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HELPING FEMALE SURVIVORS OF CHILDHOOD SEXUAL ABUSE DEVELOP POSITIVE COPING: A GROUP INTERVENTION

by

Dana Beaton-Stokell

A Practicum Report
Submitted to the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements
For the Degree of
Master of Social Work

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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Helping Female Survivors of Childhood Sexual Abuse Develop Positive Coping: A Group Intervention

BY

Dana Beaton-Stokell

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of Master of Social Work

ABSTRACT

This practicum involved the creation, implementation, and evaluation of a twelve week group intervention focused on the development of positive coping skills in adult female survivors of childhood sexual abuse who have been impacted by compulsive coping behaviours. Eleven women participated in two groups held at The Laurel Centre in Winnipeg, Manitoba. The group purpose was: to help women who have survived childhood sexual abuse to recognize and honour the adaptive ways in which they coped with the effects of the abuse; to examine these coping behaviours from a cost/benefit perspective, and provide a space for women to choose whether to continue or begin to replace these behaviours; and to explore more positive ways of coping with the effects of the sexual abuse that reflect the goal of the self in balance, including the physical, emotional, intellectual, and spiritual aspects of the self. Session topics included creating safety, self-care, emotional protection planning, boundaries, creativity, openness to new things, finding the sacred and accessing joy, and exploring spirituality. Several methods of evaluation were used, including both quantitative and qualitative measures: a weekly standardized self-esteem measure, a weekly positive coping rating scale, a weekly critical incident evaluation log to correspond with the self-esteem and coping measures, ongoing verbal feedback from participants, ongoing clinician process recordings, and a final group feedback form. Overall results of the practicum indicated significant satisfaction with the group experience, with participants meeting group and individual goals of increased self-care, skill-building, and sharing with other women. Other goals were met in a beginning way, including improvement of self-confidence, increased inner strength, and the recognition and management of patterns.

DEDICATION

This is dedicated to:

My parents, for providing me with the start I needed to be who I am today;

My partner, James, for always sustaining me in the present; and

My baby son, Noah, for making me look so forward to the future.

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And finally, thank you to all the women who participated in the coping groups; you all worked so hard, and shared so much...you were all inspiring to me in so many ways.

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CHAPTER ONE

INTRODUCTION

> The child trapped in an abusive environment is faced with formidable tasks of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness. Unable to care for or protect herself, she must compensate for the failures of adult care and protection with the only means at her disposal, an immature system of psychological defenses (Herman, 1992, p. 96).

The purpose of this practicum was the creation, implementation, and evaluation of a twelve week group intervention focused on the development of positive coping skills in adult female survivors of childhood sexual abuse who have been affected by compulsive coping behaviours. Two groups with a total of eleven participants were implemented, at The Laurel Centre, a counselling agency in Winnipeg, Manitoba, that works with women who have experienced childhood or adolescent sexual abuse, and who have addiction or compulsive coping issues. This practicum report describes the learning process by outlining the details of the practicum. This chapter describes the background of the practicum intervention, the rationale for group work, and the practicum objectives; it then provides the theoretical framework and the organization of the practicum report.

BACKGROUND

The decision to focus my practicum on survivors and the development of positive coping skills was based on several factors. Firstly, my area of focus as a social worker is feminist therapy with women who are survivors of abuse, and I wanted my graduate studies to reflect my commitment to work in this area. Secondly, in my work with survivors, I began to perceive a need

for a focus on the development of positive coping skills during every phase of the therapeutic process. Finally, I found a lack of literature in the area of positive coping development in survivors; the majority of articles focus on the 'negative' coping strategies many survivors commonly employ to ameliorate the effects of the sexual abuse, and how to move beyond them, but little discussion exists about methods to replace these coping methods with more positive ones. The original idea for a positively-focused group about coping for survivors came out of a discussion with a co-worker after a particularly intense group session we had just finished co-facilitating. While debriefing, we noted that it would be a refreshing change to co-facilitate a group that had a primarily positive focus rather than the traditional sexual abuse groups that tend to result in participants revisiting the pain of their abuse experiences. We talked about the potential of a future-focused group that would attempt to help women develop a repertoire of skills to assist them in coping with the varied long-term effects of childhood sexual abuse, a group that could be useful at any stage of the therapeutic process, and could help women have more positive day to day lives while they engage in the lengthy and arduous journey of healing. From this beginning, the idea for a group that acknowledged the importance of the concept of the self in balance, with attention to all four aspects of the self, physical, emotional, intellectual and spiritual, was born.

PRACTICUM OBJECTIVES

The main goal of the practicum was to develop, implement, and evaluate a group intervention for female survivors of childhood sexual abuse who have been affected by compulsive coping behaviours that would provide the opportunity to begin to learn and incorporate new,

more positive, coping skills that reflect the goal of the self in balance. The specific group purpose was threefold: first, to help women who have survived childhood sexual abuse to recognize and honour the adaptive ways in which they have coped with the effects of the abuse; second, to examine these coping behaviours from a cost/benefit perspective, and provide a space for women to choose whether to continue or begin to replace these behaviours; and third, to explore more positive ways of coping with the effects of childhood sexual abuse - ways that reflect the goal of the self in balance, including the physical, emotional, intellectual, and spiritual aspects of the self.

The main question I hoped to answer in the process of the practicum was whether the intervention I developed would increase levels of positive coping and whether, in turn, this would increase levels of self-esteem in participants. I also hoped to discover the types of environmental and contextual factors that impacted the ability of participants to begin to develop more positive coping skills.

My personal learning goals were several: first, I hoped to increase my skills in feminist group facilitation, specifically in the areas of the development and planning stages of a group intervention, the practice of co-facilitation, the balancing of structure and flexibility in the group process, and how I view my role as a feminist group facilitator. Second, I hoped to learn more about how single system research designs integrate into practice, and how to incorporate data collection and analysis into my understanding of intervention, including the creation of appropriate measures. Third, I hoped to increase my understanding of the impact of childhood sexual abuse on women, specifically in the area of compulsive coping and the development of positive coping alternatives.

RATIONALE FOR GROUP WORK

The rationale for the use of group work for this practicum was based on the potential of group therapy for survivors. Several authors recommend group therapy for survivors, either alone or in conjunction with individual therapy, noting that it is an intervention that is helpful in facilitating healing and reducing the long-term effects of the abuse (Bass & Davis, 1988; Courtois, 1988; Donaldson & Cordes-Green, 1994; Gil, 1988; Herman, 1992). Group therapy has a component of mutual support, encouragement, and connection with other women that individual therapy lacks, as well as the feeling of understanding that comes from working toward change with other women who have had similar experiences. Group work from a feminist perspective has the added components of consciousness-raising and a broad scale social analysis which I viewed as key in work with survivors because of the social prevalence of sexual abuse. The group setting also affords participants with the opportunity to practice and model new skills, and because the practicum objectives involved the process of learning new coping skills, the use of an intervention with these qualities seemed particularly appropriate.

THEORETICAL FRAMEWORK

The group intervention developed for this practicum incorporated the principles of feminist therapy, trauma work, survivor therapy, and strength-oriented perspectives such as the solution-focused approach. Feminist therapy values women and womens' experience, and views the long-term effects of childhood sexual abuse as adaptive and creative coping strategies rather than symptoms of a pathology. Group work from a feminist perspective provides women with the opportunity to heal from sexual abuse in commonality with other women in a safe setting where

power sharing is practiced. Trauma work examines the impact of childhood trauma on the adult, and encourages the development of safety and the practice of remembering and mourning the trauma we have experienced as a way to heal. Survivor therapy grew out of feminist therapy and the trauma model, and specifically articulates a method of work with survivors of childhood sexual abuse. Strength-oriented perspectives, similar to the feminist perspective, strive to see the strengths in an individual rather than the weaknesses or symptoms, and offer many interventions for recognizing and capitalizing on these strengths. Within this practicum, the feminist perspective and trauma theory balance the solely future-focused approach of the solution-focused model with an honouring of past experiences.

The values of generalist social work, and its ecological or person-in-environment perspective, are also incorporated in this practicum, especially the belief in the intrinsic value of all people. The traditional values and the practice of helping women to adjust or adapt to their environment that are inherent in the generalist social work values are challenged by the feminist perspective in this paper. The values in the Social Workers Code of Ethics were also incorporated.

ORGANIZATION OF THE PRACTICUM REPORT

This practicum report reviews issues and interventions related to coping behaviours in childhood sexual abuse survivors. Chapter two is a review and discussion of relevant literature, relating to the long-term effects of childhood sexual abuse, survivors and compulsive coping, current models of intervention, the theoretical framework of the practicum, group work with adult survivors, and issues of group structure, stages, screening, and co-facilitators. Chapter three

reviews the practicum procedures, including information on the setting, the participant selection and screening, and a discussion of the basic group model. Chapter four provides a detailed discussion of the group process, on a session by session basis. The summary of the results and implications is presented in chapter five, and the final chapter evaluates the practicum experience, including a discussion of learning benefits and recommendations for future delivery of the group intervention.

CHAPTER TWO

LITERATURE REVIEW

This chapter is a review of the literature relevant to the issue of coping in female survivors of childhood sexual abuse; it shows that the issue of developing positive coping has been given little attention, despite the fact that most authors view this as a key factor in healing. The issues involved in coping for survivors are reviewed, as are current issues in intervention. The chapter also discusses the definitions that are relevant to the practicum report, and describes the long-term effects of childhood sexual abuse on survivors. It describes the theoretical framework of the report and examines the literature on group work with survivors, as well as on group structure, the phases of groups, and the process of screening and selection. It ends with a discussion of the group worker and her impact on the group participants.

RELEVANT DEFINITIONS

In general, the issue to be studied is the level of positive coping in adult female survivors of childhood or adolescent sexual abuse who have been affected by compulsive coping. This section will discuss the following relevant definitions: child sexual abuse, compulsive coping behaviours, self-esteem, and the self in balance concept.

Child Sexual Abuse: Walker (1998) proposed the following "broad working definition", created from a feminist perspective, of child sexual abuse:

> It is essential to recognize as crucial elements the misuse of power and authority, combined with force or coercion, which leads to the exploitation of children in situations where adults, or children sufficiently older than the victim to have greater strength and

> power, seek sexual gratification through those who are developmentally immature and where, as a result, consent from the victim is a non-concept. Such gratification can involve explicit sexual acts - anal or vaginal intercourse, fondling, masturbation - or may involve invasive and inappropriate actions not directly involving contact: watching a child undress, bathe, use the toilet, in order to gratify the perpetrator rather than meeting the needs of the child; forcing a child to watch adults having sex or making them watch pornographic videos. What is central is the exploitation of the child; the denial of their rights and feelings, and the essential gratification of the abuser through the child, the child being regarded solely as an object for the perpetrator's use and to meet their needs (p.11).

Compulsive Coping Behaviours: The Laurel Centre (1997) has developed a definition of compulsive coping as a part of their clinical statement:

> A compulsive coping behaviour is any behaviour or process that the individual habitually engages in to try and manage emotional states and distress that result from traumatic experiences. These behaviours are then used in less distressing situations, with decreased consciousness around the choice to use these behaviours. Engaging in these behaviours can escalate into a cycle of dependence, where the quick and easy short-term effects of the compulsive behaviour begin to erode the maintenance and development of other skills necessary to manage and resolve distress, which results in increased dependence on the compulsive coping strategy. Compulsive coping behaviours can include drug addiction, self-mutilation, promiscuity, gambling, crisis-seeking, etc.

The Laurel Centre views compulsive coping behaviours as adaptive and resourceful. Therapists assist clients in honouring the creative ways in which they have survived the effects of the abuse. They further acknowledge that women generally have some or many positive coping skills in addition to the compulsive coping behaviours. Part of the goal of therapy is to encourage the increased development of existing positive coping skills, while also helping clients learn new coping skills.

Self-Esteem: The following definition was created by Hart (1993):

> Self-esteem means holding yourself in esteem and knowing you are worthwhile. In affirming your dignity, you know that you have the right to be treated with respect. You

> have the right to be happy. Self-esteem involves a sense of personal competence and confidence in one's ability to deal with life (p.7).

I have assumed a relationship between an increase in levels of positive coping and an increase in levels of self-esteem, but I was unable to find any literature or research to support this assumption. It is based on my clinical experience and the feedback from my co-workers and supervisors. I would argue that as women are able to better cope with the long-term effects of the abuse, they will feel more competent. As they depend less on the compulsive coping behaviours that they view as problematic, I believe they will experience less of the shame and self-blame so often associated with these behaviours and thus experience an increase in general self-esteem.

The Self in Balance: This concept is based partly on Shakti Gawain's book *The Four Levels of Healing* (1997), and partly on the medicine wheel teachings that are a part of Aboriginal culture. The self in balance is a way of living and a way of viewing oneself and the world around us; it involves being aware of the different parts of ourselves - the physical, emotional, intellectual, and spiritual - and nurturing and feeding each part. Neglect of one aspect impacts all of the other aspects, as they are all interconnected; a healing process must focus on all four, as each is a part of the whole.

LONG-TERM EFFECTS OF CHILDHOOD SEXUAL ABUSE

The long-term effects of childhood sexual abuse can be as individual as each survivor, but research has shown that some common themes exist (Briere, 1996; Courtois, 1988; Gil, 1988; Walker, 1995). The most commonly reported effects are low self-esteem, depression, anxiety, shame, self-destructive behaviour, difficulty with interpersonal relationships, lack of assertiveness,

substance abuse, and sexual difficulties. (Beitchman et al., 1992; Briere, 1996; Courtois, 1988; Gil, 1988; Herman, 1992; Walker, 1995). Several of these authors, and others, have categorized the long-term effects into groups (Briere, 1996; Courtois, 1988; Donaldson & Cordes-Green, 1994; Gil, 1988), as identified below.

Courtois, in her book *Healing the Incest Wound* (1988), provides a summary of research into the long-term effects of sexual abuse, naming six categories of effects in survivors: (1) emotional reactions, including anxiety and fear responses, depression, and self-harming behaviours; (2) self-perceptions, meaning general low self-esteem and self concept; (3) physical/somatic effects, such as chronic pain, fear-related effects, and stress-related effects; (4) sexual effects, including arousal and desire disorders, orgasmic disorders, and issues with sexual emergence; (5) interpersonal relating and functioning, divided into the categories of relationships - difficulties with relationships in general, with intimate relationships, with family of origin, and in parenting; and (6) social functioning, ranging from isolation to compulsive social interaction. She argues that the effects "may be chronic manifestations of acute aftereffects or develop in a delayed fashion...some appear and remit sporadically and rather spontaneously" (p.104). She also argues that the severity of the symptoms varies with the type of abuse, based on duration and frequency of the abuse, the type of sexual acts, the use of force and aggression, the age at onset, the characteristics of the perpetrator, initial reaction of the victim, the level of assistance provided to the victim, parental reactions, and the institutional response.

Briere, in his book *Therapy for Adults Molested as Children* (1996), named four categories of long-term effects: (1) post-traumatic stress; (2) cognitive effects; (3) emotional effects; and (4) interpersonal effects. He notes that survivors will have a varying combination of

effects, each of which would fall under one of the above categories, but that he feels most survivors will experience the two core effects of "other-directedness" and "post-traumatic intrusion" (p.54). He defines other-directedness as a quality of hypersensitivity to the emotions and actions of others, and describes post-traumatic intrusion as a group of symptoms such as anxiety attacks, flashbacks, and nightmares.

Donaldson and Cordes-Green, in their book *Group Treatment of Adult Incest Survivors* (1994), describe four categories of long-term effects, based on an extensive literature review: (1) emotional and cognitive effects; (2) social and interpersonal functioning; (3) physical and sexual functioning; and (4) psychiatric diagnoses.

Gil, in her book *Treatment of Adult Survivors of Childhood Abuse* (1988), named three categories based on a sample of 99 people from her clinical practice: (1) psychosocial problems; (2) physical and eating disorder problems; and (3) relationship and sexual problems.

Herman, in her book *Trauma and Recovery* (1992), does not name categories of effects, but provides support for the above-named authors with her discussion of such effects as impairments in self-care, low capacity for forming stable relationships, a lack of self-identity, reenactment of trauma, fear of abandonment, inability to deal effectively with interpersonal conflict, lack of trust, vulnerability to repeated victimization, and coping behaviours that become maladaptive and prevent an integrated identity.

Although not all of the above authors specifically name compulsive coping behaviours as an effect of childhood sexual abuse, all name behaviours that can be viewed as protective actions which may be used to cope with the overall effects. All of the authors make mention of substance

abuse or chemical dependency, and some mention suicidality and self-harming behaviours, eating disorders, promiscuity, and/or dissociation.

SURVIVORS AND COPING

Female survivors of childhood sexual abuse are recognized to be at significant risk for developing adjustment difficulties in adulthood, as reviewed by Beitchman, Zucker, Hood, DaCosta, Akman, and Cassavia (1992). There exists an extensive body of literature regarding the treatment of women who are survivors of childhood sexual abuse, and several approaches have been outlined to deal with the impact of this type of trauma (e.g. Bass & Davis, 1988; Briere, 1992; Burstow, 1992; Courtois, 1988; Herman, 1992; Walker, 1995). In recent years, clinicians have begun to recognize the role of childhood sexual abuse in women's addictive behaviours (Root, 1989; Barrett & Trepper, 1991; Bollerud, 1990; Evans & Sullivan, 1995; Harris, 1996; Simmons, Sack & Miller, 1996). Literature searches turned up little formal research in the area of coping in childhood sexual abuse survivors. An article about coping strategies and post-traumatic stress reactions in women who were sexually assaulted (Valentiner, Foa, Riggs & Gershuny, 1996) provided related information about the most helpful types of coping with post-traumatic stress symptoms (PTSD). The researchers found that mobilizing support by expressing feelings to others, and positive thinking in the sense of cognitive distancing, optimism and acceptance were the most helpful coping strategies, while wishful thinking, meaning that victims attempted to pretend the event did not happen or that they refused to think about it, was the least helpful in ameliorating the effects of the trauma. Although these results were with a population that had experienced recent adult sexual assault, there is value in the study of coping with PTSD

symptoms, which can apply indirectly to survivors of childhood sexual abuse. An article by Binder, McNeil, and Goldstone (1996) studied the level of adaptive coping in adult survivors of childhood sexual abuse who felt they were functioning well. The authors found that several common factors were reported by survivors as helpful in dealing with the abuse: a supportive person in the childhood environment when the abuse took place, hopefulness about escaping the abuse, a special talent or ability that they could focus on throughout the period of the abuse, and the ability to externalize responsibility. This article was mainly useful in terms of predicting future adult functioning according to factors in childhood, but the information could also be helpful for therapists in the sense of providing some direction during the intense debriefing phase of therapy. As therapists usually help clients to place the responsibility with the abuser, and ask about the childhood context and what helped them cope with the abuse in order to reduce self-blame and shame, the above factors could be helpful perspectives to develop in adulthood if they were not present in childhood. Additionally, because hopefulness and optimism about one's potential for healing were seen as predictors for healthier functioning, therapists could take this as a cue to incorporate some future-focused, strength-oriented language and techniques. The solution-focused perspective is discussed later in this chapter to address this point.

Although few authors have formally studied coping in adult survivors of childhood sexual abuse, many have discussed the issue of adaptive coping strategies in a qualitative sense from clinical experience; mainly outlining the types of coping, exploring the way coping strategies are developed, and proposing interventions to help women give up the coping strategies that have become problematic (Bass & Davis, 1988; Briere, 1996; Herman, 1992; Pearlman & Saakvitne, 1995; Walker, 1995). The concept of compulsive coping fits with the feminist perspective in that

it provides an alternative to the viewpoint that the long-term effects of childhood sexual abuse are a syndrome or a pathology. Rather, it honours the behaviours as adaptive and resourceful. Pearlman and Saakvitne note that "it is fascinating to discover the many natural mechanisms that can be activated to protect the self...the various aspects of the self are remarkable" (p. 403). Walker argues that psychiatric diagnoses are not relevant to survivors because "many of their symptoms disappear after supportive therapy that takes a feminist and trauma survivor focus, suggesting that these disorders were actually learned coping strategies and not integrated within victims' personalities" (p.126). Briere (1996) supports this argument by describing the way these coping strategies are developed. He describes the self as a collection of internal skills, and notes that three of these skills are key to a person's response to aversive events: identity, boundary, and affect regulation. Identity is a consistent sense of the self, boundary is one's awareness of the line between self and other, and affect regulation is "important to the individual's management of traumatic experiences and negative internal states" (p. 66). He argues that children in secure and safe environments will progress through developmental stages with ease, gradually developing the ability to tolerate increasing levels of emotional pain;

> In the context of sustained external security, the child learns to deal with the associated uncomfortable (but not overwhelming) internal states through trial and error, slowly building a progressively more sophisticated set of internal coping strategies as he or she grows and confronts increasingly more challenging and stressful experiences. (p.67)

When children lack the external security Briere describes, and instead have their boundaries violated by sexual abuse, they do not develop the repertoire of positive coping skills, instead being forced to develop adaptive coping skills to survive. Bass and Davis devote a chapter of their book

The Courage To Heal (1988) to coping, attempting to help survivors begin to honour what they did to survive:

> Many survivors criticize themselves for the ways they coped. You may not want to admit some of the things you had to do to survive. But coping is nothing to be ashamed of. You survived, and it's important to honor your resourcefulness. While some of the ways you've coped have developed into strengths...others have become self-defeating patterns... Often one behavior will have both healthy and destructive aspects. Healing requires you differentiate between the two. Then you can celebrate your strengths while you start changing the patterns that no longer serve you. (p.45)

Bass and Davis briefly describe the types of coping behaviours commonly used by survivors: minimizing, rationalizing, denying, forgetting, lack of integration of feelings, dissociation, a need for control or a need to create chaos, isolation, hypervigilance, humour, busyness, escape, self-harming behaviours, suicidality, addiction, food or weight preoccupation, lying and stealing, gambling, workaholism, and compulsively seeking or avoiding sex.

Herman (1992) describes how childhood coping translates into the adult world, arguing that "the psychological defenses formed in childhood become increasingly maladaptive" (p.114) and that this structure of defenses may break down later in adulthood, resulting in symptoms that may appear to mimic many psychiatric diagnoses. She describes the "doublethink" and "double self" coping strategies employed by children in abusive environments. Doublethink is a necessity because children need to preserve their primary attachments to caregivers, hence

> the abuse is either walled off from conscious awareness and memory, so that it did not really happen, or minimized, rationalized, and excused, so that whatever did happen was not really abuse. Unable to escape or alter the unbearable reality in fact, the child alters it in her mind (p.102).

The development of a double self is another way for the child to preserve her attachment to her caregivers; she develops a stigmatized identity in which she, rather than the abuser, is bad or evil,

which preserves a sense of hope and power. If she is bad, then hope remains that she can behave in a way that will stop the abuse. This view of the self as inherently bad often remains into adulthood. Herman describes doublethink and the double self as "ingenious childhood adaptations to a familial climate of coercive control, but they are worse than useless in a climate of freedom and adult responsibility...they prevent the development of mutual, intimate relationships or an integrated identity" (p.114).

In summary, the development of coping strategies by child victims of sexual abuse is an adaptive and self-preserving function that often results in problematic coping in adulthood.

CURRENT MODELS OF INTERVENTION

Few models exist for the treatment of women who are dealing with the dual issues of childhood sexual abuse and compulsive coping or substance abuse. Evans and Sullivan (1995) describe a model that employs the twelve-step approach to addiction treatment combined with an eclectic integration of treatment approaches for female substance abusers who are also survivors of childhood sexual abuse. Their model has five stages, beginning with a crisis phase, followed by skill-building, education, integration, and ending with a maintenance phase. Bollerud (1990) developed a treatment model for inpatient chemically dependent women who had survived trauma. The model includes patient education, individual and group psychotherapy, and a component of outpatient follow-up care. More recently, clinicians at The Laurel Centre have developed a feminist treatment model for women dealing with both childhood sexual abuse and compulsive coping (The Laurel Centre, 1999). The clinical model relies heavily on the work of Herman (1992) with trauma survivors, and is comprised of five stages; (1) engaging and

assessing; (2) creating safety; (3) intense debriefing; (4) integrating; and (5) moving on. These phases are not viewed as occurring in a linear fashion, but instead are cyclical in nature with some phases ongoing, and others returned to at different points in the therapeutic process. The engaging and assessing phase is about beginnings and has goals of establishing rapport, determining client goals, assessing fit between the client and the agency, and negotiating the therapeutic contract. Roles and boundaries are established and the therapist normalizes and validates the client's experiences. The creating safety phase focuses on the safety of the therapeutic relationship and further developing trust and boundaries, as well as challenging coping strategies that put the client at risk. Clients are encouraged to develop a broader range of positive coping skills and gain stronger resources, and education and consciousness raising about the issue of abuse begins. The intense debriefing phase involves the processing of the childhood sexual abuse and the context, including assessing the long-term effects of the abuse. Clients are assisted in recognizing personal power, and are encouraged to name and grieve past losses. The integrating phase is one of working toward a more balanced sense of self and achieving congruency (aligning behaviour, affect, and cognition), as well as gaining new coping skills and recognizing past patterns. This phase includes a societal analysis where the client is assisted in placing her experiences within the broader sociopolitical environment and its various forms of oppression. The final phase, moving on, is comprised of the gradual deemphasizing of the therapist's role, the increased development of a social support network, and the encouragement of the client to become her own primary resource in continued healing. Accomplishments are celebrated, potential future difficulties are discussed, and closure of the therapeutic relationship begins, including processing the loss of the relationship (The Laurel Centre, 1999). The Laurel

Centre created a diagram which illustrates the "holistic and cyclical" way in which the therapists work (See Appendix A, The Laurel Centre Clinical Statement).The model recognizes that women who were sexually abused as children often develop a repertoire of compulsive coping mechanisms to help mitigate the daily effects of the abuse, and that these coping mechanisms need to be honoured as survival strategies while also being recognized as behaviours that could potentially become problematic. The model recognizes the link between the effects of the abuse and the compulsive coping mechanisms used to deal with the effects, and that intervention needs to focus on both issues to be effective.

The Laurel Centre's model is the only model I was able to locate that deals with childhood sexual abuse and compulsive coping while also working from a feminist perspective; although many feminist theories of treatment exist for addictions (Bepko, 1991; Kasl, 1992; Wilke, 1994) as well as for sexual abuse survivors (Bass & Davis, 1988; Burstow, 1992; Herman, 1992; Walker, 1995; Walker, 1998). The majority of feminist theories and models of practice for the treatment of childhood sexual abuse and for addictions encourage therapists to assist their clients in developing positive coping mechanisms to deal with the ongoing effects of the abuse (Bass & Davis, 1988; Courtois, 1988; Herman, 1992; The Laurel Centre, 1998), but provide few practical suggestions on how this translates into practice. These models do provide helpful interventions for giving up problematic coping mechanisms, however, and are helpful as a first step. I have found no models of group work for the development of positive coping skills, but several self-help books exist that specifically address this area (e.g. Napier, 1993; Dolan, 1998). Napier's book is called *Getting Through The Day* and is designed for adults hurt as children. She addresses dissociation and its alternatives, identifying our triggers, sitting with feelings, dealing with inner

child parts, shame, social support networks, and hope for the future. A large part of her book is geared toward people with dissociative disorder, and the majority of skills she encourages focus on dissociation and special issues related to those with dissociative disorders; however, many of the techniques are useful and adaptable for group work. Dolan's book, *One Small Step*, is also designed for adult trauma survivors, specifically for those who have completed therapy and healing, but still do not feel they have achieved a life of joy. The book is comprised of readings, written exercises, and hands-on activities that address such topics as enjoying the gifts of the present, exploring the authentic self, relaxation and play, enjoying ourselves more at work, couple and family relationships, hopes and dreams, creating a joyous future, responding to life's challenges, coping when the past comes up, creating a support system, and taking care of ourselves. Her book is positively-focused, and the exercises are easily adaptable to a group intervention; she provides a section on beginning a 'small steps' self-help group, and gives suggestions on how to adapt the exercises. Her ideas fit well with my objectives for the group intervention; I used several exercises, with session four on self-care focused around her rainy day box and letter exercises. Her chapter on 'surviving rainy days' became the handout for week four.

THEORETICAL FRAMEWORK

This section will describe the four models that influenced the practicum intervention: the feminist perspective, the trauma model, survivor therapy, and solution-focused therapy.

The Feminist Perspective: There are many variations to the feminist perspective, resulting in agreement in neither theory or practice within feminist writings (Walker, 1998). However, there are some common central tenets, which I have summarized from the work of

Burstow (1992), Herman (1992), and Walker (1998). Centrally, the feminist perspective values women and womens' experience; feminist therapy uses respect, validation, power-sharing and a strength-oriented perspective to reflect this value. Feminist therapists recognize the power imbalance inherent in therapeutic relationships, and attempt to reduce this power differential by applying information-sharing and explaining their perspective clearly, by using self-disclosure as appropriate and only when it serves the client's best interests, and practicing client self-determination. The feminist perspective believes that women need to have the power to make their own choices, and for this reason the client is seen as central in therapy; she is the expert on herself, and she chooses the goals and direction of therapy. Both the theory and practice of feminist therapy acknowledge and name women's oppression as an effect of living in a patriarchal society. They draw in a discussion of the various types of oppression to help frame each woman's experience within a larger context, helping each client to see herself as part of a larger group of women who share a common experience. The theory encourages group work in therapy because of this belief in sharing experiences and breaking the silence; collectively, women's voices are more powerful, and we draw strength from the connections. As a result of this sociopolitical analysis, feminist therapy places sole responsibility for abusive behaviour with the perpetrator, never blaming the victim; for this reason, feminist theorists have been the most vocal critics of the medical and psychiatric models that serve to blame women and maintain the status quo. The theory views the abusive treatment of women and children in our society as resulting from, and maintained by, the entrenched patriarchal system in which we live.

The feminist perspective was the overarching perspective for the practicum; the other models discussed below were incorporated with the inclusion of a feminist analysis.

The Trauma Model: The trauma model is outlined by Judith Herman in her book *Trauma and Recovery* (1992), and is divided into broad phases: (1) a healing relationship; (2) safety; (3) remembrance and mourning; (4) reconnection; and (5) commonality. The phases are not linear, but complex and cyclical. Herman notes that

> the core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections...in her renewed connections with other people, the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience. These faculties include the basic capacities for trust, autonomy, initiative, competence, identity, and intimacy (p.133).

Empowerment is a cornerstone of the model, as Herman argues that "no intervention that takes power away from the survivor can possibly foster her recovery" (p.133). The first phase of recovery, developing a healing relationship, is actually a pre-phase where the arena for healing is created; it is the phase where the survivor finds safe and supportive relationships that foster her healing. These relationships can be friendships or intimate relationships, but Herman recommends that survivors find a therapist and develop a safe relationship with him or her, including careful development of boundaries and trust. She describes the special issues in transference and countertransference for survivors, and discusses the importance of a therapeutic contract. Safety is the second phase of the process, and the phase where the actual recovery begins. It begins with an assessment phase where the client states the problems, and includes the therapist doing information-sharing about the issues. Establishment of the client's safety is the main task of the phase, starting with the client gaining a feeling of control within her body and gradually moving outward toward some control of the environment, as well as creating a safe therapeutic environment, and implementing a basic self-care plan. Herman also discusses special issues of

safety when the survivor is in an unsafe situation. The next phase of recovery is remembrance and mourning, when the survivor tells the story of her trauma; this happens only once the survivor feels ready, and the client and therapist have negotiated a safe way to complete the process. The survivor describes the known memories, beginning with a narrative reconstruction, and eventually including the concomitant emotions. With this technique, Herman argues that repressed memories may surface, but also notes that full memories are not necessary for recovery, as one memory can stand for many others. This phase also involves mourning the losses that resulted from the trauma, which each client does in her own way. While this phase is never entirely over, the major work is accomplished when the client "reclaims her own history and feels renewed hope and energy for engagement with life" (p. 195). The phase of reconnection is the phase where the client undertakes the task of creating a future for herself; she learns skills in assertiveness to take back her power, works at gaining a sense of self-esteem, and building a support system. The last phase, commonality, is not necessarily the last phase, as it can occur at many points in therapy. It involves membership in a support or therapy group with other survivors, in order to establish a sense of mutual understanding and connection. In summary, Herman views successful recovery as "a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection" (p.155).

Herman's model fits well with the feminist perspective because of its nonjudgemental view of survivors and their coping strategies, and its focus on empowerment, and it has a detailed and thorough description of the impact of trauma without the stigmatizing use of labels, while still providing a useful model of treatment.

Survivor Therapy: This is a model of intervention, but it is summarized here because of its theoretical influence on the practicum. The model has roots in feminist theory and trauma therapy, and is an "approach that is designed to help heal victims of mostly man-made traumas" (Walker, 1995, p.285). The model was recently named by Lenore Walker (1995), although it had been used by other therapists for many years. The model differs from the trauma model and feminist perspectives in its' practical focus. It attempts to more clearly articulate an intervention in accordance with feminist beliefs and drawing on the research and knowledge within the trauma model. The key principles are education, emphasizing client strengths, and gaining an understanding of oppression. The goals are: (1) safety; (2) re-empowerment; (3) validation; (4) exploration of options; (5) cognitive clarity and judgement; (6) making one's own decisions; and (7) healing trauma effects. Walker does not directly make reference to compulsive coping, but the development of positive coping is a part of the self-care necessary to heal trauma effects, which is goal seven above, as well as a part of goal four, the exploration of options, in which clients are encouraged to explore alternatives to past problematic coping strategies.

Solution-Focused Therapy: Dolan (1991) defines solution-focused therapy as a model that seeks to co-create solutions with clients. She says that the solution-focused model is

> based on the respectful assumption that clients have the inner resources to construct highly individualized and uniquely effective solutions to the problems that bring them to therapy...(it) assumes that the construction of a solution is a joint process between client and therapist, with the therapist taking responsibility for empowering the client to create and experience her own uniquely meaningful and effective therapeutic changes (p.30).

Dolan has articulated a model of solution-focused therapy specifically designed for adult survivors of childhood sexual abuse in her book *Resolving Sexual Abuse* (1991). The model has three treatment goals:

> (1) providing stabilization and relief for the client from symptoms stemming from or related to the sexual abuse trauma;
>
> (2) altering feelings associated with memories of trauma, so that the memories and/or flashbacks are no longer intrusive or painfully prevalent in the client's daily life;
>
> (3) developing a positive, practical, and healthy future orientation that results in non-symptomatic patterns and, more importantly, in the client's living what she would consider a "satisfying" life (p.xiii).

She argues that the client needs to gain some physical and emotional stability before beginning the therapeutic process of resolving the abuse, and that once she feels more in control, she is asked to tell the therapist a relevant history, as she feels comfortable. Dolan cautions that therapists need to be aware of safety issues for clients, as flashbacks or flooding of intrusive memories can arise out of this process. She advises deep breathing and comfort objects during the process and reconnecting to the present with a physical object after the process or if the client becomes overwhelmed. The therapeutic process begins after the history is taken, and includes six important tools for therapeutic change: (1) pre-treatment changes; (2) the solution-focused recovery scale; (3) the miracle question; (4) the first session formula task; (5) the older, wiser self-technique; and (6) constructive individual and systemic questions. Pretreatment changes are improvements that occur between scheduling and attending the first session; the therapist attempts to identify such a change to reinforce the concept that the survivor has a "natural ability to experience change in helpful ways" (p.31). The discussion of pre-treatment changes leads into the 'solution-focused recovery scale for survivors of sexual abuse' which was adapted by Dolan as an external device to help clients begin to identify ways they have already begun to heal and signs that they will

continue to heal. The purpose of the scale is to shift the focus toward healing. Clients are then asked to notice the future signs of healing when they occur; Dolan points out that "noticing signs of healing rather than just signs of trauma lays the groundwork for an identity that goes beyond that of victim" (p.31). She encourages therapists to help clients focus on small changes to make the process more manageable and to use the client's significant others as part of the process of noticing existing strengths.

The miracle question is standard solution-focused practice, and Dolan has adapted it for use with survivors: "If a miracle happened in the middle of the night and you had overcome the effects of your childhood abuse to the extent that you no longer needed therapy and felt quite satisfied with your daily life, what would be different?" (p.34). Once the question is answered, survivors are again assigned the task of noticing when those changes begin to occur in their lives. Dolan warns against giving the client the impression that we are trivializing their experience; she encourages therapists to convey support and empathy throughout the process of the miracle question.

The first session formula task is also a common practice in solution-focused therapy. The therapist asks the client, between the first and second sessions, to create a written list of the things in their life they would like to have continue. The purpose of this task is to strengthen the survivor's awareness of the resources that exist in her current life, providing something to 'hold onto' during the intense parts of the therapeutic process when "focusing on the past trauma may tend to eclipse the client's awareness of the safety, comfort, and support available in her everyday life in the here and now" (p.35).

The older, wiser self technique is designed to empower survivors by creating the assumption that the client will make it through the therapeutic process to grow older and wiser; the therapist asks the client:

> Imagine that you have grown to be a healthy, wise old women and you are looking back on this period of your life. What do you think that this wonderful, old, wiser you would suggest to you to help you get through this current phase of your life? What would she tell you to remember? What would she suggest that would be most helpful in helping you to heal from the past? What would she say to comfort you? And does she have any advice about how therapy could be most useful and helpful (p.36)?

The client is asked to write a letter to the 'older, wiser self', telling her what she is currently struggling with, and then reply by taking the role of the older self in a letter offering advice and comfort. This technique also reinforces the perspective that the client harbours the inner wisdom to heal herself.

The final therapeutic tool is constructive individual and systemic questions. These are questions formulated to assist the client in focusing on what is already working to some degree, on imagined solutions, and on ideas for how to make the solutions happen. The responses are individual, and create an individualized treatment plan. Constructive individual questions help the client and the therapist identify a personal definition of what the client needs to resolve the trauma. Examples include "what will be the first, smallest sign that things are getting better? What will be different in your life? Is there some small way that this is already happening?" (p.37). Constructive systemic questions assist the client in discovering ways that she can utilize the support and resources of significant others. Examples are "what do you think that your (significant other) would say would be the first sign that things are getting better? What do you think your (friends, boss, significant other) will notice about you as you heal even more? What

difference will these changes make in your relationship with (significant other)?" (p.38). The changes discussed need to be explored to their ultimate positive conclusion in order for this technique to be optimally effective.

This model is not meant to be brief in terms of number of sessions, but instead continues until clients experience the desired level of change and alleviation of symptoms (p. ix). Dolan's model is a creative adaptation of the traditional solution-focused model, and its perspective was incorporated as a part of the clinician / student's framework while creating the group intervention, couched in the viewpoint of feminist theory, although none of the tools mentioned above were used in an explicit way. The strength-oriented perspective that frames the solution-focused approach was viewed as being compatible with the feminist perspective, as was the inherent belief in the client's ability to create desired change. The model and its tools, however, were viewed as more useful when incorporated as a part of an eclectic approach to intervention.

GROUP WORK WITH SURVIVORS

Butler and Wintram (1991) describe an overview of feminist group work that includes several elements. One element is the need for a balance between structure and flexibility; the authors argue that group facilitators need to provide some structure based on their knowledge and experience, but that being flexible is a good way to share power with the members and allow them to have a feeling of ownership over the group. A second element is the need for some group conflict to help the women learn conflict resolution and join with one another while recognizing their differences, and a third element is the use of a variety of exercises and activities to help participants reach their fullest potential within the group. These activities include individual, large

group, and pairs exercises, and the use of visualization, artwork, discussion, and journalling activities. Women are given the space to make their own choices and be the authority on themselves, as well as being encouraged to join with a group of other women for a sense of community. Butler and Wintram (1991) argue that women find out who they are within a group setting by hearing themselves and seeing how the members respond to them in group.

Several authors note the usefulness of group work for adult survivors (Bass & Davis, 1988; Courtois, 1988; Donaldson & Cordes-Green, 1994; Gil, 1988; Herman, 1992; Walker, 1995). Courtois argues that a safe and nurturant group environment

> allows for the breaking of the secrecy, isolation, and stigma resulting from the abuse and fosters exploration and resolution of the trauma and its aftermath...the sharing and empathy derived from common experiences and reactions, as well as the analysis of the interactions between members, are of great therapeutic value (p. 244).

She outlines a rationale for group work with survivors, citing several benefits: (1) identification with other members and establishing a therapeutic alliance with them; (2) recognition of commonalities among members; (3) breaking secrecy and acknowledging the abuse; (4) the group as support network or new surrogate 'family'; (5) context and catalyst for the exploration of emotions and beliefs; (6) context and catalyst for the challenging of beliefs and childhood messages; (7) a unique forum for grieving; and, (8) observation and exploration of interactional patterns and client dynamics. A group intervention for developing positive coping seemed particularly relevant for these reasons and because Courtois argues that the recognition of commonalities is especially normalizing in terms of the experience of after-effects and coping strategies. Donaldson and Cordes-Green (1994) state that the ability to create bonds with other group members may reduce feelings of helplessness and increase a sense of personal power.

Herman (1992) argues that "the solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience" (p. 214).

GROUP STRUCTURE, STAGES AND SCREENING

Group Structure: The length of groups for survivors as reported on in literature range from four to twenty sessions (Bass & Davis, 1988; Cole, 1985; Donaldson & Cordes-Green, 1994; Gil, 1988; Saxe, 1993). Courtois (1988) argues that groups of between ten and twenty sessions are the most useful; groups with less than ten sessions have "limited utility" (p. 249) but groups with more than twenty sessions encourage dependency on an authority figure and prevent the development of other helpful relationships. She does feel that short-term groups are best because they "limit the level of anxiety experienced by a survivor considering joining a group" (p. 250). Gil (1988) points out that women "may feel more able to make this short-term commitment" (p. 205). Herman (1992) also supports the time-limited format because the format encourages bonding more quickly, but cautions against groups shorter than twelve weeks because they do not provide enough time to establish trust and safety, which she views as a requirement for group utility. Gil (1988) offers twelve week groups and then "recontracts with the same clients for additional sessions" (p. 204), while Donaldson and Cordes-Green (1994) argue that groups longer than twelve weeks allow for more growth and more time to gain coping skills. Little research exists on the utility of groups of various lengths, and Herman (1992) and Schadler (1992) note that group members complain about the time limit of a group no matter how long or short the group. Groups at The Laurel Centre are generally twelve weeks, based on agency experience and client feedback.

Group Stages: Several authors believe that the stages in group work for survivors are similar to the stages in individual therapy (Briere, 1996; Courtois, 1988; Gil, 1988; Herman, 1992). Although these authors differ in the number of stages they identify, most begin with a phase of creating safety and negotiating group rules, followed by a phase of deep work on sharing experiences and working through the trauma, and ending with a phase of practicing new behaviours within the group and beginning to use the behaviours outside of the group environment. Many authors consider a formal celebration and closure session to be an important feature of a time-limited group (Briere, 1996; Courtois, 1988; Gil, 1988). Herman (1992) uses a different group format by providing a twelve week group for each of the three phases of her model: the group designed to establish safety helps members to create boundaries and begin to practice self-care, the group for remembrance and mourning focuses on healing the past by working through the trauma, and the group for reconnecting helps the survivor create social support networks and reintegrate into the community. All of the above authors recommend that facilitators foster an environment of flexibility along with the structure of the phases.

Group Screening: Despite groups being a highly recommended format for healing, a screening process is encouraged in order to assess prospective participants for readiness to participate in a group intervention (Courtois, 1988; Walker, 1995). Donaldson and Cordes-Green (1994) describe the pre-group interaction as a vital component, noting that participants begin to prepare for the group in the initial individual screening session. They are provided with the opportunity to gain information about the group, ask questions of the therapist, and get a sense of the therapist's way of working. Courtois (1988) defines the pre-screening interview as involving the following:

> the therapist or co-therapists meet individually with each potential member to assess her motivation, dynamics, issues, interpersonal skills, and general suitability for the group. The intake interview has several other purposes, including introducing the survivor to the goals, structure, and functioning of the group, and serving as a preliminary forum in which she acknowledges and talks about the abuse and her reasons for wanting a group experience (p.256).

Authors differed in their opinions about reasons to potentially exclude participants. Schadler (1992) warns against including women who are suicidal or psychotic, and Courtois (1988) noted the following contraindications for group participation: "acute psychosis, active homicidal or suicidal behaviour, severe substance abuse, lack of motivation to change, dread of self-disclosure, a high degree of denial, and paranoid, sociopathic, and strongly narcissistic or borderline personalities" (p.254).

THE GROUP WORKER

Most authors recommend a co-therapist team for survivor groups (Courtois, 1988; Herman, 1992; Saxe, 1988). Herman argues that the task of bearing witness to the stories of survivors is a formidable task that should be shared, and that the team should be two women who create a climate of peer cooperation. She feels that a male-female co-therapist team would reenact the traditional pairing of a high-status man and a low-status woman, creating a climate of subordination and dominance. Courtois recommends the co-therapist team as it allows for "mutual therapist support and shared observation and processing of group interaction patterns and issues" (p.263), but she has less commitment to the team being female. She agrees that "strong justification" (p.263) exists for a female co-therapist team, but feels that the male-female team should be tested for its effectiveness as well. The issue of compatibility is also key; the

therapists must feel comfortable with one another and feel able to work as a team and support one another.

More crucial than the gender or co-leadership issue is the issue of experience and understanding. Both Courtois (1988) and Dolan (1991) argue that the therapist needs to have an understanding of child development, long-term impacts of childhood sexual abuse on adult survivors, and group dynamics. There is disagreement on the issue of whether the therapists should, or should not, be survivors themselves. Walker (1995) believes that non-survivors are at a disadvantage because their empathy for survivors may be inhibited, and their ability to respond to the needs of survivors impaired. Davies and Frawley (1994) feel that a traditional neutral stance may hinder the survivor's healing, while Dolan (1991) feels the more important issue is not whether the therapist is a survivor, but rather that she has worked through her victimization. Courtois (1988) discusses the advantages and disadvantages to both alternatives, noting that some clients feel that a non-survivor would not understand them, while others feel that non-survivors provide a more positive role model with a 'normal' childhood. The issue of vicarious traumatization is discussed by Pearlman and Saakvitne (1995), who encourage group therapists to create a balance in work, rest and play to reduce the inevitable effects of trauma work. In summary, group therapists must have worked through their issues and be able to nurture themselves and provide a good role mode for group members. They must also have an understanding of the issues faced by survivors and of groups and how they work.

CONCLUDING SUMMARY

The literature on coping in female survivors of childhood sexual abuse shows how adaptive coping strategies used in childhood can become problematic for adult survivors, as well as highlighting the importance of the development of a repertoire of positive coping skills to ameliorate the day to day long-term effects of the abuse. A review of the group literature supports the use of a group intervention for survivors who need to develop positive coping; working in connection with other survivors is seen as being a normalizing and validating experience, especially when the group intervention has a feminist orientation with its empowering, strength-oriented focus. The experience and education of the therapist is also key to the healing process of the group, as is the therapist's attention to her own issues of previous and vicarious trauma.

CHAPTER THREE

PRACTICUM PROCEDURES

This chapter provides a description of the agency setting for the group intervention, information about the practicum committee and the participant selection and intake procedures, a discussion of the group co-facilitators, and ends with an overview of the group model, including the objectives and the session format.

THE SETTING

The practicum intervention took place at The Laurel Centre at 62 Sherbrook Street in Winnipeg, Manitoba, which is the clinician / practicum student's place of employment. The Laurel Centre, formerly known as The Women's Post Treatment Centre, opened in 1985 as an agency that provided counselling to women survivors of childhood sexual abuse who have been affected by compulsive coping. The idea for such an agency grew out of the experiences of two women working in the addictions field who were concerned about the number of their female clients who were struggling with the dual issues of addiction and childhood sexual abuse. The mission statement of The Laurel Centre is:

1) To enable the provision of counselling services for women who have experienced childhood or adolescent sexual victimization and want to resolve long-term effects of the abuse. The agency recognizes compulsive coping behaviours as one of the long-term consequences related to unresolved trauma.

2) To address the issue of social denial - of the seriousness and prevalence of the problem of childhood sexual abuse - and the detrimental long-term effects (one of which is compulsive coping behaviours).

The philosophy of The Laurel Centre, according to the 1999 Annual General Report, is as follows:

> The Board and Staff of The Laurel Centre believe:
>
> - that women have a right to social, political, and economic equality and power
> - that childhood sexual abuse has a long-term damaging effect over one's well-being (physical, emotional, social, spiritual, intellectual), and one of these effects is the adaptation of compulsive coping behaviours
> - that problematic adaptation is a consequence of inadequate resources and supports, rather than a reflection of deficiencies within the woman
> - that women have the right to choose the course of their own healing process
>
> Given these beliefs, The Laurel Centre provides counselling which allows women to understand the context of their lives and to make the link between their compulsive coping behaviours and the trauma experienced in their childhood. This understanding empowers them to make life-affirming choices and to resolve the impact of trauma by integrating physical, emotional, intellectual, social, and spiritual aspects of self in context.

The direct clinical work at the agency begins with the intake process which involves a brief assessment, usually by telephone, for the agency criteria of a history of child and/or adolescent sexual abuse and compulsive coping behaviours. Women are placed on the waiting list, which is currently twelve to fourteen months long. Once a woman's name nears the top of the list she may enter either the precounselling or the parenting group, or if group counselling is not an option, she begins individual counselling. A Youth Program, for clients aged 16 to 24 years, exists to address the specific needs of women from this age group. The agency works with approximately 300 clients per year, with the average length of counselling being one year (The Laurel Centre, 1999, p.19). Clients are either self-referred or are referred by a variety of community agencies, and typically have a long history of help seeking from addiction and mental health services (p.25). The agency also regularly delivers a sexual abuse group, and has run a sexuality group in the past

which will continue to be run occasionally, and a newly created anger group was delivered for the first time in January 1999. The agency has a couple counselling program for clients of the agency and their partners, which grew out of the belief that continued growth for clients often depends on the continued growth of their couple relationship. Other services provided by The Laurel Centre are the training and awareness program and the newly created Girls Outreach Program run in partnership with the Andrews Street Family Centre. The training and awareness program aims to share knowledge with other professionals and the community as a whole through the provision of workshops and presentations on the issue of childhood sexual abuse and its long-term effects. The Girls Outreach Project provides outreach education to girls aged 8 - 16; the focus is to help the girls establish boundaries, develop self-confidence, and gain awareness about the issues of abuse and violence (See Appendix B for The Laurel Centre Therapy Program Chart).

THE PRACTICUM COMMITTEE

The practicum committee consisted of: the main advisor, Kim Clare, MSW, of The University of Manitoba, Faculty of Social Work, Winnipeg Education Centre campus, who provided ongoing student supervision on an as-needed basis; external examiner Heather Block, BSW, Executive Director of The Laurel Centre, who provided clinical supervision on-site; and Ellen Tabisz, MSW, adjunct professor in the Faculty of Social Work and previous Executive Director of The Laurel Centre.

PARTICIPANT SELECTION AND INTAKE

The group intervention was offered as an option to all clients of The Laurel Centre who were involved in long-term counselling during the months of November and December, 1998. Due to the mandate of the agency, all group participants would have survived childhood or adolescent sexual abuse and have compulsive coping issues. Because the group was offered to all clients, the possibility existed that participants had been involved in individual therapy for several years or for only a few weeks. The intent was to allow a maximum of ten participants per group. One group ran in the evening and one in the afternoon, to allow for flexibility in accommodating participant schedules. Each interested client was referred by their individual therapist and an intake session was booked with the clinician / student. It should be noted that I offered the group to all of the clients in my own caseload, and I booked intake sessions myself with the interested clients. I will discuss the issue of how this impacted the intervention (and consequently the measurement process) in chapter five. The purpose of the intake sessions was fourfold: a) to provide potential participants with more detailed information about the group being offered, including the objectives and the session outline; b) to complete a brief assessment of potential participants, including information about their support systems, expectations, and previous group experiences; c) to describe the practicum aspect of the intervention, including the measurement plan, the questionnaires, and consent information; and d) to make an initial connection with the co-therapist(s) to assist in the development of safety in the group intervention. There was no intent to screen out participants; the women were allowed to judge for themselves whether they felt ready to participate in a group process, with the only disclaimer being a request that participants not come to sessions under the influence of drugs or alcohol. This is consistent with

the practice of The Laurel Centre, which does not easily screen clients out for suicidality or substance abuse because of the understanding that women use adaptive coping behaviours in order to survive on a day to day basis; to screen women out on the basis of these behaviours would rule out many clients in need of the service (See Appendix C, Group Intake Form; Appendix D1 & D2, Consent Information; and Appendix E, Consent Form). The final number of participants for the first sessions were six in the evening group and seven in the afternoon group; one person dropped out of each group after the first session, for a final number of eleven participants. One woman dropped out because she felt that the group would not meet her needs, and the other did not show up for the second session and dropped out of her individual work at the same time. She did not contact the agency again and attempts to contact her were unsuccessful. In addition, one participant for each group dropped out before the groups had started; one woman ended up choosing to participate in an anger group running concurrently at the agency, and one woman opted out because of personal commitments. The final eleven participants attended fairly consistently, with absences mainly due to illness.

Of the eleven participants, there was a range in ages from twenty-five to fifty. The women identified a range of compulsive coping behaviours within the context of the intake sessions: more than one woman identified alcohol abuse, overeating, sleeping, suicidality, and overfunctioning. Other coping behaviours mentioned by participants were depression, self-harm, over-exercising, anxiety, and crying. It should be noted that every woman was able to name at least one positive coping mechanism she used regularly. Demographic information is presented in chart form (see figure one and figure two, below) for each of the two groups.

Figure One

DEMOGRAPHIC INFORMATION - GROUP 1

Client	Age Category	TLC Grp Exp?	Other Grp Exp?	Length of Therapy	Employmt Status	Relationsh Status	# of Children
1	45 - 49	yes	yes	15 months	disability	single	0
2	35 - 39	yes	no	8 months	working	single	1
3	35 - 39	no	no	1 yr 8 ms	homemkr	married	1
4	45 - 49	yes	no	5 years	disability	single	2
5	50 - 54	no	yes	3 months	assistance	single	2
6	25 - 29	no	no	9 sessions	assistance	married	0

Figure Two

DEMOGRAPHIC INFORMATION - GROUP 2

Client	Age Category	TLC Grp Exp?	Other Grp Exp?	Length of Therapy	Employmt Status	Relationsh Status	# of Children
1	35 - 39	yes	yes	18 months	working	married	2
2	25 - 29	yes	yes	8 months	working	com-law	0
3	30 - 34	yes	no	6 ½ yrs	working	single	0
4	25 - 29	yes	no	6 months	working	com-law	0
5	40 -44	yes	no	3 yrs 3ms	working	com-law	2

There were some themes evident in the responses to the intake questions. All of the women had previous group experience and all but two had similar responses to the question of what they liked least about previous groups, saying that having a member in group who dominates the discussion or takes up too much group time was frustrating. Most of the women liked the sharing and support aspects of group, and liked a variety of exercises. Two women did not like the artwork exercises in previous groups, but said they would try them, and three women said that journalling was difficult, but that short journalling tasks were not as daunting. An interesting aspect of the intake responses was that all of the women, for the question on expectations, pointed out that they knew what positive coping was and knew what they 'should' do when stressed or in crisis, but wanted to learn about new and creative, but practical, ways to incorporate positive coping. There was also unanimous agreement that they wanted to hear other women's stories, especially about how they cope, and that they anticipated support from the other group members.

THE GROUP CO-FACILITATORS

Both of the practicum groups had a co-facilitator; each was a volunteer new to the agency. The potential volunteers were pre-screened by the clinician / student and the agency Executive Director. The volunteer chosen for the afternoon group was a social worker with a BSW degree who had five years of experience in the child welfare field and was employed as a family support worker. The volunteer for the evening group was a student of the Applied Counselling Certificate Program at Red River College; she had just completed the first half of her practicum at The Laurel Centre as an intake worker, and expressed an interest in co-facilitating

the group as the second half of her practicum. The volunteer for the afternoon group was unable to be involved in the intake process, and the evening group volunteer was involved in all but two of the intake sessions. In the case of the two sessions she was unable to attend, I arranged for the two women to arrive early to meet the co-facilitator so that they would not be the only two participants who had not met her before the first session. Both of the volunteers were involved in pre-planning the group sessions according to the existing agenda, as well as debriefing after sessions.

THE GROUP MODEL

Purpose: The group I created is called "Developing Positive Coping", and is a twelve week group intervention designed for survivors of childhood sexual abuse. The purpose or objective of the group is threefold:

1) To help women who have survived childhood sexual abuse to recognize and honour the adaptive ways in which they have coped with the effects of the abuse;

2) To examine these coping behaviours from a cost / benefit perspective, and provide a space for women to choose whether to continue or begin to replace these behaviours; and

3) To explore more positive ways of coping with the effects of childhood sexual abuse that reflect the goal of the self in balance; including the physical, emotional, intellectual, and spiritual aspects of the self.

The group was developed as a response to the perceived gap that can exist in service to women who have compulsive coping or addiction issues. Therapy tends to help women learn to leave behind problematic coping behaviours, without helping women learn concrete ways to replace the

coping mechanisms left behind with more positive coping skills. The concept was influenced by Yvonne Dolan's book, *One Small Step* (1998) which focuses on helping survivors of abuse move beyond the label of 'survivor' to a life of joy. She sees the label of survivor as a badge of courage, but also feels that many women finish therapy having worked on the effects of the abuse and reducing their dependence on problematic coping mechanisms without learning how to have a full and joyful life, and that they tend to continue to view everything through the lens of a survivor rather than a 'thriver'. Unlike Dolan's book, this group is designed not only for women who are nearing the end of therapy and are at the point of integrating their work, but also for women who are just beginning therapy, those who may have recently given up a long standing coping mechanism, and needing tools to help them get through the day, as well as women at any other point in therapy. I feel that all survivors could potentially benefit from this type of intervention.

Format: The group used various types of activities: large group discussions and 'brainstorming', individual journalling exercises, artwork, visualization, breathing and relaxation exercises, readings, and 'homework' tasks between sessions. The sessions were designed around a common format:

a) Breathing Exercise: we opened each session with a breathing exercise to 'open the circle', clearing a space to begin the session and, potentially, helping each woman feel more centred or grounded. The breathing exercise was the same each time, asking women to take several deep breaths and imagine healing light entering their bodies with each breath, and the stresses of the day or week leaving their bodies with each exhalation to help them be more able to be present for the group. The exercise was done slowly, and took three or four minutes.

b) Check-in and Check-out: all of the sessions then started with a check-in and ended with a check-out. This is a practice of completing a 'round' in which each participant has the chance to speak briefly without interruption about how she is feeling, using a speaking stone to signify that the holder of the stone is the current speaker. This provides each woman with at least two opportunity for uninterrupted speaking time and lets the other group members and the co-facilitators know where the other members are at for the session, or how they feel as they leave.

c) Leftovers: we dealt with leftovers from the previous session immediately after the check-in, in a round format (described below), including the homework from between sessions and any other issues participants felt the need to discuss. Each week we also handed out the copies of any brainstorm topics from the previous session, for example, the group expectations and group agreement.

d) Session Introduction: the co-facilitators introduced the topic and went over the agenda (which was always posted on large flipchart paper in a visible location throughout the session) for the evening, providing a context for the session within the self in balance wheel and the four aspects of self. We would also read the quote for the session, which was an inspirational or hopeful quote that was related to the session topic. (See Appendix F, Group Quotes).

e) Order of Activities: the activities were planned to begin slowly, build in intensity, and then end on a lighter note. The first activity was generally a brainstorm or large group exercise so that the women could join together as a group around an issue or topic, followed by an individual or pairs exercise that was more intense, then a break of ten minutes for refreshments and informal joining. Sessions wrapped up with sharing about the individual or pairs exercise, and a 'lighter' exercise, then discussion about homework and the next session's topic.

f) The Use of "Rounds": when I reviewed all of the intake forms, I noticed that all but two of the participants had similar responses to the question about what they liked least about previous group experiences. They disliked one participant dominating the discussion or taking up too much session time. In response to this, we proposed the use of a round format with a speaking stone used when sharing or debriefing about an exercise or activity. This format is separate from the concept of "brainstorming", where participants are encouraged to speak their ideas as they come to them, around a certain issue or question. The use of rounds or a speaking stone does not preclude the supportive nods or quiet encouragement of others. All of the members agreed to this in the first sessions, and we instituted its use throughout.

g) Homework and Handouts: each session included handouts of relevant articles and/or materials, often from self-help books; the hope was to help participants gain more information about the topic in a different medium. Homework tasks were assigned each week to assist participants in processing the work of the session.

h) Self-Care Basket: as participants completed the check-out, a basket full of small, inexpensive self-care items was passed around, and each woman could choose an item for herself; the hope was to encourage ongoing self-care. The participants were asked to bring small items, as they were able to, in order to replenish the basket.

As with many groups, there is an educational component that runs throughout the sessions, and a component of group support that often cannot be articulated. Being exposed to the experiences and feelings of other women can be more powerful and impactful than any of the purposeful activities. The group used the self in balance framework as a guide; as the objectives state, the hope is to bring the physical, emotional, intellectual, and spiritual aspects into balance.

The group outline reflects the self in balance concept by providing topics to address each of the aspects of the self:

GROUP OUTLINE

Introduction and Creating Safety

Week One - Introduction to Group

Week Two - Ways We Have Coped

Physical Aspect of Self

Week Three - Creating Safety

Week Four - Self Care

Emotional Aspect of Self

Week Five - Emotional Protection Planning

Week Six - Boundaries and Assertiveness

Intellectual Aspect of Self

Week Seven - Creativity

Week Eight - Openness to New Things

Spiritual Aspect of Self

Week Nine - Exploring Spirituality

Week Ten - Finding the Sacred and Accessing Joy

Closure and Celebration

Week Eleven - Pulling it All Together

Week Twelve - Ending Celebration

After an introductory session and a session that looks at the ways participants have coped in the past, sessions three and four address the physical aspect of the self with the topics of creating safety and self-care. These are designed to help women increase personal safety and understand and increase their level of self-care. Sessions five and six deal with the emotional aspect of the self; the session on emotional protection planning helps participants develop a concrete plan for times of emotional stress, and the boundaries and assertiveness session assists women in identifying and maintaining their personal boundaries. The intellectual aspect of the self is explored in sessions seven and eight; session seven explores creativity and its potential importance in healing and coping, as well as ways to incorporate creativity into our lives, and session eight, called Openness to New Things, presents the importance of expanding our inner experience beyond therapy and abuse issues. Sessions nine and ten explore the spiritual aspect of self, first by looking at the role of spirituality in healing and coping, and next at finding the sacred in our everyday lives. The eleventh session attempts to pull the previous sessions together and integrate the work by revisiting the self in balance concept, and reexamining participant expectations. The final session functions as a celebration and hopes to achieve a sense of closure. The group agendas follow, each including the objectives of the session.

Week One
Introduction to Group

Objectives

1) To introduce group members to one another and the group process
2) To create a group agreement
3) To discover participant expectations
4) To introduce the concepts of self-care and journalling
5) To introduce the medicine wheel concept of the self in balance

Activities

1) Welcome to Group
   - -introduce leaders
   - -restate purpose of group
   - -go over outline and agenda

2) Breathing Exercise and Check-in
   - -introduce concept of check-in and check-out
   - -participants introduce themselves and check-in

3) Create Group Agreement
   - -brainstorm in large group what we need to feel safe
   - -create list to be posted each session

4) Expectations
   - -in pairs, discuss what they expect from being in the group
   - -participants report back and create group list

5) Medicine Wheel / Self In Balance
   - -introduce concept of the self in balance
   - -present drawing of medicine wheel to be posted each session
   - -brainstorm: examples of positive coping for each aspect of self

6) Self-care
   - -introduce concept and importance of self-care
   - -provide self-care list handout

7) Check-out and Self-care Basket
   - -introduce self-care basket

HOMEWORK: journal about what you hope to get out of the group for yourself

Week Two
Ways We Have Coped

Objectives

1) To enable participants to identify their adaptive coping behaviours as survival skills (Including addictive behaviours)
2) To reduce guilt and self-blame by normalizing coping behaviours
3) To enable participants to make a choice about employing current coping by increasing awareness of the costs/benefits of these behaviours

Activities

1) Breathing Exercise and Check-in

2) Leftovers / Homework

3) Coping Skills
   - -introduce concept(discuss socially acceptable/unacceptable coping)
   - -large group brainstorm: Ways We Have Survived
   - -discuss ways we have been put down for these behaviours / shame

4) Costs and Benefits
   - -introduce the idea of the costs and benefits of coping skills and how coping skills can become another problem.
   - -choose one or two of the coping skills that seem applicable to most participants and create a flipchart of costs/benefits

5) Journalling
   - -each person journals about one of their coping skills they would like to change, and does a cost/benefit chart. Share feelings about exercise in large group.

6) Strengths
   - -brainstorm a list of the strengths we have developed as survivors

7) Check-out

HOMEWORK: continue to journal about the cost/benefits of current coping skills.

Week Three
Creating Safety

Objectives

1) To develop an understanding of the concept of safety and its importance
2) To examine ways to increase personal safety

Activities

1) Breathing Exercise and Check-in

2) Leftovers / Homework

3) Safety
   -introduce concept and importance

4) What Can We Do When We Feel Overwhelmed?
   -brainstorm list of ideas

5) Collage
   -create a collage of what you need to feel safe
   -share / debrief in large group

6) Visualization
   -visualization to create a safe space

7) Check-out

HOMEWORK: try to do one small thing this week to increase the safety of your spaces.

Week Four
Self Care

Objectives

1) To gain an understanding of the importance of self-care
2) To examine ways that participants can begin self-care or increase self-care in their daily lives

Activities

1) Breathing Exercise and Check-in

2) Leftovers / Homework

3) Self-Care
   -discuss the concept of self-care and its importance

4) Rainy Day Boxes
   -introduce the concept of a Rainy Day Box and provide handout
   -brainstorm the types of things we could put in our boxes
   -create Rainy Day Boxes: provide shoe boxes to be covered with flipchart paper and decorated (can be painted, coloured, things can be glued on - sparkles, shells)

5) Rainy Day Letter
   -introduce concept of Rainy Day Letter to be included in the boxes
   -each participant writes herself a Rainy Day Letter
   -share / debrief rainy day box and letter in large group

6) Check-out

HOMEWORK: continue to work on the Rainy Day Box, and find things to place in it. Make some self-care coupons for yourself.

Week Five

Emotional Protection Planning

Objectives

1) To introduce the concept of emotional protection planning and when we may need them
2) To create detailed emotional protection plans to help participants cope in times of stress

Activities

1) Breathing Exercise and Check-in

2) Leftovers / Homework

3) Emotional Protection Plans
   - -introduce concept of emotional protection planning
   - -discuss when we may want to use the plan
   - -individually complete emotional protection plan sheets
   - -share feelings about exercise in large group

4) Using Emotional Protection Plans
   - -brainstorm: what could get in the way of our using the EPP? What could help us use them? Choose an obstacle and brainstorm solutions.

5) Affirmations
   - -introduce concept of affirmations
   - -create group list of affirmations
   - -participants create several affirmation cards for themselves

6) Relaxation
   - -discuss importance and function of breath work
   - -present 5-4-3-2-1 relaxation method
   - -practice in pairs

7) Check-out

HOMEWORK: use the affirmation cards and try the relaxation exercise. Journal about these experiences.

Week Six

Boundaries and Assertiveness

Objectives

1) To introduce the concept of boundaries and their role and importance in our lives
2) To identify our boundaries and ways to maintain them
3) To introduce the concept of assertiveness and its role in boundary maintenance

Activities

1) Breathing Exercise and Check-in

2) Leftovers / Homework

3) Boundaries
   -introduce concept of boundaries, their importance, impact of abuse on boundaries
   -boundary exercise: experiment with our reactions to various types of boundaries in pairs, using masking tape to represent boundaries.
   -share / debrief in large group

4) How can we maintain our boundaries?
   -brainstorm in large group

5) Assertiveness
   -define assertiveness and discuss the role of assertiveness in boundary maintenance. Provide handouts.

6) Check-out

HOMEWORK: complete assertiveness exercise sheet

Week Seven
Creativity

Objectives

1) To explore the concept of creativity and its potential importance in our healing and living in balance
2) To explore ways participants could incorporate some creativity into their lives

Activities

1) Breathing Exercise and Check-in

2) Leftovers / Homework

3) Creativity
   -introduce concept of creativity and how it can be healing. Discuss The Artist's Way by Julia Cameron.
   -brainstorm ways we can incorporate creativity into our lives.

4) Clay Pots
   -participants decorate clay pots - paint, decorate with shells, beads

5) Imaginary Lives
   -participants list ten imaginary lives they would like to lead
   -share in large group and create list
   -discuss ways we could begin to incorporate small aspects of these imaginary lives into our own lives

6) Check-out

HOMEWORK: journal about the types of creativity we may have hidden within us.

Week Eight
Openness to New Things

Objectives

1) To explore the importance of expanding our inner experience
2) To understand why participants need to take breaks from therapy
3) To examine ways participants could begin to learn new things to prevent overload of abuse information

Activities

1) Breathing exercise and Check-in

2) Leftovers / Homework

3) Openness to New Things
   -introduce concept, importance of having intellectual variety, especially during therapy
   -brainstorm list of why we need breaks from therapy: what happens when we don't take breaks?

4) Individual Exercise
   -participants make a list of ten things they enjoy doing; provide as a handout with examples
   -in large group, ask when the last time was that participants did the things on their list. Discuss

5) Sensory Relief Exercise
   -participants create a booklet of images (drawings or from magazines) that help to remind us of positive sensory experiences, to be used as sensory breaks for self-care and stress relief
   -share / debrief in large group

6) Check-out (give out plants for clay pots from last session)

HOMEWORK: participants choose two items from their list of ten items, and do them throughout the week. Journal about the experience.
-Buried Dreams exercise, p. 86 from The Artist's Way

Week Nine
Exploring Spirituality

Objectives

1) To explore the role of spirituality in participants' lives and healing
2) To explore ways that participants could begin to experience or strengthen their spirituality

Activities

1) Breathing Exercise and Check-in

2) Leftovers / Homework

3) Spirituality
   -discuss spirituality and the many different forms it can take, and how CSA can make us cynical about spirituality.
   -brainstorm: what has allowed us to keep searching and remain hopeful despite the negative things that have happened to us?

4) What does spirituality mean to us?
   -individual participants journal about what the spiritual means to them and how they feel connected to it, if at all
   -debrief / share in large group

5) Groundedness / Being Present
   -discuss groundedness and being present as a type of spirituality
   -brainstorm: practices that help us connect with the spiritual, then choose one practice and outline the steps

6) Visualization
   -facilitators lead a visualization about discovering our spiritual selves

7) Check-out

HOMEWORK: participants journal about ways they want to increase spirituality in their lives, if at all.

Week Ten
Finding the Sacred and Accessing Joy

Objectives

1) To explore the sacredness and beauty in the everyday world
2) To discover ways to begin to recognize the sacred as a way to enhance the spiritual aspect of self

Activities

1) Breathing Exercise and Check-in

2) Leftovers / Homework

3) Finding the Sacred and Accessing Joy
   -introduce the concept of finding the sacred in the everyday and how this enhances the spiritual aspect of self
   -brainstorm a list of some small joyful things we could delight in

4) Small Joyful Things
   -participants create cards with ideas of small joyful things from the brainstorm list to place in their rainy day boxes

5) Plan Final Celebration Session
   -plan the celebration session as a group, in round format

6) Check-out

HOMEWORK: participants start trying to create sacred spaces and times for themselves and journal about this.

Week Eleven
Pulling it All Together

Objectives

1) To re-examine participants' expectations of the group
2) To attempt to integrate the work in the perspective of the self in balance and to revisit the medicine wheel

Activities

1) Breathing Exercise and Check-in

2) Leftovers / Homework

3) Review Expectations
   -review the list of expectations created in session one, and reflect on them in the large group

4) Self in Balance
   -revisit medicine wheel, discuss self in balance and how we can integrate what we have learned into that larger framework. Participants individually complete self in balance handout, and journal about how the wheel has changed for them

5) Collage
   -each participant will create a self in balance collage on a self in balance wheel - the areas can be filled with drawings, and words/pictures cut from magazines to represent the ways she can continue to positively cope to keep her self in balance. Shared in large group

6) Check-out

HOMEWORK: participants journal about ways they will continue what they have learned in the group.

Week Twelve
Ending Celebration

Objectives

1) To reflect on the process of the group
2) To have a sense of celebration and closure as the group comes to an end

Activities

1) Breathing Exercise and Check-in
   -reflecting on the group process and how it feels to end

2) Mailboxes
   -participants receive small pieces of paper, and they write appreciative notes to the other participants. These are placed in envelopes, one for each person, to be opened and read after the participants leave the session

3) Celebration
   -food, activities, etc. as planned by group participants

4) Check-out
   -using a shell and water ritual - as participants check-out, a bowl of water is passed around with a bowl of shells. Each person chooses a shell, and places it in the bowl of water, naming one thing she is leaving behind in the water, then washing the shell and removing it, naming one thing she is thing she is bringing with her from the group. The shells are kept as a reminder of the group and what each woman is taking with her.

The group intervention included potential post-session debriefing with clients, and the clinician / student was available by telephone or for individual sessions in the case of crisis. All of the participants were engaged in individual therapy at the agency and processed some of the group work with their individual therapist.

CHAPTER FOUR

THE GROUP PROCESS

This chapter provides an overview and discussion, on a session by session basis, of the two "Developing Positive Coping" groups that were implemented with a total of eleven participants. There were twelve sessions, two and a half hours each in length. As previously described, the sessions were divided into six phases of two sessions each based on the four aspects of self within the self in balance concept, and in this chapter, each section will be preceded by a brief description of the pertinent phase. Phase one, which includes sessions one and two, was the introductory phase, and was mainly concerned with establishing safety. It focused on introductions, the creation of a group agreement, and a beginning look at the concept of coping. Phase two included the two session topics that addressed the physical aspects of the self, creating safety and self-care. These topics were intended to help participants examine and increase current levels of personal safety and self-care. The third phase sessions were concerned with the emotional aspect of the self, and included the session topics of emotional protection planning and boundaries / assertiveness. The objectives included the development of a concrete plan for times of stress and the identification and maintenance of personal boundaries. Phase four represented the intellectual aspect of the self with sessions on creativity and openness to new things. The intent was to explore the role of creativity in coping and healing and examine the importance of expanding our inner experiences beyond the trauma. The fifth phase addressed the spiritual aspect of the self, and the session topics included exploring spirituality and finding the sacred in the everyday. The hope was to begin an exploration of spirituality and its role in healing and to begin

to foster a sense of wonder to help participants see more of the small positives in their daily lives. The final phase was primarily concerned with celebration and closure. the eleventh session on 'pulling it all together' attempted to integrate and reflect on the work of the group, and the final session was a celebration of one another and the work that had been done, and an opportunity for closure.

The sessions, which are described below, were guided by the group objectives and by individual group session plans. I summarized the group process in writing at the end of the sessions, and some of the impressions are included below. No identifying information will be disclosed in the discussion and participants will not be quoted; only my general impression of the impact of the sessions based on verbal feedback by participants during check-outs and the sharing portions of the exercises will be included. The two groups will be discussed together, with differences highlighted when relevant. A brief discussion of the differences and similarities between the groups will be included in the summary of group process at the end of the chapter. The use of the pronoun "they" will be used when referring to the work of the group participants to avoid confusion about which activities the co-facilitators were included in. It is important to note that the co-facilitators used the pronoun "we" when speaking in the group, in the interest of being inclusive. The use of the pronoun "we" when referring to the delivery of the intervention will continue throughout, as the groups were both co-facilitated with a volunteer.

THE GROUP SESSIONS

Phase One (Sessions One and Two): There were two main goals for the first phase; safety and the introduction of the group. Establishing a safe space was a priority throughout the group,

but it was the primary task in the first phase. Feelings of apprehension and anxiety are common as a group begins and we attempted to lessen this by providing some structure. We reviewed the group sessions outline, introducing the concepts of check-ins and check-outs, creating a group agreement, brainstorming a list of expectations, and presenting information about coping. Additional structure was provided by the posting of the daily agenda, which was reviewed at the beginning of the session; participants agreed that posting the agenda for each session would increase comfort levels, and so it was done throughout the twelve sessions. Bonding between members was facilitated by the use of gentle joining exercises. The goal of introducing the group was easily met by reviewing the session guide, introducing the group framework of the self in balance wheel, and exploring the concept of coping.

SESSION ONE: Introduction to Group

The objectives of the first session were: (1) to introduce group members to one another and to the group process; (2) to create a group agreement; (3) to discover participant expectations; (4) to introduce the concepts of self-care and journalling; and (5) to introduce the medicine wheel concept of the self in balance.

All of the women in both groups who had agreed to attend the group came to the first session. They seemed nervous, with little chatting while they removed coats and poured themselves coffee or tea. We formed a circle, completed a breathing exercise to clear a space for the session, and after welcomes and introductions of the co-facilitators, we described the check-in and check-out concept, inviting women to take the speaking stone and share their name and, if they felt comfortable, their thoughts or feelings on beginning the group. Each woman conveyed some level of apprehension about beginning a new group, but a few noted that because they felt

safe at the agency, already being long-term clients, their anxiety level was lower than if they were beginning a new group at an unfamiliar agency; there were nods all around, and another participant mentioned that she had been in previous groups at the agency and recognized a few faces.

We began the session by restating the purpose of the group, handing out and reviewing the session outline, and discussing the agenda for the evening. We then went into the issue of safety, and described the concept and importance of a group agreement, noting that we felt it was important to create a group agreement before proceeding to any exercises; the women seemed to agree, with nods all around. We used markers and a large sheet of flipchart paper, and added the title "What Do We Need To Feel Safe?". We encouraged participants to state their needs for safety in a brainstorm format, adding points to the list once each women agreed to wording; we noted the difference between this and the traditional way of brainstorming, where we write down anything that is said, viewing all responses as valid in some way. In this case we wanted to ensure agreement on all points. We started the process by suggesting a few points, such as confidentiality and starting and ending on time. We used the group agreement process as an opportunity to discuss the idea of using a round format to address the concern about one member dominating the group, which all the participants agreed was a good solution. Both of the groups took the time to make the group agreement their own, with one group taking 45 minutes and the other taking 50 minutes; we had assumed the process would take 20 to 30 minutes. I remarked in my process recording after both groups that it was good to see that the women negotiated the agreement so thoroughly, and that it seemed to be a good joining experience. Both of the groups completed

surprisingly similar agreements, with differences mainly in the wording. (See Appendix G, Group Agreement sample).

We continued with a pairs exercise about stating our expectations for the group, which they then shared in the large group and listed on flipchart paper. The women were quite active throughout the process, and were very supportive of one another. It also seemed to be a helpful joining exercise, especially for those who were more reticent about speaking in the larger group (See Appendix H, Expectations sample). The participants in one of the groups also engaged in a discussion of the general life goals outside of the group process. The women in that group shared openly about their life goals, and the exercise seemed to bond them together in the shared desire for personal growth.

We introduced the self in balance wheel and the four aspects of self, asking women to list examples of coping under each of the aspects on the wheel. The co-facilitators later created a poster of the wheel to be displayed throughout the group (See Appendix I, Self in Balance Wheel). There was a positive response to this exercise as well. We ended with a discussion of self-care, handing out a list of self-care activities, introducing the self-care basket, and passing the stone for check-out (See Appendix J, "Be Good To Yourself" handout). Every one of the participants spoke about feeling less nervous than when they came in, and most said they were excited about the remainder of the group. We spoke after closing about the idea of journalling; encouraging participants to keep a separate journal for the duration of the group to assist in processing the issues that come up. We also handed out a self in balance wheel, assigning a homework task of filling in the four aspects of the wheel for themselves. An additional homework

task was to begin a journal, framing it as a self-care task, and to journal about their individual expectations.

The responses to the first session seemed overwhelmingly positive, and I felt that the careful pre-planning had helped the group get off to a good start. I had remarked in the process recordings for both groups that it seemed that the members had already bonded and "gelled" successfully.

SESSION TWO: Ways We Have Coped

The objectives of the second session were: (1) to enable participants to identify their adaptive coping behaviours as survival skills; (2) to reduce guilt and self-blame by normalizing coping behaviours; and (3) to enable participants to make a choice about employing current coping by increasing awareness of the costs and benefits of these behaviours.

For this session, we displayed the poster versions of the self in balance wheel each group had created to refer to as we placed each session within the context of the wheel. We also displayed a poster version of the group agreement, hoping to show the commitment to safety throughout the duration of the group. After the breathing exercise and check-in, we went over the agenda for the session and read the quote for the day. We then went into leftovers, handing out copies of the previous session's group agreement, the expectations, and the self in balance wheel. In a round format, we discussed the homework tasks; most of the women had completed the tasks and they shared how it had felt, while some of the women spoke to the issue of fear of tasks outside of sessions. We addressed the homework issue as a group and decided that there was no pressure to complete tasks or to share about homework if they chose not to; as co-facilitators, we did note that we agreed but also encouraged members to attempt homework tasks, or at least

think about the tasks, as we felt they would enhance the therapeutic impact of the group. The women agreed with this statement.

We began the session with a discussion of coping, noting that it was the first "work" session, and discussed the objectives, commenting that the next session would be the first to correspond with the self in balance wheel. We talked about coping as adaptive skills that we develop as a way to survive the abuse and continue to survive the effects of the abuse as adults, and addressed the issue of socially acceptable versus unacceptable coping behaviours. We all talked about the behaviours we traditionally view as coping, such as drinking, smoking, and dissociating, as well as coping that is applauded by society, like overworking, caring for others while neglecting oneself, and obsessive attention to weight or appearance. We pointed out that the latter type of coping behaviour is more likely to be applauded or encouraged in women than in men, and talked about why that would be, addressing the issue of social role stereotypes. We moved into brainstorming about ways they have coped in the past or present, and noted that naming a coping behaviour does not necessarily mean they employ that method themselves; women later said that they felt more comfortable with the exercise once this was said (See Appendix K, Ways We Have Survived sample).

Using our list of coping methods, we began a cost/benefit exercise. The group chose two coping methods that they agreed most of them could identify with, one socially acceptable method and one that was less socially acceptable. One group chose drug abuse and food issues like overeating or undereating and weight preoccupation, and the other group chose dissociating and food issues. We then created a flipchart for each one, with the name of the coping method at the top, and a column for costs and for benefits (See Appendix L1 & L2, Cost/Benefit List). The

purpose was twofold; first was to acknowledge the costs of the coping behaviours in an honest way, and the second was to validate the ways that the behaviours helped them to survive. After the break, each participant was given time to complete a cost/benefit chart of her own with a coping method of her choice, after which the women shared in round format. The women in both groups shared a great deal, and supported one another throughout, with each woman saying that she found the exercise helpful in some way. In both of the groups, the participants asked that sharing time be extended for the exercise, so one group negotiated to leave out the brainstorm exercise about the strengths of women, and the other group opted for making the strengths of women exercise shorter. We gave the participants positive feedback about being able to ask for what they needed and to negotiate with one another around their needs.

For the group that opted to complete the strengths of women exercise, we brainstormed a list of strengths we have as women and survivors; the intent was to end the group on a lighter, positive note, and to become more aware of the strengths we all share (See Appendix M, Strengths Of Women). In the check-out, many participants spoke about how powerful the cost/benefit exercise was for them, and all of the women nodded in agreement as these comments were made. We provided a handout on coping as a reading for homework, and asked participants to continue journalling about the costs and benefits of their current coping mechanisms.

In my process recordings, I remarked that it was very exciting to see the women asking for what they needed, and that it seemed remarkable that they were so willing to share of themselves this early in the group. I also noted that the women seemed to be reaching out to one another in a very supportive way, which seemed to be building group cohesiveness quickly.

Phase Two (Sessions Three and Four): The sessions in this phase correspond with the first of the four aspects of self: the physical aspect. The physical aspect of the self includes all that we associate with the body and our abilities. Under this aspect, the participants cited coping methods such as dancing and singing, exercise, boundaries, bubble baths, cooking, and snuggling with pets. Attention to this aspect involves caring for the physical self, including feeding ourselves well, getting enough rest, moving our bodies in a variety of ways, and receiving enough physical affection. The goals of this phase are to help participants understand and increase safety in their lives, and to increase their levels of self-care. I was aware that safety is as much an emotional concept as it is a physical one, but I felt that even emotional safety could be increased with physical activities, such as holding grounding objects, so the topic was placed within the physical aspect of the self in balance wheel.

SESSION THREE: Creating Safety

The objectives of the third session were: (1) to develop an understanding of the concept of safety and its importance; and (2) to examine ways to increase personal safety. After the breathing exercise and check-in, we reminded participants that the session was the first to represent an aspect of the self in balance wheel, referring to the poster version up on the wall. We spoke to the issue of the physical aspect of the self and its importance in healing and positive coping. We continued with leftovers, and several women mentioned that the cost/benefit journalling homework was powerful and helpful. A few of the women shared their self in balance wheels with the group.

We then introduced the concept of safety, discussing the impact of trauma and why so many survivors feel unsafe in their daily lives. We talked about the importance of safety, both for

the group and in general, and brainstormed a list of things they could do to increase feelings of safety when overwhelmed (See Appendix N, What To Do When We Feel Overwhelmed). The groups came up with many ideas, and they seemed energized by the process. We moved into a collage of what we need to feel safe; each woman took a sheet of construction paper, and cut out words and images from magazines, gluing them into a collage on her sheet. We shared the exercise afterward, and most of the women shared that they were surprised to find the exercise so impactful, and all shared that they found the collage comforting to look at. The participants were again quite supportive of one another, and very open during the sharing process. We discussed the ways we could incorporate some of the ideas from the collages into our lives and environments. The collage also provided an opportunity for increasing group cohesiveness and joining; the women sat together while they looked through magazines for images and glued them onto their collages, and talked amongst themselves throughout.

We completed a safe space visualization with one of the groups, as it was negotiated out by one group; it was a fifteen minute detailed visualization where participants created an elaborate safe space for themselves that they could return to again whenever they desired. The women shared some of the imaginative spaces they came up with, and most felt it was a useful idea, especially for times when physical safety and comfort items are inaccessible or inappropriate.

The homework task was for each participant to try and do one small thing to increase the safety of her space, to be journalled about if they chose. The response was positive at the check-out, and I noted again in the process recording that there seemed to be a great deal of sharing for such new groups. It was also positive that in one of the groups, a participant shared a positive incident from the previous week with the group, for which she received positive feedback and

support. It showed that this group seemed quite bonded already, and the woman who shared noted in the check-out that she was glad she had told the group her news.

SESSION FOUR: Self Care

The objectives for session four were: (1) to gain an understanding of the importance of self-care; and (2) to examine ways that participants can begin or increase self-care in their daily lives. After our usual beginning exercises, we began the leftovers and homework round. A number of the women reported that they had made some small changes to increase their safety and that they felt good about that. They received positive feedback from the other women for their efforts.

We then introduced the topic, discussing the issue of self-care and its importance. We noted that it is especially crucial during the therapy process, and that it is vital to increasing self-esteem. We asked the members to talk about some of the things they would do for a friend if she was having a hard time, and they were able to name many things they could do to help her feel better about herself. We then asked the women how many of those things they had done for themselves in the last while. The women looked surprised and most admitted that they had done very few of them. We talked about why women tend to take care for everyone else in their lives before themselves, framing it as a social role expectation of women. We talked about the important role self-care has in helping us remain able to continue caring for others, and how self-care makes us better mothers, partners, friends, and co-workers. We began an exercise, "The Rainy Day Box", designed to help increase self-care activities. The Rainy Day Box is a concept developed by Yvonne Dolan (1998), and we distributed a copy of the chapter on 'rainy days'. The participants each received a box to cover with blank paper and then decorate with paint or magazine images. The boxes are meant to hold self-care items and other objects that provide

comfort or happiness, to be used in times of distress, or as a daily ritual of self-care. The exercise was also meant to give the participants an opportunity to spend time creating an item that was devoted to their own self-care, which might be something they would not normally take time to do, and so it was included in session time rather than as a homework task. We created a brainstormed list of items they could put in our boxes (See Appendix O, Rainy Day Box Items). This process seemed to be energizing, and they appeared excited to begin their boxes once we completed the exercise. The women created their boxes, and then shared them with the large group. Many of the women put a great deal of thought and work into decorating their boxes; they said they found the process meaningful and were already planning the items they would place inside the boxes.

After the break, we moved onto the Rainy Day Letter. Participants wrote a letter to themselves to be read as self-care or during difficult moments. The letter provided encouragement, gave affirmations, and noted some things that could be helpful if they felt sad or overwhelmed. The letter would be kept in their Rainy Day Boxes. In the sharing round after writing the letter, several of the women remarked that they were surprised at how difficult it was to write positive things about themselves; we talked about that issue as a group, and the women concluded that they were glad that they had completed the letters. During the check-out, all of the women named several things they would be putting into their boxes, and the homework task was to find a special place to keep their boxes, and to fill them with their chosen items. We reminded everyone that the self-care basket items they chose each session could be added to the boxes.

I stated in the process recording for session four that I was pleased that the response to the Rainy Day Boxes was so positive; I had been concerned that the exercise would be seen as

silly or juvenile, despite how excited I was about it. We tried to frame it as part of the way to meet the group goal of finding concrete ways to increase positive coping, but the group seemed to find the idea fun right from the start and made the process meaningful for themselves.

Phase Three (Sessions Five and Six): The fifth and sixth sessions represent the emotional aspect of self on the self in balance wheel. I viewed the emotional aspect of the self as one that included all of our feelings about ourselves and others; it is the part of ourselves that experiences the range of human emotion. The types of positive coping that were chosen by the group participants for this aspect of the self on our poster were things like laughter, sharing feelings, allowing ourselves to feel, having a good cry, and using affirmations. The goals of the phase are to assist participants in creating and utilizing an emotional protection plan, and to explore the issues of boundaries and assertiveness. There were many topics that could have gone under the heading of the emotional aspect of the self, but I felt that emotional protection planning was crucial because it could be applied to a myriad of contexts and used with varying levels of stress, from mild to severe. The topic on boundaries and assertiveness was chosen because of the tie to levels of self-esteem, and because boundaries are an issue for most survivors to some degree, as stated in the literature review.

SESSION FIVE: Emotional Protection Planning

The objectives for the fifth session were: (1) to introduce the concept of emotional protection planning and explore when a plan may be needed; and (2) to create detailed emotional protection plans to help participants cope in times of stress. After the beginning exercises, we began the leftovers piece, with several of the women sharing what they had put in their Rainy Day

Boxes and where they were keeping them. We introduced the session topic and discussed the emotional aspect of the self, referring to the group self in balance wheel on display. We then defined emotional protection planning; approximately half of the women had completed an EPP during their healing work, and they shared what they found helpful and unhelpful. We had anticipated that the women could be familiar with the concept, and so had planned to spend only a small part of the session completing the EPPs, with the majority spent discussing the obstacles to using the plans and how to avoid them. All of the women who had an EPP shared that they had not updated theirs in some time, and would like to redo them in group. They also came up with the idea of having EPPs tailored for use in different environments, such as home and work/school. After completing the EPP sheet (See Appendix P, Emotional Protection Plan) we handed out an exercise about personal barriers to using the EPP (See Appendix Q, Emotional Protection Planning). After completing the exercise, they shared in the large group, and then began a brainstorm in two parts: naming what could get in the way of using one's EPP and naming what could help use their EPPs (See Appendix R, Using Emotional Protection Plans). This part of the session seemed valuable, and the participants were enthusiastic about the potential of the plans; they came up with nearly twice as many helpers to using the EPPs as they did barriers.

We then did an exercise on the use of affirmations. We introduced the concept of affirmations as positive affirming statements we can say aloud or think silently to ourselves. We talked about using them at times when we feel sad or overwhelmed, but also that it was useful to make a daily practice of them, even when feeling good about ourselves. We then created a group list of potential affirmations. We handed out blank file cards and some decorative stickers, placing a basket of markers in the centre of the circle. We asked each woman to create five or more

affirmation cards for herself, using either her own or the group affirmations. All of the women made and decorated at least five of the cards. They really seemed to respond to the idea, although several women talked about how hard it was to believe the affirmations they had chosen. We talked about what they could do with the cards; some of the women said they would put them on the refrigerator, the bathroom mirror, their corkboard at work, or in their Rainy Day Boxes.

We then taught the group a relaxation exercise; the 5-4-3-2-1 method named on their emotional protection plans. It involves getting comfortable and then naming five sights, five sounds, and then five tactile sensations, and starting over at four sights, four sounds, and so on from there. It is meant to be a very concrete grounding exercise to bring a person back to the present, as well as being relaxing; consequently it can be used to cope with flashbacks, avoid dissociation, just to feel calmer, or to help with falling asleep. We described and demonstrated the technique, and then the group tried it in pairs. It seemed well received, and only two women had heard of it before the session.

After the check-out, we talked about the homework task. We asked that everyone try the relaxation exercise, use their affirmation cards, find a place to keep their EPP, and make a few self-care coupons for themselves to add to their Rainy Day Boxes. During the check-out, many women had said they found the session helpful, with one women noting it was the most practically helpful session so far, and a few women said that they thought they would use their EPPs.

In my process recordings, I noted that it was helpful to have had a mix of women, some who had done EPPs before, and some who had not. The women who had done them before spoke far more eloquently than we could have about the utility of the plans.

SESSION SIX: Boundaries and Assertiveness

The objectives for this session were: (1) to introduce the concept of boundaries and their role and importance in our lives; (2) to identify personal boundaries and ways to maintain them; and (3) to introduce the concept of assertiveness and its role in boundary maintenance. During the leftovers section the women spoke about their affirmation cards and shared where they had decided to keep them; several had placed them in their Rainy Day Boxes, a few had tucked then into their journals, and one women said she had put them up in different rooms all over her house as daily reminders of her work toward more self-care. Some of the women had continued to decorate their cards and a few had taken extra file cards and made more at home. The women shared quiet support with one another through nods, smiles, and quiet remarks of encouragement. More than one women acknowledged how hard it is to feel the right to affirm oneself.

We proceeded with a discussion about boundaries, which ended up being quite involved and profound in both groups. Many women seemed to identify with one another as they spoke about their issues with boundaries being either very rigid or very lax. We spoke as a group about the impact of sexual abuse on boundaries and noted that there were many commonalities within the circle. In the case of both groups, we let the discussion continue about ten minutes longer than we had planned, as it seemed valuable. The boundaries exercise (See Appendix S, Boundary Exercise) was the main activity of the session, and involved dyads experimenting with various boundaries drawn around them with masking tape. We read out the instructions as the group paired up within the larger circle, and then shared feelings about each change of boundaries with the group. The purpose was to allow women a chance to identify and learn more about their own boundaries, but we acknowledged to the participants that it could be impactful and encouraged

them to participate to the level of their own comfort and safety. Based on participants' responses the exercise seemed very powerful. Everyone had different comfort levels when they were with and without boundaries, and when their partners were at different distances away. Some constructed open or discontinuous boundaries, and others created solid, impenetrable boundaries; however, all of the women spoke openly about the types of boundaries they needed and why, many women felt fearful if they lacked their boundary representation, and were able to speak about that fear with the group. In the round of sharing, the women were unanimous about being impacted by the exercise, even those who had done similar exercises in previous groups; there were more than a few tears as the women spoke about the insights gained in the process of the exercise. This seemed to be a breakthrough session in terms of increased sharing, but the women seemed glad to have the break announced, as the exercise seemed somewhat draining.

After the break, we did a brainstorm activity asking the question 'what can we do to maintain our boundaries?'. Both groups had a productive brainstorm, and were quite animated throughout. We drew in a sociopolitical analysis by discussing how women are often forced to be vigilant about boundaries in a world with so much violence against women. We moved into a discussion on assertiveness, speaking of the role of assertiveness in boundary maintenance, and talking about why assertiveness can be difficult for both survivors and for women in general. We provided several handouts, as we did not have enough session time to devote to a long discussion or for exercises about assertiveness. The handouts defined assertive, non-assertive, and aggressive behaviours, and gave some assertiveness scripts, with exercises to try at home. The women seemed particularly responsive to a handout called "42 Ways To Say No, Or Buy Time Until You Can", and we talked about the difficulty women often have in saying no, tying that to expectations

of women in our society. (The handout was obtained from an internet website). During the check-out, women reiterated the comments from earlier about the impact of the boundaries exercise, with most saying that they were glad they had experienced the process. We asked the women after the check-out whether the exercise felt too powerful or emotional for the group; but the women agreed in a round that it was difficult to do, but still important. The homework was to read the assertiveness package, and to journal about the boundaries exercise, noting how they felt about it, and what kind of work, if any, they felt they needed to do on their boundaries.

My process recording was longer for these sessions than for previous sessions, other than the first sessions, as I had a great deal of my own reflecting to do about the impact of the boundaries exercise. I noted that I felt surprised by how deeply the women said they were impacted; I knew that several women would have done the exercise in previous groups at The Laurel Centre, and consequently, I underestimated the impact of their repeating it. I remarked that I would be more prepared for strong reactions in future groups. I wrote that I felt pleased that the feedback was positive and that the participants found the exercise useful, if painful. The overwhelming reflection I had was that the sessions seemed valuable, and that the women truly identified with and validated one another.

Phase Four (Sessions Seven and Eight): These sessions, 'Creativity' and 'Openness to New Things', correspond with the intellectual aspect of the self on the self in balance wheel. The intellectual aspect was the most difficult to define, as the temptation is to think of it as only thoughts and learning. Rather, I viewed it as more than just our learning process and broadened it to include the concept of the mind and its potential: all of our thoughts, beliefs, values, and

memories. Nurturing this aspect of the self means enriching the mind in any way we find fulfilling, and is not limited to formal learning; the group gave examples such as reading, going to movies, writing, thinking positive thoughts, and learning new skills or new information. The goals for this phase include expanding our inner experiences, and exploring creativity and its role in our lives and in our healing processes.

SESSION SEVEN: Creativity

The objectives for this session were: (1) to explore the concept of creativity and its potential importance in our healing and living in balance; and (2) to explore ways participants could incorporate some creativity into their lives. During the leftovers round all of the participants reflected on the boundary exercise from the previous week and how it had continued to impact them, with most women noting that additional insight had come out of their further processing the exercise. Many also noted that during the week they had found themselves examining their interactions with others in a new light, with the boundaries concept in mind, which further increased their understanding of their own boundary issues.

We began the session topic by noting that we had begun the phase of the group that corresponded with the intellectual aspect of the self. We spent some time talking about that aspect and what we had added to our self in balance poster as positive coping that addressed the intellectual self. We then continued with a discussion about creativity and why it is important for living life in balance; we noted that creativity does not have to mean something strictly artistic, or something we are already good at, but that it can include many daily activities that we can complete creatively. We asked participants to brainstorm ways they could incorporate creativity, encouraging them to include activities not normally associated with the creative (See Appendix U,

Incorporating Creativity). They seemed to find the process inspiring, and came up with many ideas.

We moved into a creative activity after brainstorming; we hoped to inspire continued creativity in the participants by allowing time they might not normally allow themselves for an activity with no other purpose than fun and imagination. We also hoped that it would give them a tangible reminder of the group and their healing journeys. We gave each woman a clay flower pot and provided paint and glue, along with various objects that could be glued onto the pots as decoration, and allotted an hour of group time to work on them. We let the women know that we would be bringing soil and flowering plants to the next session so that they could plant something living into their pots, as a symbol of their own growth within the group and while on their healing journeys. It was surprising how much the women became engrossed in the process; in the sharing round afterward, there was unanimous praise for the activity, with many women remarking that they had not taken the time for fun in awhile. It seemed to be a good joining activity also, providing the women with a chance to connect informally.

After the break, we did a fun exercise which asked the women to create a list of imaginary lives they would like to lead. This is an idea from Julia Cameron's book *The Artist's Way*, which asks the reader to list other lives to lead that we would find fun or fascinating in some way, and to list them without overthinking, just letting one's imaginations go. We handed out coloured paper, and the women found spots around the room to start writing; we then came back to the large group and shared the lives we had listed (See Appendix V, Imaginary Lives). The women were very imaginative, and there was a great deal of laughter throughout the activity, along with many nods and comments of agreement as women read their lists aloud. It turned out to be a joining

exercise as well, which we had not anticipated, but the women remarked that they felt they had received some insight into one another's hidden dreams and true personalities. We commented that we all already have little bits of those spirits within us, and that if we are not leading one of those lives it could be circumstance that prevents us, not a lack of potential. We ended the activity by talking about ways we could begin to incorporate some small aspects of our chosen imaginary lives into our own lives.

The check-out was animated as the women expressed their enthusiasm for the session, saying they enjoyed the pots and the imaginary lives, a few women saying they needed to laugh more like they had today. Several other women echoed these remarks, one saying that she liked to laugh sometimes in session, since it is more common to cry in groups. Someone spoke to the healing power of laughter in response to the comment. One woman remarked that she liked the way the sessions seemed to alternate between heavier, emotional sessions and lighter, fun sessions; I remarked that it had not been intentional, but that it did seem to be helpful. A few women said they thought they would try to make time for creativity and to start thinking of some of their daily activities as having the potential to be completed creatively. The homework task was to try and incorporate a small aspect of one of our imaginary lives and to journal about ways to incorporate creativity into our lives.

In my process recording, I wrote that I was surprised again by the response to activities I feared may have been seen as silly, noting that there seemed to be a great deal of power in such innocuous activities; all of the women seemed to get a hint of their own potential in areas they had not considered. It was exciting to see someone who appears to have low self-esteem, and therefore low expectations for herself, say that she would like to be a fire fighter, a peaceworker,

a Laotian monk, a famous actress, or a freedom fighter. For a short time, I think we all became engrossed in the process of listing all of the exciting lives we could lead, and truly believed we could be those things.

SESSION EIGHT: Openness to New Things

The objectives for this session were for participants: (1) to explore the importance of expanding their inner experience; (2) to understand why they need to take breaks from therapy; and (3) to examine ways they could begin to try learning new things to prevent overload of abuse information. After the breathing and check-in, we began the leftovers round, and talked about the homework. A few women shared about the ways they had incorporated pieces of an imaginary life, which seemed to inspire more of the enthusiasm of the previous session. A few women even had some extra imaginary lives to add to the list, which the group members added by hand to the typed list we had just handed out. All of the women spoke about the impact they experienced from contemplating the imaginary lives, and a few mentioned using visualizations of an imaginary life throughout the week, for grounding or dealing with flashbacks. One woman said she had bought another two pots to paint at home, and several women said they would like to do the same.

We introduced the session agenda and talked about the concept of being open to new things. We talked about intellectual variety and its importance, and how we can overload ourselves with abuse information while in therapy. We discussed the value of reading non-self help books, and learning or thinking about things unrelated to abuse in order to take breaks from therapy. We further talked about the need to spend time outside of group or individual sessions processing issues, but needing to take breaks from it as well. The group brainstormed what

happens when there is no break from therapy, work, family, and so on; this seemed to be valuable exercise, fulfilling its purpose of reinforcing the need for self-care that nurtures all aspects of the self.

We continued with an individual exercise that asked the women to find a spot in the room and write down ten activities they enjoy doing - any kind of activity, providing a handout with examples. In a round in the large group, participants shared those that felt comfortable, and talked about the last time they had allowed themselves time for the things they listed. Most of the women remarked that they did not give themselves much time for things they enjoyed, and we talked about the importance of finding time for them, as a part of both living life in balance and as self-care.

After the break, we moved into an artwork exercise, called Sensory Relief, taken from a book called *Managing Traumatic Stress Through Art*, by Cohen, Barnes, and Rankin. The exercise involves creating a book of images that can help reduce stress and achieve groundedness by conjuring up positive sensory experiences. We first gave out the written exercise, which asks participants to list sensory experiences that they find pleasant, in the categories of scents, sounds, tastes, textures, and sights. Each woman then received a small blank notebook with a coloured cover that could be decorated, and we put out magazines so everyone could choose words and images that evoked the experiences they had listed, and glue them into their books. We had a round of sharing afterward, and the women seemed anxious to share the images they had chosen. They were all able to choose images that were particularly soothing, and they gave each other positive feedback about their work. We discussed the ways the books could be used; the women mentioned keeping the book at work in case of flashbacks, in their Rainy Day Boxes as a self-care

item, or next to their beds to look at before going to sleep. The response was very positive, and the women took the time to find just the right images for their books; the overall comments were that they found the exercise fun, and the end result useful.

Before check-out, we gave each woman a geranium plant and put out potting soil to plant them; the timing was perfect, as it was mid-March and spring was close. This experience felt symbolic, and after a long winter everyone appeared ready for some colour and new life. The women seemed to really enjoy selecting the plant they wanted, and planting it in their pots to bring home. We talked about the symbolism of the plants and their healing; new growth, and eventual blossoming.

During the check-out we received only positive feedback about the session. We then talked about the homework: we asked everyone to try one or two things from their list of ten things they enjoy doing, and to journal about how it felt to try them. We also distributed an exercise called Buried Dreams, from *The Artist's Way* by Julia Cameron. This exercise asks participants to list five hobbies or classes that sound fun, five things they would never do that sound fun, five things they used to enjoy doing, and five silly things they would like to try once. This was meant to further examine ways they could incorporate more new things into their lives, and take more time for themselves.

My process recordings noted that the best responses to activities seemed to be those that provided tangible resources for positive coping; the Rainy Day Boxes, the affirmation cards, and the sensory relief books. All of these were also joining activities for the women, which seemed to be something they enjoyed, and which also likely increased their comfort in sharing about the more painful parts of group.

Phase Five (Session Nine and Ten): Sessions nine and ten were on 'Exploring Spirituality', and 'Finding the Sacred and Accessing Joy', and they fall under the spiritual aspect of the self in balance wheel, completing the sessions that correspond with the self in balance format. The spiritual aspect is often the most neglected aspect of the self (Gawain, 1997). It involves our souls, our deeper selves, our beliefs, and our overall way of viewing the world and our place within it. Nurturing this aspect involves finding time to enjoy the parts of our lives that are the most meaningful and important; the groups named meditating, experiencing nature, affirmations, music, time spent with animals, and sharing circles as examples of positive coping under this aspect. The goals for this phase are to explore the role of spirituality, discuss ways to begin a spiritual practice, and discover ways to enhance the spiritual aspect of the self through noticing daily sacredness.

SESSION NINE: Exploring Spirituality

The objectives of this session were: (1) to explore the role of spirituality in participants' lives and healing and (2) to explore ways that participants could begin to experience or strengthen their spirituality. During the leftovers round, women shared their feelings about the homework: most of the women had tried something from their list of things they enjoy doing, and shared how that felt. We also debriefed the Buried Dreams exercise, which most said they had enjoyed. The group began speaking spontaneously about their plants, talking about where they had put them, and how it felt to have them in their spaces.

We began the session topic by introducing the spiritual aspect of the self, and looking at what they had named under that aspect on their poster of the self in balance wheel. We talked about the impact of childhood sexual abuse on spirituality and spoke about the various forms that

spirituality can take, noting that it encompasses far more than organized religion. We moved into a brainstorm about spirituality, asking the group to name what keeps them hopeful despite the things that have happened in their lives (See Appendix W1 & W2, What Keeps Us Hopeful). The brainstorm took longer than expected, as the women had many ideas for what keeps them hopeful; I found it inspiring to be present for this exercise.

We then allowed time for an individual exercise where participants journalled about what spirituality means to them, and how they feel connected to the spiritual, if at all. We debriefed the exercise in the large group and several women opted to read their pieces aloud; the results were profound, and the other group members asked for copies from those who felt comfortable. The exercise showed that many of the women had very developed spiritual sides to themselves. When we talked about that, the women described how the abuse and the process of therapy resulted in an exploration of their spiritual selves. One woman remarked that abuse caused her to question the existence of a higher power, and that her healing process required her to connect to that power because of its necessity to her healing journey.

After the break, we began an exercise where the participants broke into pairs and described some practices that could help in connecting to their spirituality. We then distributed a handout about creating a spiritual practice. This handout emphasizes that a spiritual practice may have nothing at all to do with formal religion and can be a solitary as well as a group activity. The hope was to generate some ideas for incorporating spiritual practices to enhance the balanced self, especially for those women who had not connected to the spiritual aspects of their lives. In one group, we did the exercise in pairs and shared with the large group afterward; the other group negotiated to do the exercise as a large group. In both cases, the discussion within the large group

was quite animated and many ideas grew out of the process. One group discussed how to make everyday tasks spiritual, using sweeping the floor as an example. The other group described the process involved in the purposeful enjoyment of a sunset as a spiritual practice.

During the check-out, several women said that they had gained a new view of spirituality, and that they themselves were more spiritual than they had thought before the session. We suggested that women journal about the ways they would like to increase spirituality in their lives, if at all, and for those that chose to do so, to begin a spiritual practice that spoke to them in some way.

My process recordings spoke about the deep level of understanding demonstrated by the group members; I remarked that even those who claimed to lack a spiritual self were able to identify several practices that reflected a deep spirituality. I noted that the groups seemed very solidly joined in their efforts and that they seemed to share a familiarity with one another which was inspiring to watch.

SESSION TEN: Finding the Sacred and Accessing Joy

The objectives of this session were (1) to explore the sacredness and beauty in the everyday world and (2) to discover ways of beginning to recognize the sacred, thus enhancing the spiritual aspect of the self. After the beginning exercises, we moved into the leftovers round; about half of the women had chosen to actually begin or renew a spiritual practice, and they shared these and how it had felt. The rest shared about the journalling exercise. Most said they left the session feeling positive about the possibilities for enhanced spirituality.

We introduced the topic by talking about the idea of seeing the sacred in the everyday and how this can enhance the spiritual aspect of the self; we also had a handout called "22 Ways to

Find the Sacred in the Everyday" and a reading from *Everyday Sacred* by Sue Bender. We began a brainstorming exercise we called Small Joyful Things (See Appendix X) where participants named little activities that could bring them joy; both groups were very animated and the resulting lists were prolific. After brainstorming, the participants did an artwork activity where they made themselves tiny cards, each with a 'small joyful thing' written on it. The suggestion was to use the cards to increase the number of small joyful moments in a day, and we talked about how the cards could be used. The women suggested placing them in the Rainy Day Boxes or having them in a little basket or cloth bag and choosing one each morning to try and do at some point in the day. The response to the exercise was positive. In the sharing round one woman came up with the idea of making more of the cards and giving them as a gift to a friend who could use more daily joy, perhaps presenting them in a little velvet bag or a decorated container. The other group members agreed it was a good idea, and we talked about the personal rewards in spreading joy to others.

We then had a group round to plan the final session; we described the planned activities we had in mind, and then the group negotiated for having potluck snacks and informal chatting. We all decided what each of us would bring, and the co-facilitators agreed to type out the list for next session. We then talked about endings, and how it was feeling to near the end of the group; in a round, the group members all shared that the group had gone quickly so far, and that they were sad to see it end. For homework we asked the women to use the joy cards they had made, and asked them try and create some sacred spaces and times for themselves and to journal about the experience.

My process recordings again included comments about the deep spirituality of the group. I noted that the session appeared to be received positively by both groups, and that their enthusiasm

was infectious. I talked about the joy cards, reflecting that the exercise seemed fun and that I felt inspired by their sense of playfulness. The participants in both groups created long lists and spent more time on the exercise than I had thought they would. I remarked that the exercise was useful, and could be used in individual work. I also spoke about the responses to ending, noting that some of the women seemed reluctant to discuss the ending session yet still engaged in the planning discussion. I wrote that I felt pleased that all of the women remarked that they would miss the group, taking the comments as positive feedback about the group process.

Phase Six (Sessions Eleven and Twelve): This phase includes the "Pulling It All Together" and "Ending Celebration" sessions, both of which are about wrapping up, closure, and celebrating the group's work. The session on pulling it all together was included to help frame and summarize the eight sessions that represented the aspects of the self as well as to look back on the group and the work they had done. The final session is meant to facilitate closure by openly discussing our reactions to the group process as well as having a chance to celebrate our work and say goodbye to one another.

SESSION ELEVEN: Pulling It All Together

The objectives of this session were: (1) to re-examine participants' expectations of the group and (2) to attempt to integrate the work in the perspective of the self in balance by revisiting the medicine wheel. During the check-in, many of the women expressed sadness that we were so close to the end of the group and more than one woman expressed her hope that there could be an exchange of phone numbers so that members could reconnect after the last session.

We began the leftovers round and talked about where everyone had put their joy cards and whether they had used them. The women had found many inventive ways of using the cards, and

had created different ways of storing them. A few women who were still unsure about where to put them said they might use some of the ideas from the other women.

We began by talking about what we hoped participants would get out of the session in terms of reviewing expectations and revisiting the self in balance wheel, and we posted the list of expectations created in the first session (See Appendix H, Expectations).We noted at the outset that some of the expectations were not the type that could be achieved in only twelve weeks, but that they could feel good about learning about them, or beginning to address them in a small way. We were concerned that the process of reviewing the expectations could potentially create some negative self-talk if participants had not achieved what they had hoped. We read them aloud one at a time, and addressed each one in a general discussion format, asking the women to speak about the level to which they felt that the expectation had been met. In general, the expectations that the women felt had been met were: normalizing experiences through sharing, taking care of themselves through attendance at group, using the group as a grounding place, seeing themselves as more than just their experiences, taking better care of the physical self, and learning skills to deal with depression, isolation, and shame. The women indicated that some of the expectations were met in a beginning way: redefining their sense of themselves, improving self-confidence, gaining balance and integration of the four aspects of the self, recognizing and managing the patterns in their lives, and developing the inner strength to take charge of their lives. We talked about the importance of honouring all of the changes they had made; honouring that for the other women in the group, but especially for themselves. The bulk of the feedback received in the eleventh sessions will be discussed in chapter five, under the qualitative findings and discussion.

After the break, we revisited the medicine wheel framework, and brainstormed ways the participants could continue to integrate the positive coping they had learned. We then created self in balance collages. Each of the women received a copy of the self in balance wheel from the first session, and created a collage using magazine words and images to represent what the four aspects meant for her now, including her hopes for the future. Included as an appendix is a sample of a collage done by one of the women, who gave me permission to use it in my practicum report (See Appendix Y). We then shared and debriefed the exercise in the large group; the women chose to pass their collages around as their turn in the round came, and the women expressed their appreciation for the work done in group.

We finalized the plans for the final session, and did a check-out about how it felt for group to end. All of the women expressed their sadness at the group's ending, as they had in the previous session, with most saying that they were unsure how they would react to the last session and the actual goodbyes. We talked about the difficulty in saying goodbye, but noted that it is an important phase of a group which acknowledges our ability to move forward. For homework, we asked that the participants journal about the ways they will continue what they have learned in the group, and their goals for the future in terms of developing positive coping.

In my process recordings, I talked about the impact the group seemed to have had on the women. They seemed to have made significant connections with one another, and many had made positive changes. I also remarked on how hard everyone had worked and how much they had challenged themselves.

SESSION TWELVE: Ending Celebration

The objectives of the session were: (1) to reflect on the group's process; and (2) to have a sense of celebration and closure as the group comes to an end. We started with our usual beginning exercises and in the check-in all of the women talked about how it felt for the group to end. Several said they had thought about not coming and avoiding the goodbyes, but in the end, everyone (except one woman who was ill) from both groups attended. We began with the only pre-planned activity: the mailboxes exercise, which involves each woman, including the co-facilitators, having an envelope with their name on it placed on the floor, and receiving enough coloured note paper to write an appreciative and affirming note to each of the other women in the group. The envelopes are sealed once all of the notes are in it and the women take their envelope with them after the session to read the notes at home. In the sharing round after the activity, many women commented that it was easier to say goodbye on paper where they could speak more freely than if we had completed the exercise in person.

We had a break to set up the table and uncover all of the food, and we had about an hour to eat and chat informally, with no planned activities. There seemed to be no awkwardness in either group and the women ate and chatted comfortably. We allowed a half hour for the final check-out process, as we planned to include an ending ritual called a "shell and water ritual". We began with a regular check-out, where the women spoke about feeling sad to leave the group behind. In each group, the participants agreed as a group to exchange phone numbers, and a sheet was passed around, with an agreement for a particular woman to call everyone in one month. This idea was suggested by a group member in the case of both groups, and the co-facilitators left the decision up to the group. We began the ending ritual: a bowl of water and a bowl of shells are

passed around the circle, and each person chooses a shell and places it in the bowl of water, naming something she is leaving behind in the water. She then washes the shell and removes it, naming something she is bringing with her from the group. The woman keeps the shell as a memento of the group. For example, women left behind self-blame, negative self-talk or shame, and took with them self-love, perseverance, or peace. The ritual was powerful and we completed it reverentially and respectfully. The co-facilitators thanked the women for their participation and their hard work, and we wished them all well on their healing journeys. Several women hesitantly asked how they would find out the gender and name of the baby I was about to have, as I was eight months pregnant at the end of the group, so we agreed that they could find out from their individual therapists, and I added that I would be leaving pictures with the receptionist. The women hugged one another and said their goodbyes, agreeing to talk in a month. We handed out group feedback forms, asking women to hand them in to their therapists when they were completed. They filed out of the group room and out of the building, much more quietly than in past sessions.

My process recordings for the final sessions described my feelings about ending, and I talked about receiving many gifts and lessons myself. I described the learning benefits, which will be discussed in chapter six. I noted that the women did seem able to celebrate one another and themselves and the work of the group. I wrote that I felt pleased with the ending shell and water ritual, which seemed to help in achieving closure. Finally, I remarked that I thought the groups did seem to have been helpful and impactful for the women.

POST-GROUP ACTIVITIES

As stated above, the group passed around a sheet of paper to record phone numbers. We made copies for each woman, and they agreed upon one person as the organizer of the first get-together, one month from the last session. It was not possible to have a co-facilitated follow-up session, as is the common practice at The Laurel Centre and many other agencies, due to my advanced pregnancy and impending maternity leave; my due date was three weeks from the last session. This was discussed with the women in the intake sessions and at the first group session to provide advance notice for those who had attended previous groups at The Laurel Centre and might expect a follow-up session.

SUMMARY OF GROUP PROCESS

Based on the ongoing verbal feedback of participants, the group model was appropriate for the development of positive coping strategies. The participants appeared to move toward group and personal goals within the group experience. The educational aspect seemed useful for gaining an understanding of coping and the self in balance concept. The variety of activities provided an atmosphere of playfulness wherein the women were able to relax and participate, facilitating the meeting of the group and personal goals. The session on pulling it all together provided the group with a chance to review their expectations and honour the work they had done within the group, and the final session allowed an opportunity for goodbyes and closure. Overall, the group was well-received and feedback was mainly positive. This verbal feedback will be explored in the chapter that follows, which discusses the qualitative and quantitative findings.

CHAPTER FIVE

RESULTS AND IMPLICATIONS

This chapter presents the results and implications of the intervention evaluation, beginning with a description of measurement, including measurement tools, the design plan, and the recording plan. It then presents both the qualitative and quantitative findings and discussion of the findings, and ends with the implications of the results.

The discussion of findings is difficult in the case of this practicum due to the poor return rate of data in the two groups. Of the total of eleven clients who participated in the groups, I have complete data from three, and partial data from two more. This statement only applies to the coping rating scale and the SERS measure, with their accompanying qualitative data; the pre- and post-tests had an even lower return rate, with only two clients returning both the pre- and post-tests for a resulting comparative graph. I received five out of eleven group feedback forms. The return rate makes the quantitative data analysis particularly difficult, but in the case of qualitative data analysis, I was able to rely on the additional verbal feedback throughout the group, particularly from session eleven, where we reviewed the group expectations. I speak to the issue of data return rate in chapter six, under the discussion of future recommendations.

The feminist perspective values qualitative over quantitative data because of the emphasis on hearing women's voices, yet it acknowledges the importance of accountability within the therapeutic process. Butler and Wintram (1992) argue that we need to combine the richness of qualitative data with more scientific methods, noting that "progress in knowledge about the range of therapeutic effects will come by identifying precise, yet measurable changes in functioning"

(p.9). They recommend the use of a variety of assessment tools incorporating both forms of data. In the case of this practicum report, the general lack of quantitative data has necessitated the focus on general feedback and the qualitative data received, although I present an analysis of the quantitative data that was received.

MEASUREMENT

This section describes the types of measures chosen for the design, including why they were chosen, who collected the data, and when and under what circumstances the data was collected. The three measures are a self-esteem measure, a rating scale on level of positive coping, and an evaluation log.

Measure of Self-Esteem: This measure is a standardized scale called the Self-Esteem Rating Scale (SERS), created by W.R. Nugent and J.W. Thomas to measure the level of self-esteem. (See Appendix Zi & Zii, SERS). The scale has forty items, and scores range from +120 to -120. The scale was chosen because it is designed to measure both positive and negative, or problematic and non-problematic, levels of self-esteem; this fits with the strength-oriented feminist intervention. It is also designed to examine several areas of self-esteem, including general self-worth, social and self competence, problem-solving skills, intelligence, and relative self-worth. The relevance of a self-esteem measure is the assumption that an increase in level of positive coping skills will correlate with an increase in level of self-esteem. Other reasons for the choice of the measure include a low number of items and ease of scoring for practitioner; I tried the scale myself, and it took ten minutes to complete, was easy to understand and use. It also had simple scoring instructions, and the scoring itself took about eight minutes. I felt the scale was face valid,

but realized that this would have to be checked with individual clients, which was done periodically throughout the group process. The creators report excellent internal reliability (alpha of .97), good content and factorial validity (I could not access the article, and no basis for this was stated in the book of measures), and good construct validity (significant correlations with the Hudson's Index of Self-Esteem, and the Generalized Contentment Scale, and low correlations with demographic variables). One concern is that test-retest reliability was not reported; I knew I would have to watch for a stable baseline. The measure was administered by the practitioner at the initial intake session, and was to be completed by each participant once per week, on a standard day, throughout the intervention and follow-up period. This was to provide a baseline of four self-esteem scores, an intervention phase of twelve scores, and a follow-up phase of six scores. Data was to be brought to the weekly group sessions, although some participants gave them to their individual therapist, and some forgot some to bring them to some of the sessions and handed them in at a later date.

Positive Coping Rating Scale: This measure was chosen to provide information about the level to which clients are utilizing positive coping methods in their lives. I designed the measure myself because I wanted to track participants' coping levels from a positive, strength-oriented perspective, and because I could not find an existing measurement tool that fit with what I hoped to measure. The scale contains ten points, with a score of one indicating that very little positive coping was utilized throughout the week, a score of four indicating that some positive coping was used, a score of seven indicating that mostly positive coping was employed, and a score of ten indicating that almost all of the coping employed was positive. Participants could choose any of the points from one to ten, but I chose to anchor four out of ten points to make the

measure more visually simple. (See Appendix Z1, Positive Coping Rating Scale). There is no information about reliability or validity because the measure is self-developed; however, I felt the scale was face valid, and checked face validity in the intake session, with willingness to change the anchor points if necessary. The measure was explained and administered by the practitioner at the initial intake session, and was to be completed by participants once per week, on the same day as the SERS measure. This would provide the same number of scores for baseline, intervention, and follow-up as the SERS measure. Data was to be recorded in the critical incident log book (explained below) provided by the practitioner and brought to the weekly group sessions.

Evaluation Log: This measure is a critical incident type of log, and was chosen for three reasons: first, to provide a context related to participants' level of positive coping; second, to provide qualitative information about self-esteem to help the practitioner be sure the SERS scale has concurrent and content validity; and third, to help control for the history and maturation threats to the internal validity of the design plan. Participants were provided with a notebook that had removable pages and was to be kept separate from any other journal they might keep about the group. Each participant was asked to record a qualitative statement about her level of self-esteem, immediately after completing the SERS measure. She was also given a five to ten minute journalling exercise that asked the question: how are you feeling about yourself right now? In addition, participants were asked to record a qualitative statement about the context of their reported level of positive coping, immediately after choosing a weekly score from the rating scale. There was another five to ten minute journalling exercise that asked the question: what was going on for you during your week that may have contributed to your level of coping? The participants were told that they could write as little as a sentence or two for either statement, which would be

considered an acceptable amount of data to correspond with the weekly measures, but were encouraged to write as much as they liked, or felt relevant. Because the log corresponds with the SERS measure and the rating scale, its use began at the intake phase and continued throughout the intervention and follow-up phases. The notebook sheets for the week were to be brought to the weekly group sessions with the other data.

Pre-test and Post-test: The agency at which the intervention took place utilizes a pre- and post-test that are administered before and after individual or group therapy. The measure consists of a combination of several standardized measures: a health symptoms checklist, a general health survey, a self-esteem scale, a brief symptom inventory, an impact of events scale, a perceived social support scale, and includes questions about alcohol and drug use, gambling, use of medical and mental health services, and demographic information (See Appendix Z2i, Z2ii, Z2iii & Z2iv, TLC Clinical Measures). The post-test also includes a client satisfaction questionnaire. In keeping with agency practice, the practitioner asked participants to complete the measure during the initial intake session, and again at the conclusion of the six week follow-up period.

Group Feedback Form: The Laurel Centre uses a standard Group Feedback Form, which was administered at the end of the group intervention and used as qualitative feedback (See Appendix Z3, Group Feedback Form).

Limitations: The main limitation of the measurement plan is that the only source of measurement data is the individual participant, but little flexibility was available here. The phenomena being measured are internal processes and are not observable in a concrete manner by an outside source. I considered ways that I could record data as an observer, but concluded that I

could not reliably measure participants levels of positive coping or self-esteem by observation alone. The use of the standardized measures assists with methodological triangulation. Another limitation is the lack of validity or reliability in the coping measure.

RECORDING PLAN

As stated above, the data was to be recorded by clients. The practitioner scored the SERS measures for the week after the group sessions wherever possible, and plotted the results on a graph. The SERS graphs had to be created individually for each client because the range of scores is so large, and the intervals need to be sensitive to changes in level of self-esteem. I could not assume that using intervals of ten or twenty would best depict change. The graphs were based on the range of scores recorded in the first few measures and then were constructed to just contain the data. This best ensures the detection of visual patterns of change, and graphs were changed later if scores moved off of the existing graph. The coping rating scale scores were plotted by the practitioner on a separate graph. The pre- and post-tests are entered into a computer program created for the agency, resulting in one graph that plots all of the results of the different questionnaires, combining the results on one graph after the post-test is completed. The practitioner was aware of history or maturational threats to internal validity as depicted in the evaluation logs, and asked for feedback about the measurement process to check for an instrumentation threat to internal validity.

DESIGN PLAN

The design is A-B-A style, in replicated form across eleven clients. The first A phase, or baseline, corresponds with the four week intake and assessment phase of the intervention, and includes the weekly SERS measures and the weekly rating scale measures, totaling four data points for each measure in this phase. The evaluation log is ongoing throughout all three phases, and consists of qualitative data. The B phase, or intervention, is the twelve week group intervention, using the same measures as the baseline phase, with the same frequency. The second A phase, or follow-up, is the six week period of no group contact, during which participants will bring the data to their weekly individual sessions at the agency.

DESIGN JUSTIFICATION

This section discusses the justification of the design in three ways: how the design fits with the intervention, how the design supports clinical decision-making, and how the design supports the evaluation of the intervention.

Fit With Intervention: The design fits well with the intervention because it was patterned after the time frame of the intervention: the four week intake and assessment period, the twelve week group intervention, and the six week follow-up period. This had been the time frame of the intervention before the design plan was conceptualized, and so I believe that the intervention was not compromised by the evaluation design. In addition, I believe there was a reasonable amount of data collection expected of clients.

Clinical Decision-Making Support: This section includes a discussion of three types of support for clinical decision-making: description, correlation, and causality.

Description: The design let the practitioner know, as the intervention unfolded, how each participant was progressing, if at all. This is preferable to waiting for general client satisfaction surveys after the intervention has been completed. Visually, I was able to evaluate progress at a glance, by examining the graphs in each phase and across phases. In the A phase, the data provided information about possible deterioration and the need for more individual pre-group intervention, or about possible improvement without intervention. In the B phase, the data supported clinical decision-making around the intervention, both with individual clients, and with the group as a whole. By showing similarities across participant graphs I was able to make decisions about the entire group intervention and if it needed to be intensified or changed. It also made me aware of clients who may need more intervention outside of the group sessions. In the second A phase, I was able to determine if a participant's progress had deteriorated and whether they might have needed additional support around positive coping from either the practitioner or their individual therapist at the agency.

Correlation: With this design, I was able to see the relationship between the level of self-esteem and the level of positive coping behaviours. By comparing across phases, I was able to determine if the change in the targets coincided with the introduction of the intervention, and whether withdrawal of the intervention seemed to influence the target. Even early in the B phase, the intent was that I may be able to begin to see some visual evidence of correlation between the intervention and the change in the target. By comparing across group participants, I was hoping to be able to determine if the intervention seemed to elicit change with certain types of previous coping patterns more than others, or with particular participants more than others based on their

length of previous therapy with the agency or other related factors, using the evaluation logs as a guide for contextual data.

Causality: This design was intended to increase the possibility of approximating causality, if the data conformed to the more ideal pattern of the A-B-A design, and because it controls for some of the threats to internal validity. The A-B-A design controls, to some degree, for several types of internal validity; history, maturation, testing, instrumentation, and causal ordering, and to a lesser degree for statistical regression, although clear regression may be inferred if clients with extreme scores in baseline move toward the group mean. It does not control for mortality or diffusion of the intervention. The design itself does not control for threats to construct or external validity, but the variability of a group intervention does enhance external validity.

Data Evaluation Support: This design has a better chance of approximating causality than the B or A-B designs because it includes baseline as well as follow-up data for comparison to the intervention data, but the data has to conform somewhat to ideal standards to approximate causality. I was aware that carryover was a likely complication to data evaluation in the case of my intervention, and contrast could have been a problem with some clients. Order of presentation was not an issue because the design is A-B-A rather than A-B-A-B.

QUANTITATIVE FINDINGS AND DISCUSSION

The quantitative data for this practicum came from three sources: the positive coping rating scales, the SERS questionnaires, and the pre- and post-tests provided by the practicum setting. I received full results for the SERS and coping measures from three of the eleven participants, and partial results from two more, but only two out of eleven participants returned

both the pre- and post-tests to result in the comparative graphs. The results for each measure will be presented in turn, with a discussion of findings included. Results are presented on a client by client basis because of the low return rate: there is limited utility in discussing aggregated results with so few subjects, either for comparison within or between groups.

Positive Coping Rating Scale: The scores from the weekly rating scales discussed in the measurement section are discussed below. The results of the visual analysis of the graphs will be discussed on a client by client basis. Note that the first two data points correspond with the Christmas holidays.

For client one (see Table 1), the group seems to have impacted her level of positive coping; her scores were lower throughout the baseline phase, and rose at the beginning of group, staying higher throughout the group and follow-up phases. Contextual information showed that she felt depressed about the holidays, a feeling she continued to express throughout the first five measurement dates, and she indicated a breakthrough in her healing at week seven, with no mention of the group. Consequently, it appears that personal factors had more impact on her coping levels than did the group. The coping levels stayed higher after the group began, however, not sinking as low as baseline scores again throughout the measurement phase, which could possibly be due to the group. For client two (see Table 2) the group seems to have had little impact on her level of coping until perhaps at the very end in the follow-up phase: again contextual data indicated that some general 'ups and downs' at work and home caused the variability in scores. For client three (see Table 3) the group seems to have had no impact on her level of coping, which stayed nearly the same throughout. She indicated high levels of suicidality in her qualitative statements, which was discussed with her individual therapist, and she indicated

very low levels of positive coping, yet she rated her satisfaction with the group as very high in her group feedback form. For client four (see Table 4), there are only fourteen data points available, but it does not seem that the group greatly impacted her levels of positive coping. The scores rose before the group began, although this is common in a baseline phase when the client knows the intervention will begin shortly, and stayed fairly level throughout, other than a lower data point that corresponds with a death in her family. A slight impact is evident however, and her scores may have continued to rise if she had completed the remainder of the measures; also, her group feedback form indicated that she felt very satisfied with the group. For client five (see Table 5), the group seemed to have an impact on her levels of coping for the first half of group, but her qualitative statements indicated a slip back into previous compulsive coping, after which her scores lowered and she stopped completing the measures. The slip was preceded by some unwanted contact from an abusive ex-partner. If measurement had continued, they might have indicated that the group could have helped her come back from the slip, but with existing data, it seems the group was somewhat helpful. Overall, the group seems to have been somewhat helpful in increasing levels of positive coping, but personal factors outside of group seem to have had as much of an effect. This could be partly because the group participants did not seem to view the group as a part of their general context, and answered the question accordingly.

SERS Questionnaires: These were the weekly standardized self-esteem questionnaires discussed in the measurement section. The results of the visual analysis of the graphs will be discussed on a client by client basis. The self-esteem graphs were created for each individual client because of the large range of scores possible (+120 to -120). The intervals needed to be sensitive to individual levels of change and so the graphs were constructed to just contain the data to best

ensure the detection of visual patterns of change, therefore the intervals of the y-axis are different for each graph. It is also important to note that the first two measures on the graphs correspond with the Christmas holiday.

For client one (see Table 6) the level of self-esteem does seem to be impacted by the group; her scores rose slowly during the baseline phase, and generally rose throughout the group intervention. An increase in self-esteem is not surprising during the baseline phase; it is common for client problems to improve when they are anticipating a new intervention. The scores were also lower in the baseline phase due to the holidays, as indicated by her qualitative statements. In the follow-up phase, her self-esteem level continued to increase the week after the group, but dropped the week after that, only to increase and level off again in the last two weeks of follow-up measures. The level did not go as low as baseline phase again throughout the measurement period. The contextual statements provided more insight; the client indicated that on the day of the measures for week nineteen she felt depressed, which may have led to the lower score, and then in week twenty where there is a jump in her level of self-esteem, she indicated that she had just had a good week because she stayed with a family member, getting out of her stressful home environment. Overall, the results seem positive, but it should be noted that her scores stayed in the negative zone, with the exception of two points. The self-esteem graph seems to correlate visually with her coping graph, indicating that the two variables are related to some degree. For client two (see Table 7), the group also seemed to have some impact on her level of self-esteem, but not until later in the group. She had higher scores in baseline than for any other phase, but her level of self-esteem seemed to increase for the second half of group and throughout the follow-up phase. She did have the highest overall scores of the five clients, however, with her scores going

below zero only twice. Again contextual data provided more information; decision-making about issues at her work corresponded with the variable scores on the first half of the graph. The high initial score could be due to the holidays; she indicated she had gotten all of her Christmas preparations completed and felt good about that. I also wonder if she had gotten used to the measure, and the scores began to more closely align with her average scores. Overall, this graph seems somewhat inconclusive because of the variability, but it is possible that the group played a role in the gradual stabilizing of her self-esteem scores. The gradual increase could also indicate that she was slowly incorporating more of the group information. Her two graphs seem to correlate visually to some degree. For client three (see Table 8) the group does not seem to have had a positive impact on her level of self-esteem but this is likely due to contextual factors. She spent the duration of the baseline, group, and follow-up phases feeling suicidal, and noted in her group feedback form that the group was helpful because it kept her from harming herself, and she generally rated her satisfaction with group as very high. It could be argued that the group was helpful for her in terms of keeping herself safe, but she did not seem to experience an increase in self-esteem. Within the contextual information I found no explanation for the variability of the scores. The two graphs seem visually unrelated, but the low self-esteem scores correlate with the low levels of positive coping. For client 4 (see Table 9), data was available for the first fourteen points; the baseline phase and the first eight weeks of group. The beginning results show an increase in self-esteem that could be partially attributed to the group. The contextual data show a death in the family just before the lowest data point, which helps to explain the drop, but there were no contextual factors evident to describe the increase in self-esteem other than the group and her increase in positive coping. Her two graphs seem quite visually related. For client 5 (see

Table 10), the self-esteem levels seem quite related to the effects of her coping. The contextual data indicate that she had not used her compulsive coping method for a few weeks before the first measurement day, but that she had a slip just before the second measurement day, which was over Christmas. She indicated that she gradually 'got back on track' throughout the group, which may indicate that the group helped with that process, and that she slipped back into old coping patterns in the eighth week of group. She stopped completing the measures after the tenth week of group and missed a few groups in that period, which seemed to impact her level of self-esteem. Her graphs also seem visually related. Overall, in terms of the self-esteem data, clients again seemed more impacted by personal factors than by the group, although some evidence exists that the group and its focus on the development of positive coping had an impact on level of self-esteem.

TABLE 1

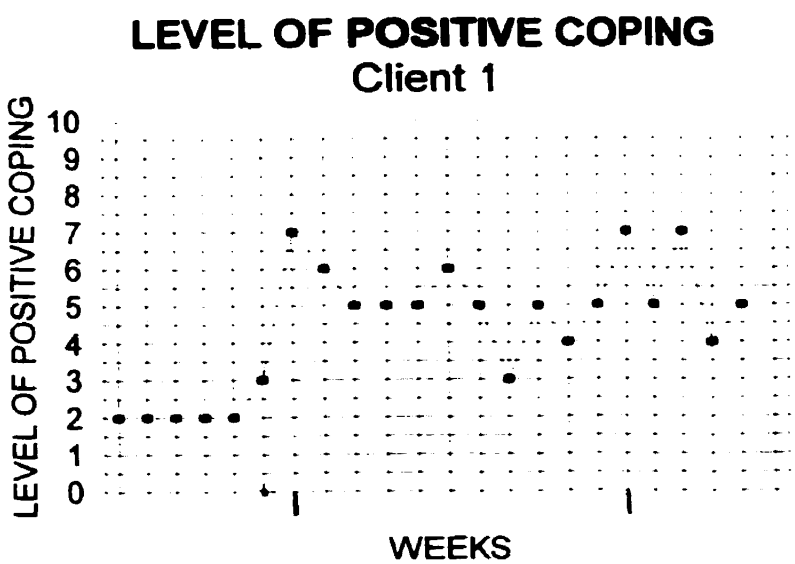


TABLE 2

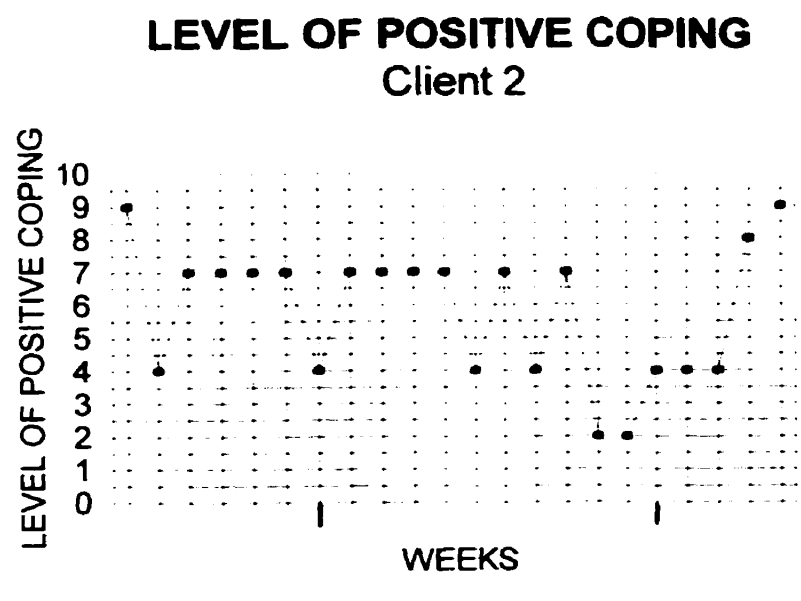


TABLE 3

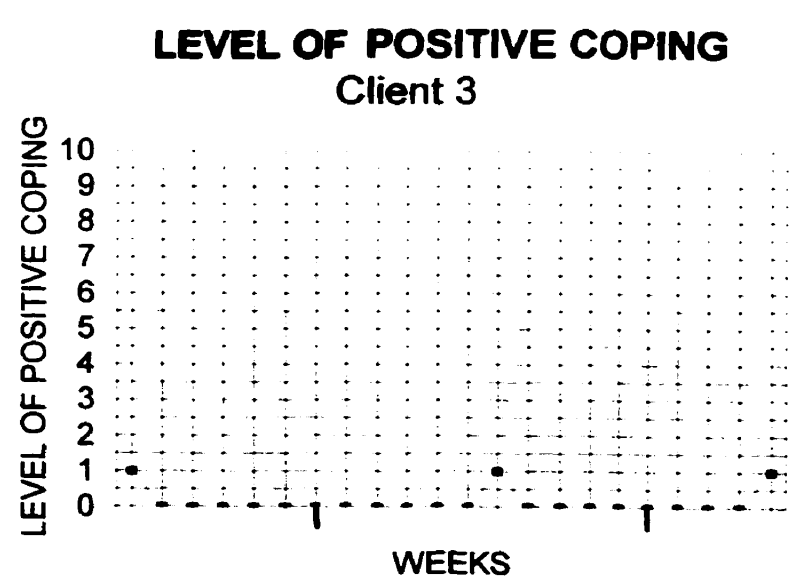


TABLE 4

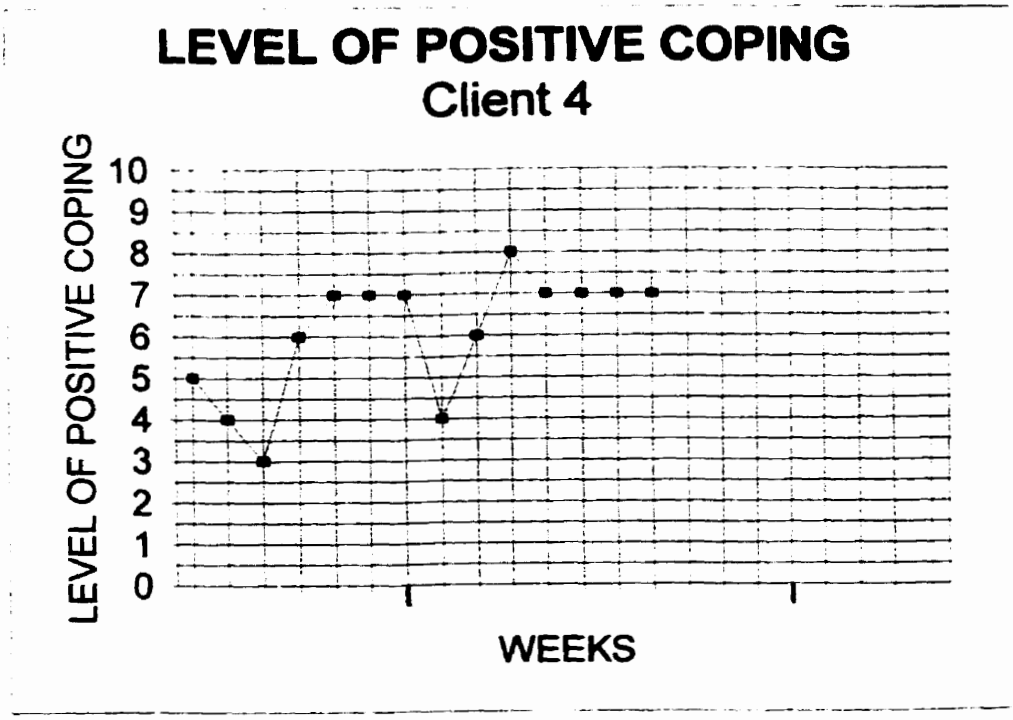


TABLE 5

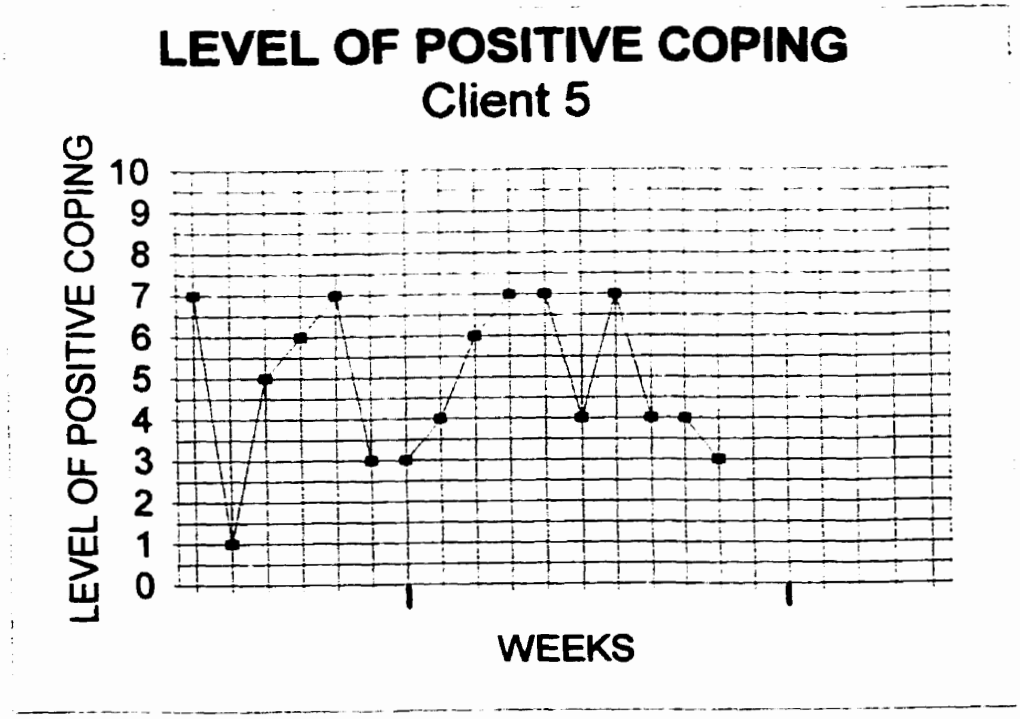


TABLE 6

LEVEL OF SELF-ESTEEM
Client 1

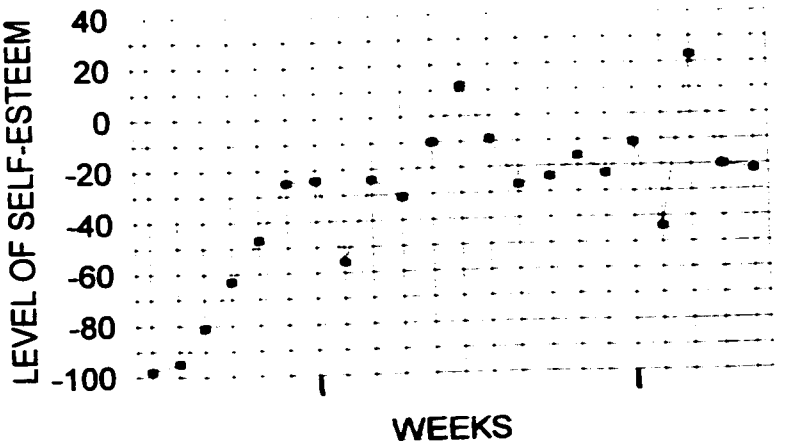


TABLE 7

LEVEL OF SELF-ESTEEM
Client 2

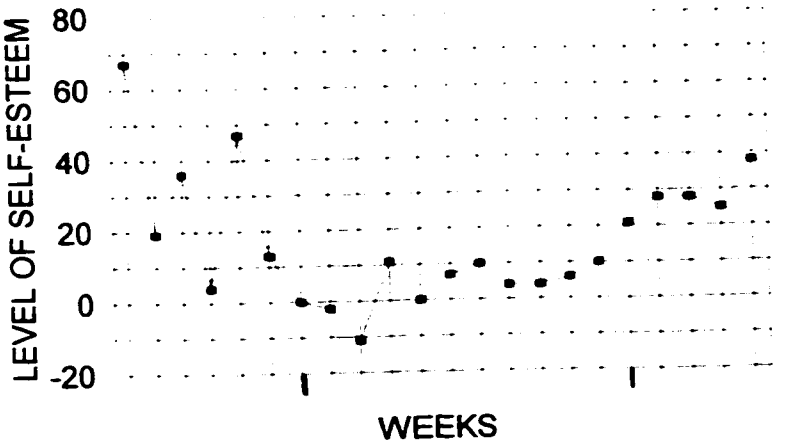


TABLE 8

LEVEL OF SELF-ESTEEM
Client 3

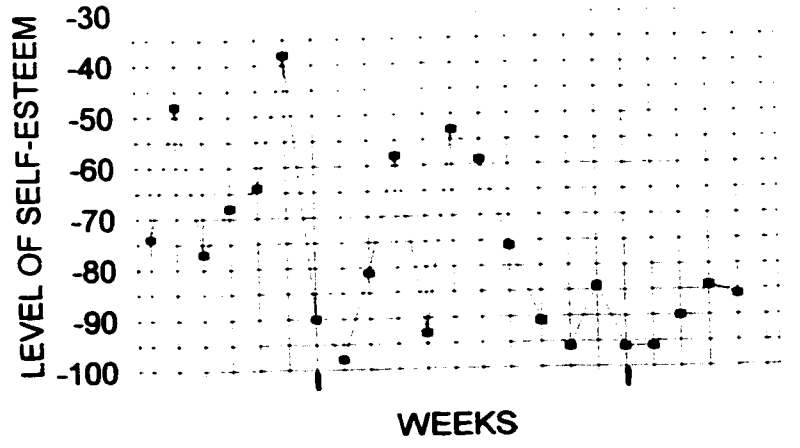


TABLE 9

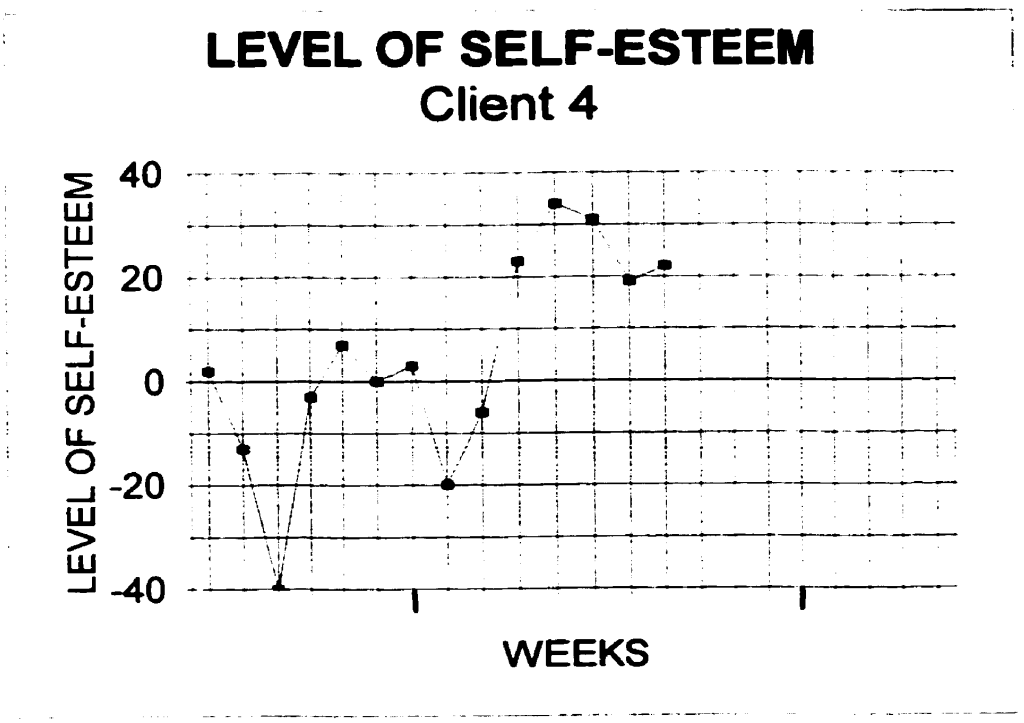
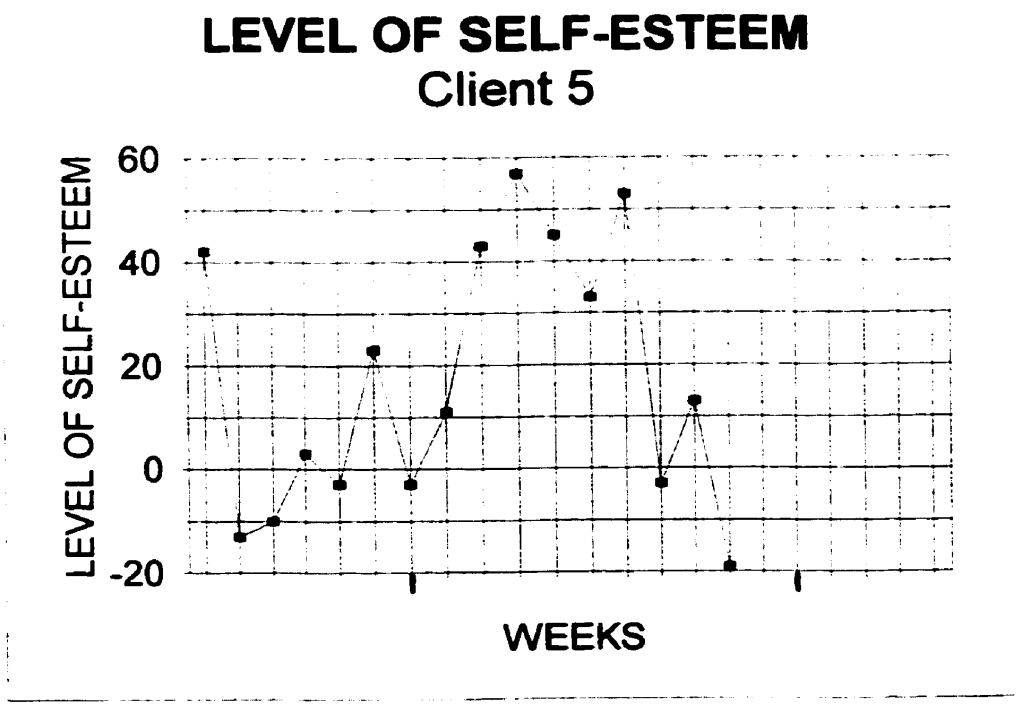


TABLE 10



Pre- and Post-tests: The pre- and post-test had the lowest return rate, and there are only two comparative graphs to analyze. Because of the limited utility of analyzing only two graphs, they will not be included in this report.

Quantitative data analysis was severely limited by the low return rate, but there was some indication of positive change resulting from the group evident in the data. The qualitative data, which is discussed in the next section, was more plentiful, and will provide the opportunity for further analysis of group effectiveness.

QUALITATIVE FINDINGS AND DISCUSSION

The qualitative data for this practicum came from four sources: the self-esteem statements accompanying the SERS measures, the qualitative statements about levels of positive coping, the group feedback forms, and my process recordings after the group sessions, including the verbal feedback that was ongoing throughout the group intervention. Each will be discussed in turn, with a summary at the end of the section.

Coping Statements: These statements were also weekly statements recorded in the evaluation logs, completed after the positive coping rating scale each week. The statements answered the question 'what was going on for you during your week that may have contributed to your level of coping?'. The statements provided qualitative data to correspond with the positive coping rating scale scores to explain outliers in the data points. For the purposes of qualitative analysis, I looked for comments about how the group impacted the ability to employ positive coping strategies, and for themes about the individual contextual issues that impacted levels of positive coping. Three of five women mentioned that beginning the group was making

them feel more able to cope positively. The themes about context were similar to the themes discussed above for the self-esteem statements, but there were some new themes evident: illness and a lack of sleep impacted the ability to cope positively in all of the women, as did busyness, either at work or at home. The women mentioned that multiple roles and tasks kept them from making time for positive coping, when it became easier to rely on comfortable methods of coping. Several women mentioned instances where planning ahead or making lists allowed them to complete tasks more efficiently, thus allowing more time for self-care. The actions of others, again, had an impact: feeling unsupported decreased the ability to cope positively, and connecting with others who supported the concept of self-care helped the women feel more deserving of taking time for themselves. The decision to foster a positive attitude about life and self helped women 'push' themselves to try some positive coping methods, while negative self-talk and a feeling of being overwhelmed with the work of healing decreased efforts at positive coping. The holidays again had a significant impact on coping: this was a theme mentioned by all of the women in their coping statements.

Self-Esteem Statements: These were weekly statements recorded in the evaluation logs after participants completed the SERS measure. Participants were asked the question 'how do you feel about yourself right now?', and could answer in a short one sentence statement or a longer journalling exercise. These statements were used to provide contextual data to correspond with the SERS measures to explain unexpected increases or decreases, as was discussed in the quantitative findings and discussion. For the purposes of qualitative analysis, I read the statements looking for comments about how the group impacted levels of self-esteem, and for themes about contextual issues that impacted self-esteem. No comments about the group impacting levels of

self-esteem were recorded, but there were several common themes evident in terms of general impact on self-esteem. One theme that became evident was the ability to incorporate positive coping, which provided some evidence to confirm my assumption that coping impacts level of self-esteem. All of the women who handed in the measures reported instances of feeling better about themselves when they were able to employ positive coping strategies, such as the use of affirmations, and felt worse about themselves when they slipped into past patterns of coping. All of the women spoke about support from others impacting their self-esteem; feeling loved or supported by family and friends increased self-esteem, and feeling neglected or hurt by others made the women feel worse about themselves. Some of the factors that more than one woman mentioned as increasing self-esteem were assertive behaviours, positive self-talk, making decisions one feels good about, work successes, setting boundaries with others, and the meeting of small goals. Some contextual issues that decreased self-esteem in more than one participant were the issue of poverty, and the impact of the holidays; several women mentioned feeling badly about themselves because of the continuous stress of not having enough money and resources, and most talked about the holidays, as the first measures were over the Christmas/ Hanukkah season. The new year seemed to have a bigger impact, as it reminded women of goals they had not met, and many women talked about having high expectations of themselves about resolutions for the coming year.

Group Feedback Forms: The five feedback forms that I received were a mix of afternoon and evening group members; two from the evening group, and three from the afternoon group. I also received a general client satisfaction scale which was incorporated in the post-tests, completed by another client. The results of the group feedback forms were mainly positive. For

the question 'overall, how useful was the group to you?', on a scale of one to ten with one being 'not at all' and ten being 'very', the responses ranged from seven to ten; one seven, one eight, one nine, and two tens. For the question 'were your expectations met?', the responses ranged from eight to ten, this time with two eights, two nines, and one ten. The last scaled question was 'how safe did you feel in the group?', and the responses ranged from seven to ten, with one seven, one eight, one nine, and two tens. There were four yes/no questions: (1) did you feel a sense of group unity - members working towards a common goal?; (2) was the length of sessions satisfactory?; (3) was the number of sessions adequate?; and (4) were the handout materials useful/helpful?. All four of the respondents checked 'yes' for each question, and so there was unanimous agreement to the four questions. The remaining questions were long answer, and the responses to the questions follow.

Did the group experience help you to attain a better understanding of yourself, your needs, and values? Explain.

- "it made me much more aware of how difficult it is to really do self-care on an ongoing basis for me."

- "at first I didn't really know why I was there, but as time went on I got to realize that I have been coping, but it showed me new ways of how to put them in place before I go into a tailspin."

- "a little bit. I was able to keep myself safe by not harming myself."

- "yes, very much so. I understand myself a lot better now than I did. Thanks to the group for all their help in taking me to where I am now."

- "I became more aware of the need for emotional, physical, and to a lesser extent, spiritual and intellectual development."

What aspect or experience was the most valuable to you?

- "learning how much everyone is working to cope with struggles."

- "with all the difficult material we were given as homework, I got to see how I felt and acted ABOUT ME in black and white. It was hard yet useful."

- "affirmation cards to bring our self-esteem up."

- "the discussion of eating too much or undereating - I wasn't sure how I fit into that - I was always confused about it until the group."

- "In effect, my mind was opened to a greater awareness of my current reality and needs. (Also), the general sharing of experiences."

I liked:

- "the creative projects."

- "when we painted our flower pots and planted our flowers. It was like starting a new life and watching it grow."

- "the activities and the sessions overall."

- "going to group every week because I always learned something new. I was hoping to meet people to connect with and I did. Thanks to the group."

- "discussions (and) brainstorming."

I did not like:

- "???"

- "the only part I did not feel good about was the boundaries exercise."

- "missing a group, but I had no choice."

- "to tell the truth, there was nothing I did not like...things couldn't have been better for me."

- "weekly filling out of forms...I was quite surprised."

Have things changed for you since starting group? If so, how?

- "trying much harder to incorporate healthy coping as part of my life. I think it is working more often."

- "things have changed because of all the different groups I've attended at The Laurel Centre."

- "somewhat. I wasn't so alone and I was able to keep myself safe."

- "I have become a bit stronger than I was before group started."

- "Yes. There has been even more stress in my life, but I have found myself including self time and, more specifically, leisure activities and less time on everyone else."

What, if anything, would you suggest we add, subtract, or change in future groups?

- "more meditative time at the beginning of sessions to ground everyone."

- "the order in which we attend the groups - the coping group should be after the pre-counselling group, and before the sexual abuse group, not after it."

- "no changes at all."

- "I wish they could be a bit longer. Time goes by too fast for me when I am learning new things about myself."

- "To repeat the first exercises at the end of group as well."

Overall, the results seemed positive; the participants seemed to enjoy the exercises and the support from other group members, and some positive changes were made.

The client satisfaction survey that was handed in as part of a post-test was from a group member who did not fill out a group feedback form, so I will briefly summarize the responses. She rated the service as 'excellent', and responded 'yes, definitely' to the question 'did you get the kind of service you wanted?'. For the question 'to what extent has the Centre met your needs?'

she chose the highest rating, which was 'almost all of my needs have been met'. She said she would definitely recommend the program to a friend and that the service 'helped a great deal' in dealing more effectively with her problems. When asked 'in an overall, general sense, how satisfied are you with the service you received?', she chose the highest rating of 'very satisfied'. These responses fit with the group feedback form responses in that they were quite positive.

Student / Clinician Process Recordings and Verbal Feedback: These were my general comments about the interactions and responses of participants recorded after each group session into a notebook. I acknowledge that the comments are filtered through the lens of my perception and are therefore limited and biased; however, I consider them useful in conjunction with the other qualitative material. No tape recording was used and so no direct quotes are available; I merely summarized group responses.

The comments below relate to the general group process; the comments about the individual sessions and activities are included in chapter four in the discussion of the group sessions and will not be repeated here. Near the beginning of the group, my comments were mainly concerned with group joining and responses to structure versus flexibility. I noted several times that I felt that both groups were joining well and that they seemed to develop comfort in sharing early on. I noticed that the informal chatting during breaks increased over the first few sessions, and that there was laughter during creative exercises. I also wrote that when asked about the comfort level with the current structure, all of the women agreed that the structure was helpful and that they liked that we encouraged negotiating about length of activities. Toward the middle of the group, my comments were concerned with the impact of the 'work' of the group and responses to exercises. I noticed that they responded the most positively to creative exercises

as they seemed to enjoy the joining time, and that they seemed surprised by the insight about themselves that resulted from such activities, especially with collages. There was good response to homework exercises, with some lighthearted teasing about all the 'hard work' we were handing out. The time spent in sharing rounds after the exercises seemed particularly valuable. As the end of the group neared, my comments focused on the womens' varied responses to ending. All of the women said they would miss the group, but some seemed to dread the ending session more than others. Because we began talking about the final session plans in session ten, there were process recordings twice before the final session, and I noted a vast difference in the response to ending between the tenth and eleventh sessions; it seemed as if talking about the ending session caused the women to contemplate and process the issue more than if we had waited until session eleven to plan the final session.

Throughout the group, my process recordings reflected that the women displayed a great deal of insight into the issues, and showed one another compassion and understanding. My reflections after session eleven, as discussed in chapter four, noted that the women felt that the group had met their expectations and had assisted them in meeting personal goals. This is confirmed to some degree by the group feedback forms.

Summary of Qualitative Findings: The qualitative findings of the practicum showed that the group can be considered a useful intervention for the development of positive coping in childhood sexual abuse survivors. The eleven group members found the experience to be useful and positive, with agreement that many group and personal goals were met, either to completion or in a beginning way. In addition, the qualitative findings provided some evidence that levels of

positive coping have an impact on participants' levels of self-esteem and, as I had hoped, provided some insight into the types of contextual issues that impact self-esteem and coping levels.

IMPLICATIONS

Many different techniques were employed in the group intervention and it is impossible to separate the effects each exercise had on the group as a whole. The effects of the exercises, artwork, group discussions, visualizations, education, and the general group support are all interrelated, and many proved to be useful in the development of positive coping. Several implications arising out of the practicum findings follow:

(1) it is possible for survivors of childhood sexual abuse to develop positive coping in adulthood;

(2) it is possible for survivors to increase, to some degree, their levels of self-esteem;

(3) there is a relationship between the development of positive coping and levels of self-esteem;

(4) it is also possible for survivors to increase the level to which they are living their lives with attention to all four aspects of the self;

(5) coping methods are essential for survivors to ameliorate the long-term effects of the abuse, and it is possible and useful to become aware of the costs and benefits of these coping strategies and make decisions about their use;

(6) group interventions for adult survivors of childhood sexual abuse can assist in the development of positive coping through connection with other survivors.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

This chapter provides a summary of the practicum process and the learning benefits that resulted, and ends with recommendations for further intervention. The primary goal of the practicum was the development, implementation, and evaluation of a twelve week group program for adult female survivors of childhood sexual abuse to assist them in the development of positive coping behaviours. Eleven women participated in two groups, in which they shared their experiences in commonality with other survivors. As a result, they met personal and group goals - developing skills in self-care, assertiveness, and interpersonal relating, and beginning to increase self-confidence and inner strength, as well as beginning to recognize and manage the patterns in their lives.

Changes within the women due to the group intervention are difficult to measure, but there was an indication of an increase in positive coping, and some increases in self-esteem. It was found, however, that the women did gain from the group experience, by decreasing feelings of isolation, increasing their understanding of themselves, and gaining some practical skills in ameliorating the effects of the abuse. The women came to the group with a somewhat limited understanding of their coping patterns, and left having gained some insight into how their coping strategies developed, being able to honour these as adaptive, and feeling free to make decisions about their current utility.

The women shared openly, bravely completing challenging activities, and forged connections with one another, connections they later found difficult to give up. All of the women

reported having had a positive experience that resulted in many personal gifts, most of which they credited to the support and understanding of the other group members.

LEARNING BENEFITS

The personal learning goals of the practicum were: to increase my skills in feminist group facilitation with survivors, specifically in the areas of planning, co-facilitation, and balancing structure and flexibility; to increase my knowledge in the area of single system research design and its integration with practice; and to increase my understanding of the impact of childhood sexual abuse on survivors, specifically in the area of compulsive coping and the development of positive coping alternatives. I have discovered that there was far more to learn, and that I received learning benefits beyond what I had anticipated.

The main learning benefit came from the group participants. The perseverance and inner strength of the eleven women has impacted me on a deep level, and has greatly increased my understanding of the effects of sexual abuse. I gained information about compulsive coping and the development of positive coping, but the womens' words have had a far greater impact. The personal learning was greater than the professional learning by far, and I will carry the lessons with me always.

I gained a greater understanding of my style of co-facilitation, as I had hoped, and I discovered that I work best with a balance of structure and flexibility. I found it important to have an overall plan as well as a session agenda to provide focus, but that it was just as crucial to be willing to adapt the agenda when the need arose. I was aware of the fact that the groups were a part of my practicum, and that I could be tempted to be more structured than necessary; however,

the women were able to ask for what they needed, and we spontaneously adapted the sessions together when it seemed beneficial. The structure seemed to provide some safety, while the flexibility was important for enhancing the feelings of ownership and belonging of group members. I felt that I was able to work well with both co-facilitators, and the women in both groups seemed to view us as equal partners in facilitation. None of the women seemed to make more eye contact or address more questions or concerns with me rather than the volunteer co-facilitators, and both the volunteers later said they felt that they were viewed equally by participants. My dual role as a student and clinician did not present any problems for me during the group process, but I was aware of the role challenges when the issue of the measures arose. I felt pleased with the group itself, but I had some guilt about asking the women to complete the measures, despite the fact that as I designed the measurement plan I did not feel that I was overloading participants with 'paperwork'. I am aware that my fear of overloading the participants resulting in my being overly apologetic about the required recording, which I am sure had an impact on the return rate.

My experience in developing a group intervention was valuable. It was exciting to create a group with a lighter, more positive focus. I was able to adapt and create a variety of exercises to achieve group objectives, and I found the results and the positive feedback rewarding.

This was not my first experience in group facilitation, but it was my first experience in measuring the results to this level; my only previous experience was with pre- and post-tests and general group feedback forms. I was concerned about the impact of the measures on the group members, and the return rate showed that my concern may have been justified. I feel pleased, however, that only those who felt able participated in the measurement process, and that some of

the women were assertive enough to refuse. I hope to learn more about evaluation procedures and less intrusive methods of evaluation in the future. In future group programs I would use fewer measures, and I would ask group participants to complete measures during session time to increase return rates.

I feel my understanding of survivors has increased, as it has with every group I have co-facilitated, and I was able to increase my understanding of the special issues of coping and self-esteem. This was accomplished through both the review of the relevant literature and in the development and facilitation of the group intervention. The practicum experience was rewarding, and I achieved my stated personal learning goals and learned far more than anticipated.

RECOMMENDATIONS

The delivery of the practicum intervention has generated several recommendations for the future. First, I would not extend the twelve week length of the group, but I would incorporate it into a series of groups delivered at the agency. I would have it follow the "pre" group but precede the regular sexual abuse group for survivors. A group longer than twelve weeks creates a problem in that it is difficult to commit to more than twelve consecutive sessions; however, I would offer a follow-up session in the future, which I view as beneficial. As stated earlier, this option was impossible in this case.

Second, I would decrease the number of measurement tools used, and I would definitely incorporate the completion of the measurement tools into group session time, to increase the return rate. A higher return rate would make the discussion of findings and implications far more valuable. I would incorporate more participant feedback about session agendas before the group

began to increase the sense of ownership early on, and I would provide a readings package to participants during the intake session, including some beginning exercises, to increase the level of understanding going into the group process.

Third, on a structural level, this practicum has made me more aware of the need for awareness training for professionals in the community in the area of childhood sexual abuse. The majority of my learning in this area came from my own study as little preparation is received in schools of social work. The social work community should address this lack by providing course work on the prevention and long-term effects of childhood abuse. During the course of this practicum and in my work at The Laurel Centre I have been impacted by the number of women seeking service for the effects of childhood sexual abuse. Community agencies whose work focuses on abuse should be provided continued funding for the delivery of workshops to relevant professionals to increase awareness and understanding of the issues facing survivors. On a larger scale, governments need to increase funding for the provision of services to the growing numbers seeking assistance with the long-term effects of childhood sexual abuse, and for increased public awareness and education to assist in the understanding and prevention of abuse. As a society, we need to struggle against the prevailing patriarchal structure that supports the continued sexual abuse of children, as well as strive toward an abuse-free environment while providing intervention to assist adult survivors on their arduous healing journeys.

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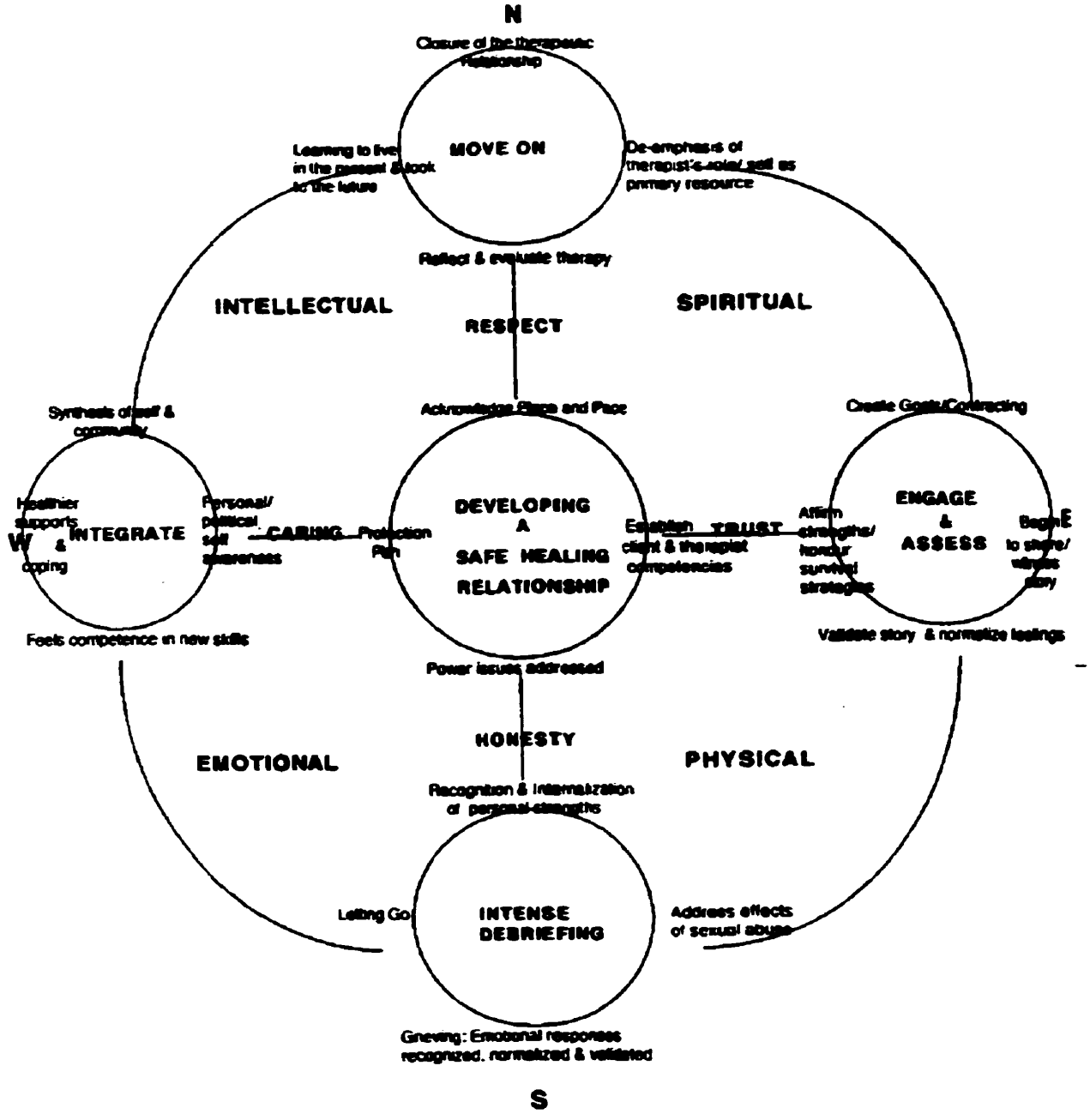
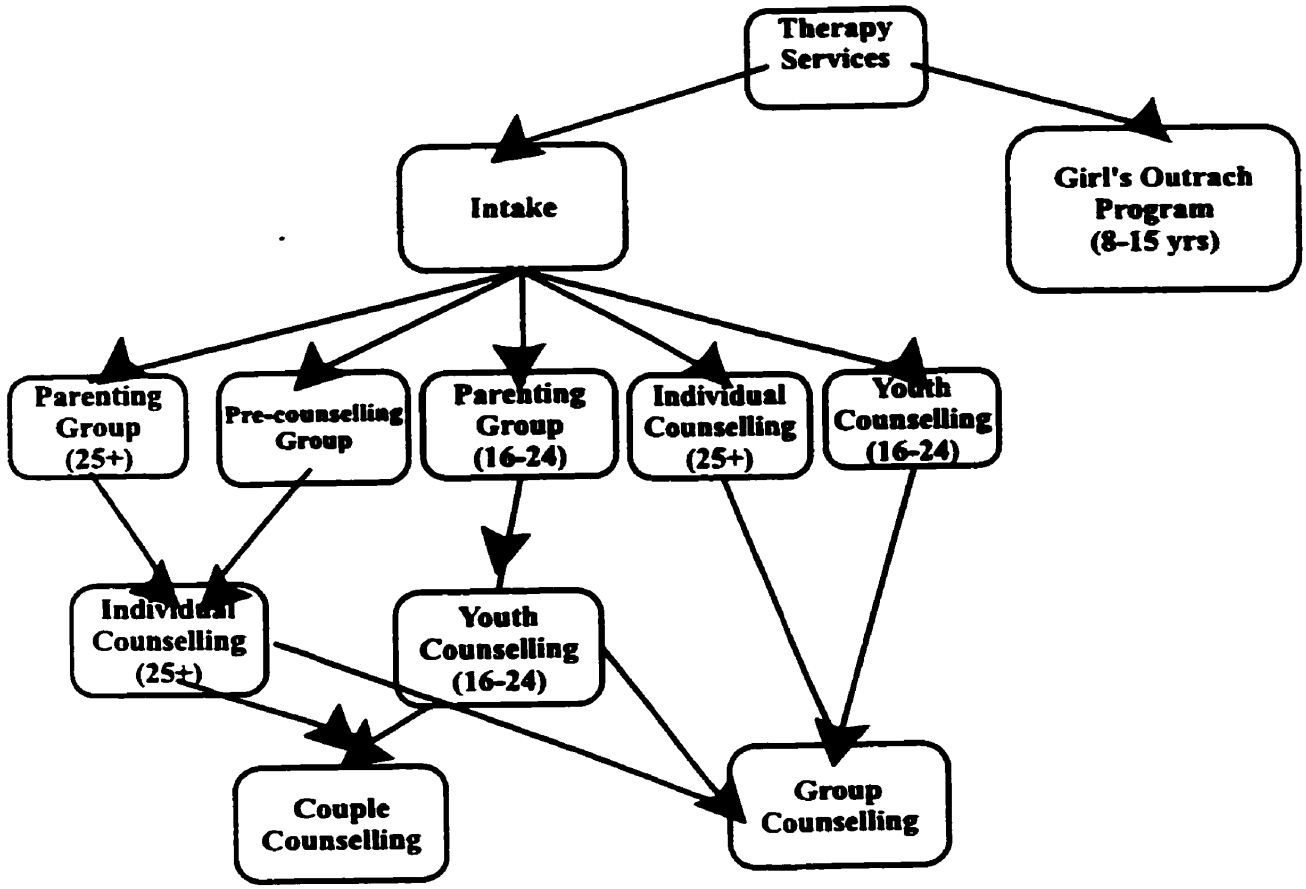
APPENDICES A - Z3

THE LAUREL CENTRE CLINICAL STATEMENT



THERAPY PROGRAM CHART



APPENDIX C

DEVELOPING POSITIVE COPING GROUP
Intake Form

1. What would you like to get from the group experience?

2. Have you had previous group experiences?

    a) What was that like for you?

    b) What did you like / not like?

    c) How did you act in the group - talkative, quiet?

3. What do you do when you are really stressed?

4. What kind of support network can you easily and comfortably call upon at this time in your life?

5. How will you feel about being in a diverse group in which people may be very different from you (class, race, age, sexual orientation, etc)?

6. What types of things might get in the way of you coming to group or completing group? a) health concerns b) childcare c) transportation?

7. Do you have any questions you would like to ask?

Review dates and times of sessions, and group outline. Hand out and explain the pre-questionnaire and measures package.

CONSENT INFORMATION

You are being asked to participate in a Masters of Social Work Practicum study that is aimed at helping women develop positive coping mechanisms. If you choose to participate, you will be asked to complete short weekly questionnaires and brief journalling questions; these measures must be filled out for the four weeks prior to the group, the twelve weeks of the group, and for the six weeks immediately following the group. The data from the questionnaires and journals will be published in the form of a Masters Practicum report. Before you make a decision about participating I want to make sure that you fully understand your rights as a potential participant.

You should be aware that:

1. Participation in this study is completely voluntary. It is up to you to decide whether or not you wish to take part in the study. If you choose not to participate, your counselling at The Laurel Centre will not be affected in any way. Your decision will not determine whether or not you receive services from the agency.

2. You may withdraw from the study at any time and this will not affect your counselling at The Laurel Centre. You have the right to rescind your consent at any time. If you do so, the information we have already collected will be destroyed.

3. The responses will be kept completely confidential. Your completed questionnaires will be identified by number and will not contain your name of other identifying information. Data obtained for the purposes of the study will be used in a manner that maintains confidentiality and your personal rights. However, it is possible that information obtained for the purposes of the study may be recognized by your referring therapist and other group members. Furthermore, because the co-facilitator and I have conducted the group, we will know who each respondent is. According to the policies of The Laurel Centre, confidentiality may be breached in the following extreme circumstances: there is a definite and imminent possibility of suicide or homicide, or a child is at high risk for physical or sexual abuse. In these instances, the appropriate authorities will be notified by the student/researcher if the participant is not willing to report or take the necessary steps to reduce the risk.

CONSENT INFORMATION, CONT.

4. You may request the results of the study. At the end of the study, you may request to see the written results.

5. The implementation of the group program will be supervised by the Executive Director of The Laurel Centre. I will also be discussing the program with my practicum advisor, Kim Clare.

6. The student will be advised and directed by a thesis committee with the following members: Kim Clare, MSW (Professor, Faculty of Social Work), Heather Block, BSW (Executive Director, The Laurel Centre), and Ellen Tabisz, MSW (Adjunct Professor, Faculty of Social Work).

7. Participation in group may precipitate crisis. As is true for most group experiences, there is the possibility of some experience of crisis, as a result of issues that are raised by the group content. The group facilitators will work in conjunction with your primary therapist to ensure that you have adequate supports and resources in place to deal with any crisis that may arise as a result of the group content.

8. Possible benefits to participation. The group is designed to assist in addressing issues of coping for sexual abuse survivors. There is the possibility of benefit to participants in the study as a result of the group intervention.

Thank you for taking the time to consider participating. If you have any questions or concerns, please feel free to discuss them with your therapist, or with Dana Beaton-Stokell.

APPENDIX E

CONSENT FORM

I, _____, give my consent to have the written information I provide during the course of the treatment group used for the purposes of a Masters of Social Work Practicum Report. I understand that I will complete weekly questionnaires for the duration of the twelve week group, as well as for a four week period before the group begins, and for a six week period after the group has ended.

I provide this consent voluntarily, and understand that I may withdraw my consent at any time without penalty.

I understand that, as a participant in this treatment group, my rights will not be jeopardized, that my privacy will be maintained, and that the data obtained for the Masters of Social Work Practicum report will be used in a manner that maintains confidentiality and personal rights.

Name of Participant (please print):_____

Signature of Participant:_____

Date:_____

Signature of Masters Student: _____

GROUP QUOTATIONS

~"There is a place in the world that only you can fill."

~"Believing in our hearts that who we are is enough is the key to a more satisfied and balanced life."
~Lillian Sue Stern

~"The golden opportunity you are seeking is in yourself."

~"Work is not always required...there is such a thing as sacred idleness, the cultivation of which is now fearfully neglected."
~George MacDonald

~"Perfectionism is self-abuse of the highest order."
~Anne Wilson Shaef

~"Within your heart, keep one still secret spot where dreams may go."
~Louise Driscoll

~"Like an ability or a muscle, hearing your inner wisdom is strengthened by doing it."
~Robbie Gass

~"What matters most is what we learn from living."
~Doris Lessing

~"No snowflake ever falls in the wrong place."
~Zen saying

~"The quality of life is in proportion to the capacity for delight."

~"There is only one journey. Going inside yourself."
~Rainer Maria Rilke

~"It is good to have an end to journey towards; but in the end it is the journey that matters."
~Ursula K. LeGuin

GROUP AGREEMENT

- we will use a speaking stone for check-ins and check-outs and for rounds when debriefing an exercise.

- confidentiality - what is said here, stays here.

- if we meet one another in public we will say hello, but we will introduce one another as friends, rather than as group members.

- we can leave the room if we need to, but we will let a co-facilitator know if we plan to leave the session completely.

- the show of emotions is OK - tears are not an interruption. We can offer kleenex as a way of acknowledging someone.

- no touching unless it is requested.

- we will respect how each individual needs to be acknowledged.

- we have the right to "tune out" or not participate in an exercise.

- we will try to start and end on time.

- we will be respectful and nonjudgmental.

- we will not interrupt one another.

-we will not give advice or opinions - experience sharing is OK.

EXPECTATIONS

FOR THE GROUP:

-to learn skills to deal with depression, isolation, and shame

-to redefine our sense of ourselves

-to normalize our experiences through sharing with the group

-to take care of our physical health

-to improve our self-confidence

-to gain balance and integration of the four aspects of ourselves (physical, emotional, intellectual, and spiritual)

-to recognize and manage the patterns in our lives

-to better care for ourselves through the consistency of attending group each week

-to develop inner strength to take charge of what we want in our lives

-to use group as a place to ground ourselves and refocus our issues

-to view coming to group as a tangible symbol of taking care of ourselves

-to see ourselves as more than just the experiences we have had

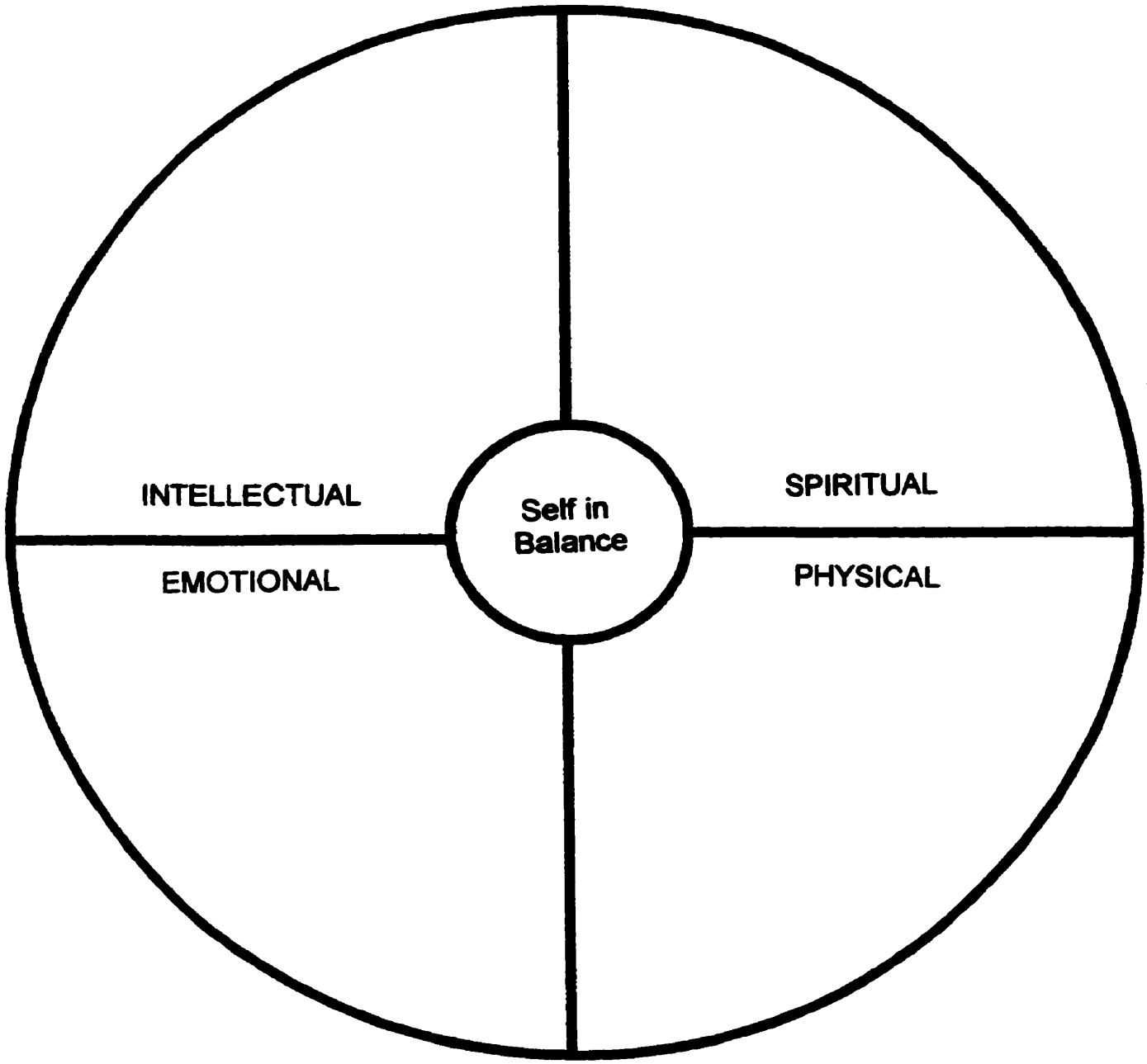
FOR LIFE IN GENERAL:

-to know that our children will grow up differently than we did

-to go back to school (or meet other life goals)

-to gain more strength to help us meet personal goals, like moving out on our own

SELF IN BALANCE WHEEL



Fill in the four areas that represent the aspects of self with words, colours, or pictures that represent how you feel you cope in this area, or what each area means for you. Do you feel you cope well physically, but need to develop your spiritual side, etc? Complete this exercise in whatever manner feels right to you. You may want to journal about it afterward.

Be good to yourself...

Keep a journal
Play the piano
Sign up for a yoga class
Take the stairs instead of the elevator
Listen to a symphony
Dance around the living room
Watch a sunset
Plant a garden
Run on the beach
Find something good in everyone you meet
Take a walk (especially a brisk walk)
Make a list of your good qualities
Laugh at yourself
Stop and smell the spring
Hug a child
Express appreciation
Cook a vegetarian dinner
Set one short-term goal for self improvement
Receive a compliment without apology
Have a good cry
Take 10 deep breaths
Reward yourself on reaching a goal
Meditate
Begin daily stretching exercises
Take a pottery class
Take a sabbatical
Recycle your newspaper and cans
Go backpacking
Quit smoking starting right now
Decide today to begin flossing
Clean out a closet
Give clothes to the goodwill
Visit someone in the hospital
Donate blood
Pull weeds
Look at clouds
Walk in the snow
Make herb tea
Listen to the rain
Fish
Get up early and listen to the quiet
Listen to children laugh
Take in a funny movie
Watch the sunrise
Buy some new clothes
Eat by candlelight
Sit by the fire
Chop wood
Have someone rub your back
Write poetry
Sing
Take a shower
Read a novel
Sit in a hot tub
Dance
Go to 31 Flavors
Fly a kite
Day dream
Doodle
Read a magazine ✓
Bake bread ✓
Take a trip
Play a board game ✓
Sew
Swim ✓
Play tennis
Tell someone you love them
Call a friend
Pop some popcorn
Go to a concert
Go to a museum
Go to a ball game
Take a drive to the mountains
Take a walk in the grass with your shoes off
Waste time without feeling guilty
Buy a present
Finish a project
Look out a window
Write a letter
Write a thank-you note
Pay a bill
Throw a non-alcoholic party
Make s'mores
Barbeque
Take a bath for as long as you want
Go window shopping
Go for a walk with a child
Go skinny dipping
Wear new socks/underwear
Put on old clothes
Have a water fight
Have a picnic
Have breakfast in bed
Ride a train
Enjoy a pretty girl or handsome guy
Swing
Go sailing
Float on an air mattress
Sleep with warm covers
Go rollerskating
Go horseback riding
Eat a pizza
Throw a frisbee
Jump in a pile of leaves
Build a fire
Drink a cup of cocoa
Get physically exhausted
Go to bed early
Watch the rain
Turn off the TV
Hold a baby
Listen to a story
Go to a meeting
Play a musical instrument

WAYS WE HAVE SURVIVED

~staying too busy (work, other ways)
~gambling
~isolating ourselves (physically / emotionally)
~zoning out
~forgetting
~cutting, other self-harm behaviours
~alcohol
~focusing on others
~prescription drugs / illegal drugs
~relationships
~fantasy
~chasing the adrenaline rush
~shopping
~strenuous exercise
~food (overeating, undereating, other weight preoccupied behaviour)
~sexual compulsivities
~playing roles
~cleaning
~dissociation
~feeling shame / guilt
~obsessive-compulsive behaviours / rituals to replace addictions
~tarot, I Ching
~positive affirmations
~music
~helping others in similar situations
~eating well
~addressing our medical needs
~showing respect
~burning candles
~smoking
~humour
~taking bubble baths
~walks
~appreciating beauty
~taking time out
~choosing positive relationships
~meditation
~focusing on making loving choices
~breathing exercises

Drug(s) of Choice

COSTS	BENEFITS
-health risks	-numbs pain
-impact on others	-provides an escape
-financial impact	-controls flashbacks
-illegal aspect	-manages emotions
-impairment of functioning (ie. work)	-medicates (for depression, anxiety)
-loss of self-esteem	-fitting in
-prevents self-growth	-reduces stress
-creates stress	-maintains status quo: we don't need to change
-emotionally crippling	

Food (under or over eating, weight preoccupation)

COSTS	BENEFITS
-health	-comfort / pleasure
-impact on others (relationships suffer)	-distracting (from thoughts / feelings)
-shame	-tactile experience
-body image	-numbing
-emotional growth is hampered	-social
-financial aspect	-structure / safety
-unconscious (not aware of choice)	-learn more about self (triggers)
-isolation	-withdraw
	-purging can expel feelings/thoughts
	-being overweight can insulate us

STRENGTHS OF WOMEN

- compassionate
- resilient
- excellent communication skills
- responsible
- wise
- courageous
- mature
- intuitive
- resourceful
- willing to try
- insightful
- assertive
- loving
- creative
- tough
- voiceterous
- sense of humour
- beautiful
- good listeners
- introspective
- analytical
- efficient
- delegators
- confident
- fighters
- lots of faith
- flexible
- adaptable
- inspiring
- optimistic
- non-judgmental
- bond with others
- rise to the challenge
- honest
- strong sense of conscience
- expressive of feelings
- intelligent
- feminine
- congruent
- aware
- open
- strong
- observant
- validating of others

WHAT CAN WE DO TO FEEL SAFE WHEN WE ARE OVERWHELMED?

~call a friend
~breathe
~drink something (non-alcoholic)
~lay with a blanket and watch TV
~turn on the lights
~hug a pet or stuffed animal
~use a security alarm
~walk away
~hypervigilance
~positioning of our bodies in a room
~physical boundaries
~close the door
~escape clause (we can leave if we want to)
~familiarity
~carry a whistle / keys
~saying NO
~closing your eyes
~time outs
~meditation / visualization
~go somewhere safe
~stretching
~standing up
~music
~safety plan
~not answering the door / phone
~call display
~having boundaries (emotional / physical)
~having some rules about safety
~have a comfort object
~write / doodle
~cook / stay in to eat
~having private space
~bubble bath
~tune out
~safe phrases / answers
~driving (with music)
~working out
~being in control of self
~choosing your company
~having choices
~dressing (clothes as armor)
~laughter
~anger
~using language
~look at something comforting

RAINY DAY BOX ITEMS

*bubble bath / bath oil
*safety plan
*stones
*stickers
*fake tattoos
*games / word puzzles / cards
*Tarot cards
*grounding object
*bible / spiritual items
*rainy day letter to self
*pictures
*art supplies
*book of humour
*recipes for comfort food
*candles
*soap
*face paints / clown nose
*tea / cocoa / flavoured coffee
*stuffed toys
*poem / piece of writing
*meaningful jewellery
*juggling balls
*chocolate / candy
*crystals
*relaxation / visualization tape
*favorite music tape / CD
*flowers / petals / potpourri
*letters / cards from support people
*exercise bands
*sensory items (soft piece of cloth)
*playdoh / silly putty
*squeeze ball
*mementos of milestones
*incense
*emery boards / nailpolish
*lotion

Emotional Protection Plan

There will likely be times in your healing journey when you are feeling overwhelmed. At these times, it is often easiest to shut down or to respond in a way which may be hurtful to you. Many people have difficulty remembering their friends' phone numbers, let alone how to respond in a protective fashion.

The following exercise will help you identify some of your internal and external supports, and practical ways to ground and comfort yourself. After completing it, keep this sheet where you will have easy access to it.

1) Name your support person(s) and their phone numbers:

_____

_____

_____

2) List crisis line numbers:

_____

_____

_____

3) Name three concrete items that bring inspiration, a sense of calm, or which are reminders of a safe place:

_____

_____

_____

4) Identify a symbol of comfort and security:

_____

5) Name a soothing song or poem:

_____

6) Make a list of simple things that satisfy the senses (taste, touch, sight, smell, hearing)

_____

_____

_____

7) Complete a grounding / breathing exercise.
8) Read affirmations aloud.

EMOTIONAL PROTECTION PLANNING

Things to think about while creating an emotional protection plan:

1) Learn to recognize the signs of building panic / crisis:

When I feel anxious, I _____
_____
_____

Right before I have a major anxiety attack, I _____
_____
_____

Try using your plan when you see these signs rather than after the crisis state begins.

2) Make a list of what to avoid in a crisis: _____
_____
_____
_____

3) What would help me to use my emotional protection plan?
_____
_____
_____

4) What would get in the way of using my plan?
_____
_____
_____

5) What could I do to get past the obstacle?
_____
_____
_____

USING EMOTIONAL PROTECTION PLANS

BARRIERS	HELPERS
-letting it go beyond the point where the E.P.P or rainy day box is helpful	-know early signs of crisis and and pay attention to them
-not allowing ourselves to feel the signs of crisis	-journal to recognize the pattern in the past and recently, leading to current feelings
-FEAR	-use affirmations
-inner saboteur/critic	-practice basic daily self-care
-crisis is a known state - familiar	-be connected to like-minded people who know it is OK to care for ourselves
-society: women are socialized to care for others, not ourselves	-read things that reinforce self-love and self-care
-guilt / shame	-know that it is OK to say NO
-isolation	-pay attention to our own needs
	-try to move away from shame and guilt...know it is OK to make mistakes
	-know that change is not a linear process-it is an ongoing spiral
	-imagine how we would help/encourage another person and do that for ourselves
	-be kind to ourselves

Boundary Exercise:

1. Find a comfortable place to sit down with your partner.

2. When you are settled take a deep breath and I want one of you to take a piece of chalk and draw a circle around yourself [person A]

3. When you have finished drawing the circle, take a deep breath and just notice how you feel in your body. Remember there are no right or wrong answers. How does it feel to have this circle around you? How has your body let you know this is what you are feeling?

4. [To the participant with out a circle, person B] How do you feel about A having a circle and you not having a circle. How has your body let you know this is what you are feeling?

5. Now I want B to draw a circle around herself.

6. How does it feel now for you B? Do you notice any difference in how you feel?

7. How about you A, how are you feeling?

8. Now A I would like you to erase your circle? How does that feel? Do you notice any changes?

9. How about you B, how do you feel? Where in your body are those feelings?

10. Now B erase your circle? How does that feel? Check into your body to notice any changes.

11. Now which of these scenarios is most comfortable? Which was least comfortable? Which was the most familiar? Which is the least familiar? Is there a difference between what is comfortable and what is familiar?

HOW CAN WE MAINTAIN OUR BOUNDARIES?

~speaking up for yourself
~physically making more personal space
~making a safe space of your own at home
~saying NO
~avoiding people who violate our boundaries
~taking a step back
~using body language / expression
~initiating your own comfort
~knowing your own rights
~being firm / persistent
~setting up limitations on your time
~remembering that everyone's boundaries are different
~listening to others - helps us know what to expect from them
~being aware of our own boundaries
~respecting our hunches - INTUITION
~being respectful of others' boundaries
~allowing those we trust to know our boundaries
~ASSERTIVENESS
~being aware of how are boundaries are different with different people / environments
~using humour / gentle sarcasm
~getting angry if we need to

INCORPORATING CREATIVITY

-woodworking
-clay pots
-making jewellery
-designing clothing
-rock painting
-sewing
-ceramics
-gardening
-womens' 'craft nights'
-dreamcatchers
-theatre
-paper mache
-stained glass
-drawing/sketching
-exercising/dance
-painting
-colouring
-knitting
-crochet
-baking/cooking
-weaving
-pottery
-quilting
-clowning
-rug hooking
-macrame
-collages
-writing
-adapting sewing patterns
-sculpting
-photography
-decorating and redecorating
-designing computer programs
-burning candles
-playing a musical instrument
-needlework/cross-stitch
-glass etching

IMAGINARY LIVES

~peaceworker in Peru
~famous singer
~killer whale
~counsellor (with sexually abused kids)
~set designer (movies/theatre/ballet)
~judge (like judge Judy)
~famous actress
~veterinarian
~motivational speaker
~mermaid
~sculptor
~astrologer
~airline stewardess
~curator at a London gallery
~psychic investigator
~tattoo artist
~artist (sketching)
~mystery novelist
~yoga instructor
~social worker
~hockey player
~freedom fighter
~interior decorator
~Laotian monk
~a woman of independent means
~trainer at Sea World
~photographer (National Geographic)
~herbalist
~astronaut
~fire fighter
~student at Oxford (any subject)
~signer (ASL)
~geologist
~soap opera actress (Y&R)
~Nobel peace prize winner
~director (theatre)
~police officer

WHAT KEEPS US HOPEFUL?

~something within our hearts

~realizing our abuse was not in God's / Creator's hands - acknowledging that there are good and bad people who all have free will

~taking the man / gender out of God

~singing

~inner strength

~realizing that everything happens for a reason and seeing the strength we've gained as a result of being a survivor

~learning that spirituality is not about sin and punishment, but about consequences

~connectedness

~knowing that someday the pain won't be as bad and we'll gain some balance

~knowing that there are good people out there

~knowing that we are not alone in this: others have survived and left behind a legacy for us

~we are stronger in the broken places (we would not be who we were if not for our pasts, including our good qualities)

~knowing that spirituality is not about religion but about how WE understand it

~seeing the spiritual in the everyday and all around us, not just in the huge almighty

~believing there is something out there bigger than us - we are not alone

~allowing ourselves to BELIEVE

~we can take what we need and leave the rest

~knowing that we can integrate recognized and unrecognized forms of spirituality that speak to us

~nature - waterfalls, animals, birds, thunder

~allowing ourselves sacred moments to TAKE NOTICE

~bubble baths

~sharing circles

~knowing that the best revenge is living well, and that we can thrive, not just survive

~breaking the cycle - we weren't protected but we can protect others

~speaking out (for some)

~knowing that tomorrow is a new day and we never know what blessings it might bring

~gratitude - counting our blessings

~when the student is ready the teacher will come

~pets - unconditional love

~protecting ourselves first

~dance / movement

~making peace with ourselves

~knowing that no one is born just to suffer - we can try to stick around to discover what we are meant to be here for

~know that JOY IS OUR BIRTHRIGHT

~"we reveal our destiny in life...it's already there...we just have to find it"

SMALL JOYFUL THINGS

-making a wish on a dandelion
-making a wish on a star
-watching for shapes in the clouds or in a fire
-playing in water
-blowing bubbles
-straw fights
-making Jell-o jigglers
-'parsley game' (at your own table)
-playing catch
-flying a kite
-swinging
-dancing in the rain
-making faces in the mirror
-playing with play-doh
-playing with makeup
-putting in pigtails or braids-enjoying your hair
-watching cartoons
-buying out-of-season fruit
-buying flowers for yourself
-baking fun things (cookie faces/shapes)
-decorating for holidays
-playing dress-up
-dunking cookies in milk
-taking funny pictures
-singing
-tree hugging
-going barefoot
-going naked
-running through a sprinkler
-water gun fights
-nerf ball gun fight
-skateboarding
-spraying people with the hose
-washing the car
-snowball fights
-catching snowflakes on your tongue
-colouring
-making snow angels
-spitting sunflower seeds
-splashing in puddles
-buying/eating candy
-skipping
-telling jokes
-going to a carnival
-kicking a stone down the street
-batting around a balloon
-drinking slurpees
-hopscotch
-walking on curbs
-playing with toys/Legos
-sitting under a full moon
-making a blanket fort

Nurture the Body, *Inform* the Mind, *Celebrate* the Spirit.
Inform the Spirit, *Celebrate* the Body, *Nurture* the Mind.
Celebrate the Mind, *Nurture* the Spirit, *Inform* the Body.

Be what you want, but always be you.

80% Teacher
20% Show Off
100% Genuine

Believe

Celebrate the solstice

Honoring the Goddess Woman

INTELLECTUAL

SPIRITUAL

Self in Balance

EMOTIONAL

PHYSICAL

Follow Your Senses

It's about what you want.

It's about health and living well.

Fat and Fit

Whatever Makes You Merry.

Don't put unnecessary medicine into this perfect little package.

APPENDIX Zi

SELF-ESTEEM RATING SCALE (SERS)

AUTHORS: William R. Nugent and Janita W. Thomas

PURPOSE: To measure self-esteem.

DESCRIPTION: The SERS is a 40-item instrument that was developed to provide a clinical measure of self-esteem that can indicate not only problems in self-esteem but also positive or nonproblematic levels. The items were written to tap into a range of areas of self-evaluation including overall self-worth, social competence, problem-solving ability, intellectual ability, self-competence, and worth relative to other people. The SERS is a very useful instrument for measuring both positive and negative aspects of self-esteem in clinical practice.

NORMS: The SERS was studied initially with two samples. Sample 1 contained 246 people, of whom 91 were male and 155 female, with an average age of 32.5 years and an average of 15.7 years of formal education. Thirty-one percent were white, 11.8% black, 4.5% Hispanic, 7.7% Asian, and the rest were mixed or other groups. Sample 2 involved 107 people including 23 males and 84 females, with an average of 15.3 years of education; 93.5% were white, 4.7% black, and the rest in other groups. Actual norms were not available.

SCORING: The SERS is scored by scoring the items shown at the bottom of the measure as p/+ positively, and scoring the remaining items (N/–) negatively by placing a minus sign in front of the item score. The items are summed to produce a total score ranging from –120 to +120. Positive scores indicate more positive self-esteem and negative scores indicate more negative levels of self-esteem.

RELIABILITY: The SERS has excellent internal consistency, with an alpha of .97. The standard error of measurement was 5.67. Data on stability were not reported.

VALIDITY: The SERS was reported as having good content and factorial validity. The SERS has good construct validity, with significant correlations with the Index of Self-Esteem and the Generalized Contentment Scale (a measure of depression) as predicted, and generally low correlations with a variety of demographic variables, also as predicted.

PRIMARY REFERENCE: Nugent, W. R. and Thomas J. W. (1993). Validation of the Self-Esteem Rating Scale, *Research on Social Work Practice*, 3, 191–207.

AVAILABILITY: Journal article.

SERS

This questionnaire is designed to measure how you feel about yourself. It is not test, so there are no right or wrong answers. Please answer each item as carefull and accurately as you can by placing a number by each one as follows:

1 = Never
2 = Rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = Always

Please begin.

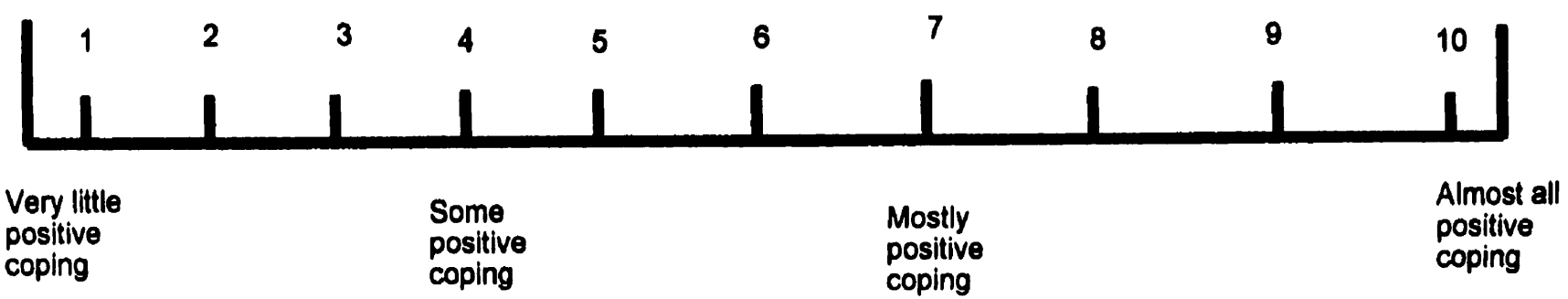
____ 1. I feel that people would *NOT* like me if they really knew me well.
____ 2. I feel that others do things much better than I do.
____ 3. I feel that I am an attractive person.
____ 4. I feel confident in my ability to deal with other people.
____ 5. I feel that I am likely to fail at things I do.
____ 6. I feel that people really like to talk with me.
____ 7. I feel that I am a very competent person.
____ 8. When I am with other people I feel that they are glad I am with them.
____ 9. I feel that I make a good impression on others.
____ 10. I feel confident that I can begin new relationships if I want to.
____ 11. I feel that I am ugly.
____ 12. I feel that I am a boring person.
____ 13. I feel very nervous when I am with strangers.
____ 14. I feel confident in my ability to learn new things.
____ 15. I feel good about myself.
____ 16. I feel ashamed about myself.
____ 17. I feel inferior to other people.
____ 18. I feel that my friends find me interesting.
____ 19. I feel that I have a good sense of humor.
____ 20. I get angry at myself over the way I am.
____ 21. I feel relaxed meeting new people.
____ 22. I feel that other people are smarter than I am.
____ 23. I do *NOT* like myself.
____ 24. I feel confident in my ability to cope with difficult situations.
____ 25. I feel that I am *NOT* very likeable.
____ 26. My friends value me a lot.
____ 27. I am afraid I will appear stupid to others.
____ 28. I feel that I am an OK person.
____ 29. I feel that I can count on myself to manage things well.
____ 30. I wish I could just disappear when I am around other people.
____ 31. I feel embarrassed to let others hear my ideas.
____ 32. I feel that I am a nice person.

___ 33. I feel that if I could be more like other people then I would feel *better* about myself.
___ 34. I feel that I get pushed around more than others.
___ 35. I feel that people like me.
___ 36. I feel that people have a good time when they are with me.
___ 37. I feel confident that I can do well in whatever I do.
___ 38. I trust the competence of others more than I trust my own abilities.
___ 39. I feel that I mess things up.
___ 40. I wish that I were someone else.

(p/+) 3,4,6,7,8,9,10,14,15,18,19,21,24,26,28,29,32,35,36,37.
(N/–) 1,2,5,11,12,13,16,17,20,22,23,25,27,30,31,33,34,38,39,40.

APPENDIX 21

Please indicate, in the journal provided, a score that you feel represents the level to which you were able to employ positive coping methods throughout the last week. Please indicate the date. Then, please write a statement that answers the question 'what was going on for you during the week that may have contributed to your level of coping?' The statement may be 2-3 sentences or as long as necessary.



LEVEL OF POSITIVE COPING

THE LAUREL CENTRE INC.

Clinical Measures

Evaluation Questionnaire Scales
Section IV / Policy 4

The Laurel Centre uses the following measurements for their evaluation of clinical services.

HEALTH SYMPTOMS CHECKLIST

Questionnaire Items:	1a-1p				
Range:	0-48		Reliability:	0.78	
Mean=	9.02	SD=	5.98	RCD=	7.77
High score=	many symptoms reported (poor health)				

MOS GENERAL HEALTH SURVEY SCALES

Physical Functioning

Questionnaire Items:	4a-4f				
Range:	0 to 100		Reliability:	0.86	
Mean=	83.4	SD=	27.3	RCD=	28.31
High score=	few limitations to physical activities (good health)				

Role Functioning

Questionnaire Items:	5,6				
Range:	0 to 100		Reliability:	0.81	
Mean=	71.3	SD=	39.2	RCD=	47.36
High score=	few limitations to usual daily activities (good health)				

Social Functioning

Questionnaire Items:	7a				
Range:	0 to 100		Reliability:	--	
Mean=	87.7	SD=	22.3	RCD=	--
High score=	few limitations to normal social activities (good health)				

Mental Health

Questionnaire Items: 7b-7f
Range: 0 to 100 Reliability: 0.88
Mean: 71.2 SD= 19.6 RCD= 18.82
High score= good emotional/psychological well-being (good health)

Health Perceptions

Questionnaire Items: 2, 8a-8d
Range: 0 to 100 Reliability: 0.87
Mean: 69.9 SD= 25.5 RCD= 25.48
High score= good overall general health

Pain

Questionnaire Items: 3
Range: 0 to 100 Reliability: - -
Mean: 65.8 SD= 33.8 RCD= - -
High score= no bodily pain in past 4 weeks (good health)

USE OF MEDICAL/MENTAL HEALTH SERVICES

Questionnaire Items: 9a-9g

BRIERE & RUNTZ SELF-ESTEEM SCALE

Questionnaire Items: 10a-10g
Range: 7 to 35 Reliability: 0.64
Mean= 13.4 SD= 3.92 RCD= 6.52
High score= lack of self-esteem

BRIEF SYMPTOM INVENTORY (BSI)

Questionnaire Items: 11a-11bo
Range: 0 to 4

Somatization (SOM)
Obsessive-
Compulsive (O-C)
Interpersonal
sensitivity (I-S)

Depression (DEP)
Anxiety (ANX)
Hostility (HOS)
Phobic anxiety (PHOB)
Paranoid ideation (Par)
Psychoticism (PSY)

High score (SOM to Psy)= **subject possesses scale characteristic to a high degree**

General Severity Index (GSI)

Positive Symptom Total (PST)

Positive Symptom Distress Index (PSDI)

High GSI= **high level of globa distress**
High PST= **high level of reported symptoms (disregarding intensity level)**

IMPACT OF EVENTS SCALE

Intrusion subscale

Questionnaire Items:	12(a, d, e, f, j, k, n)				
Range:	0 to 35		Reliability:	0.89	
Mean=	6.1	SD= 5.3		RCD=	4.87
High score=	high level of "intrusively experienced ideas, Images, feelings, or bad dreams"				

Avoidance subscale

Questionnaire Items:	12(b, c, g, h, i, l, m, o)				
Range:	0 to 40		Reliability:	0.79	
Mean=	6.6	SD= 7.0		RCD=	8.89
High score=	high level of "consciously recognized avoidance Of certain ideas, feelings, or situations"				

PERCEIVED SOCIAL SUPPORT (from Friends) SCALE

Questionnaire Items: 13a-13t

ALCOHOL AND DRUG USE

Questionnaire Items: 14-20

GAMBLING

Questionnaire Items: 21a-21d

DEMOGRAPHICS

Questionnaire Items: 22a-22l

CLIENT SATISFACTION QUESTIONNAIRE (post version only)

Questionnaire Items: 23a-23h

Group Feed Back Form - The Laurel Centre

Date _____.

1. Did you attend group? ☐Yes ☐No

(If yes please complete the following) Circle the number that is most true for you.

	Not at all					somewhat				Very
2. Overall, how useful was the group to you?	1	2	3	4	5	6	7	8	9	10
3. Were your expectations met?	1	2	3	4	5	6	7	8	9	10
4. Did you feel safe in group?	1	2	3	4	5	6	7	8	9	10

5. Did you feel a sense of group unity - members working together towards a common goal? ☐Yes ☐No
6. The length of sessions was satisfactory ☐Yes ☐No
7. The number of sessions was adequate ☐Yes ☐No
8. Were the handout materials helpful/useful? ☐Yes ☐No
9. Did the group experience help you to attain a better understanding of yourself, your needs, and values? Explain_____

_____

_____

_____

_____

10. What aspect or experience was the most valuable to you?_____

_____

_____

_____

11. I liked_____

_____

_____

12. I did not like_____

_____

_____

13. Have things changed for you since you started group? If so, how?_____

_____

_____

_____

14. What, if anything, would you suggest we add, subtract, or change in future groups?_____

_____

_____