience while maintaining the ability to empathise with the survivor's painful distress of the traumatic event (Tedeschi & Calhoun, 2006). This is reinforced in the S2T strengths-based group intervention programme by using Saleeby's (2002) framework of questions and probes to assess strength, as mentioned earlier (Saleeby, 2002). Such a framework of questions is seen as an important building block in the process of enabling posttraumatic growth in the women survivors participating in the S2T. In this process women would be encouraged to identify strengths originating from their struggle to cope with the CSA and ultimately formulate a post-trauma identity encompassing a future perspective.

The above approach is founded on our beliefs as strengths-based researchers and "expert companions" that all people have a portfolio of assets and resources, and can adapt given the right guidance (Grych *et al*., 2015:343). Thus, trauma survivors are "experts" on their own trauma and can grow through their own strengths and capacities with the guidance of an expert companion. This is strongly advocated for in group therapy (Callahan *et al*., 2004; Lundqvist *et al*., 2004).

Outcomes and activities in the S2T group intervention

When evidence-based programmes are replicated, it is critical not only to know whether a programme works, but which programme elements are essential in making the programme effective. Although the long-term efficacy of the S2T strengths-based group intervention programme is in the process of being established, it could be regarded as a promising practice that has the potential to move science to practice.

The S2T strengths-based group intervention programme is comprised of five treatment outcomes that follow the progression of victim to survivor to thriver narrative. The process is not linear and requires constant circular reflection. The group meetings can range from six to nine sessions, each with distinct outcomes, objectives, activities and narrative role in the recovery process which could be that of victim, survivor or thriver.

TABLE 2
S2T TREATMENT OUTCOMES AND ACTIVITIES

S2T Treatment Outcomes, Objectives & Narrative Role	Activities and Facilitation Techniques	Theoretical Approach
Outcome: Providing a healing group context *Objectives:* Supportive, structured, contained and accepting environment facilitated by expert companions	• Gaining informed consent, clarifying roles and expectations, setting group commitments, encouraging confidentiality • Safe word assigned to indicate feelings of being unsafe or uncontained • Group metaphor of healing chosen to indicate the groups unique common identity • Facilitation by competent facilitators as expert companions • Focus on Saleeby's (2002) framework of questions and probes to assess strengths	• Psychodynamic • PTG • Wits trauma model
Outcome: Introspection and heightened emotional awareness *Objectives:* Telling the trauma story *Narrative role*: Victim	• Draw-and-write and draw-and-talk activity (Mitchell, Theron, Stuart, Smith and Campbell, 2011) • Explore facts, feelings, cognitions and sensations at the time of abuse (Eagle, 2000) • Explore support at the time of abuse and their subjective opinion on how it affected their identity and psychosocial functioning to date (Stockton *et al*., 2011; Tedeschi, 2010) • Time-line activity (Fouché, 2006) • Facilitators to contain and process strong emotional reactions	• CBT • Psychodynamic • Wits trauma model
Outcome: Cognitive processing and restructuring *Objectives:* Identify and explore internalisations; normalise symptoms, deal with loss and reframe internalisations *Narrative role*: Survivor	• Normalise symptoms (Eagle, 2000) • Psycho-education on trauma causing factors (Finkelhor & Browne, 1985) • Address internalisations • Focus on cognitive distortions • Internalisation and boundary activities, e.g. Glasses, robot and egg analogies (Fouché, 2006; Fouché & Yssel, 2006) • Self-nurturing techniques • Metaphorical burning ritual • Letter to perpetrator • Explore the stages of loss and role of forgiveness	• CBT • Psychodynamic • Psycho-education • Wits trauma model

S2T Treatment Outcomes, Objectives & Narrative Role	Activities and Facilitation Techniques	Theoretical Approach
Outcome: *Active adaptive coping* *Objective:* Decisive action and an internal locus of control *Narrative role*: Survivor	• Explore current coping repertoires • Build constructive coping tool boxes, e.g. "strong foot" (Walker-Williams, 2012) • Self-esteem activities • Self-nurturing techniques (Walker-Williams, 2012) • Growth journal • Positive affirmations	• Psycho-education • Strengths perspective • Wits trauma model
Outcome: *Social support strengths* Objective: Connecting with family, friends and significant others *Narrative role*: Survivor	• Build action plans for positive connections in relationships • Gratitude journal	• Strengths perspective • PTG
Outcome: Post-trauma identity *Objective:* Meaning making and benefit finding (strengths emerging from struggle) *Narrative role*: Thriver	• Strengths building • Value in Actions (VIA) Questionnaire (Compton, 2005) • Re-telling the story for a "change" (Walker-Williams, 2012) • Reinforce behaviours, thoughts or strategies indicative of mastery in trauma experience (Eagle, 2000) • Visual participatory method (draw-and-talk and make-and-write) (Mitchell *et al*., 2012) • Comparison of pictures before and after intervention (Walker-Williams & Fouché, 2015) • Explore post-trauma identity (combining meaning making and benefit finding) • Group narrative, i.e. becoming the voice of future survivors (Walker-Williams & Fouché, 2015) • Congratulatory thriver ceremony (Walker-Williams, 2012)	• Strengths perspective • PTG

Evaluation methods

The purpose of using evaluation methods in the S2T strengths-based group intervention programme is to show whether the S2T enables posttraumatic growth in participating survivors of CSA. In doing so, both psychological instruments and a qualitative method, namely, a visual participatory approach (draw-and-write-and-draw-and-talk), are employed.

The following validated psychological instruments, namely the COPE Inventory (Carver, Scheier & Weintraub, 1989), Coping Self-Efficacy Scale (Chesney, Neilands, Chambers, Taylor & Folkman, 2006), Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996), the Mental Health Continuum – Short Form (Keyes, 2002), the Rosenberg Self-Esteem Scale (Rosenburg, 1965) and the General Health Questionnaire (Goldberg & Hillier, 1979) are used. Permission was obtained from the authors for use of the following scales: the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996), the Mental Health Continuum – Short Form (Keyes, 2002), and the Coping Self-Efficacy Scale (Chesney *et al*., 2006). The remaining scales are available for use in the public domain. A biographical questionnaire is included for socio-demographic information pertaining to the participants. This established aspects of the women's CSA experiences, their perceptions of how they coped through the ordeal, their reflections on the significance of this trauma in their present lives, and whether they felt they had grown from the traumatic experience and became stronger and why.

Secondly, participants participate in drawing and writing activities and then in explaining these pictures in the group context. This method is called draw-and-talk and draw-and-write, and its benefits are highlighted by Mitchell *et al*. (2011), who note that drawings can assist adults to capture memories, thoughts and feelings which are not easily transformed into words. This method is appropriate, as it provided rich data in a non-threatening way and was thus contextually most relevant to this sensitive group. To avoid subjective interpretation by the researchers, the participants are afforded the opportunity to explain and discuss their drawings with the group as well as complete their own analysis of the three drawings and writing activities.

Standard of care

Working with a sensitive population, such as adult survivors of CSA, calls for a standard of care which entails that the facilitators of the S2T strengths-based group intervention programme act in the best interests of the group members and maintain professional ethical standards. Standard of care has been described as the usual and routinely professional standard practice employed by professionals in the residential district. In addition, it also refers to the quality and conditions which should prevail in a particular mental health service, and which an ethical professional would accept (Zur, 2015).

We are also advised by Bonanno *et al*. (2011) that interventions should be used sensitively and conducted carefully and with respect for contextual and developmental congruence. Similarly, Becker (2010) cautions that confidentiality and sources of conflict, e.g. struggle for power, prejudice, intolerance of difference and hostility, may be a problem in groups. However, we observed that as a result of the stigmatisation of CSA, adult survivors in fact experience group treatment as normalising and non-prejudicial as they come into contact with other victims of CSA. In order to maintain sensitivity and confidentiality, ground rules and commitments were set at the commencement of the group sessions.

Ethical clearance was obtained from the Ethics Committee of the North-West University prior to commencement of implementation of the S2T strengths-based group intervention

programme. The group facilitators are a registered social worker and clinical psychologist, who both have doctoral degrees in their respective disciplines. They are both experienced therapists who have worked with such vulnerable women and abide by a professional, ethical code of conduct and so are well equipped to facilitate the group.

An S2T intervention protocol was developed prior to commencement of the group (Kessler *et al*., 2003; Walker-Williams & Fouché, 2015). This allowed us to monitor adherence to the treatment outcomes and sessions, and to replicate the research. The group facilitators addressed adherence to intervention protocol by completing a checklist following each session in which they recorded whether designated topics had been addressed and if risks were identified and ethically managed (Kessler *et al*., 2003).

CRITICAL REFLECTION ON THE IMPLEMENTATION AND EVALUATION OF THE S2T

The S2T strengths-based group intervention programme is currently being evaluated for long-term efficacy in order to contribute to evidence-based practice. To date it has been evaluated with two groups of South African women. A total of 18 women, between the ages of 18-50 years, 9 black and 9 white, commenced the programme, and 12 completed it. They were all victims of contact abuse and the perpetrator was known to them. Findings from both groups suggest that the women who completed the S2T strengths-based group intervention programme appear to display posttraumatic growth, enabling outcomes such as emotional awareness, decisive action, post-trauma identity and a healing group context (Walker-Williams & Fouché, 2015). These women reported that they had become experts on their own trauma and after re-authoring their trauma narratives in a safe healing group context, they can reflect on their own individual strengths and capacities born from their struggle to cope with the childhood trauma. Thus they no longer focus on what is broken, but instead begin to focus on what is strong, with a future perspective (Walker-Williams & Fouché, 2015).

Qualitative feedback from both groups of women suggests that traumatic sexualisation as a trauma-causing factor and the stigmatised loss associated with CSA should be specifically addressed in the refinement of this programme. The statistical analyses of the psychometric instruments are currently in progress. Also, the facilitation of the S2T strengths-based group intervention programme requires skilled practitioners who have experience in working with survivors of trauma because of the sensitive nature and unique dynamics of CSA.

The multidisciplinary approach of a social worker and clinical psychologist in facilitating the S2T strengths-based group intervention programme was a strength as pooling the different professions and their resources meant exchanging knowledge and expertise and thereby also learning from one another. This is strongly advocated for in the resource-deprived context of South Africa (Green & Nieman, 2014).

LIMITATIONS AND THE WAY FORWARD

Our current findings are focused only on qualitative evaluation methods and it is imperative that the quantitative measurement also be included in the outcomes of the

S2T strengths-based group intervention programme as soon as possible. Traumatic sexualisation, stigmatised loss and other possible trauma-causing factors should be addressed more comprehensively in the S2T strengths-based group intervention programme. Three Master's students are presently looking into these topics. Because of the sensitive nature of CSA the attrition rate could cause a problem. Furthermore, such interventions require professional facilitation, a possible limitation which could be addressed in speciality training and with the development of a comprehensive treatment manual. Currently the S2T strengths-based group intervention programme has not been rolled out with males and this is also a possible topic for a future doctoral student.

CONCLUSION

It appears as though a promising practice such as the S2T strengths-based group intervention programme has the potential to enable the facilitation of posttraumatic growth in adult survivors of CSA. It appears encouraging to follow a balanced approach where traditional pathogenic approaches (such as psychodynamic therapy and CBT) along with a strengths-based model (such as posttraumatic growth) are integrated with a trauma model. However, long-term efficacy needs to be determined so as to contribute to evidence-based practice.

DECLARATION OF INTERESTS

The authors declare that there are no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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