Practicum Project Report:

Working with the Effects of Addiction:

A Group Psychotherapy Experience with "Women Healing Together"

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WORKING WITH THE EFFECTS OF ADDICTION: A GROUP PSYCHOTHERAPY EXPERIENCE WITH "WOMEN HEALING TOGETHER"

BY

MARIANNE E. WILLER

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of

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of

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PART I: WHAT IS ADDICTION?

The Nature, Causes, and Kinds of Addictions

> *"The casting out of values by psychology not only weakens it, and prevents it from reaching full growth, but also abandons mankind either to supernaturalism or to ethical relativism."* - Maslow

Addiction is a complex human phenomenon that has many faces. There are many questions to be answered in the area of addictions. What exactly is an addiction, what are its characteristics, and what is its scope? What is it that drives an addiction? Why do some people, unlike most others who are involved in the same kinds of activities, conduct themselves with such abandon and intense preoccupation that the activity becomes self-destructive or diminishes or damages the person's life in dramatic ways? Why does the same substance or activity have one effect on one person but quite a different effect on another? Who is it that becomes addicted and how do they become addicted not only to specific substances but also to powerful experiences such as gambling or shopping?

Peele (1985, 1989, 1991) provides a comprehensive model of addiction which not only takes into account the physiological and pharmacological effects of drugs, but also incorporates a social-psychological level of analysis that integrates individual and cultural experiences. Peele ultimately rejects the disease model of addiction which he sees as seriously misrepresenting the nature and constancy of addictive behaviour and feelings. He provides a thorough analysis and critique of all aspects of the disease model and the related research evidence and insists that:

> *A successful addiction model must synthesize pharmacological, experiential, cultural, situational, and personality components in a fluid and seamless description of addiction motivation. It must account for why a drug is more addictive in one society than another, addictive for one individual and not another, and addictive for the same individual at one time and not another. The model must make sense out of the essentially similar behavior that takes place with all compulsive involvements. In addition, the model must adequately describe the cycle of increasing yet dysfunctional reliance on an involvement until the involvement overwhelms other reinforcements available to the individual...*
> *Finally, ... a satisfactory model must be faithful to lived human experience.* (Peele, 1985)

Addiction is defined by tolerance, withdrawal, and craving. Addicts are recognized by

their heightened and habitual need (or craving) for a substance, by the suffering they experience when the substance is discontinued, and by their willingness to give up everything else for the sake of the drug.

The concept of addiction has undergone significant change during the twentieth century. At one time addictions were believed to reside exclusively in the province of drug abuse, such as alcohol, narcotics, barbiturates, tranquillizers, or other illicit drugs. Accordingly, it was the drug's physiological effects on the body that supplied the two major diagnostic criteria for addiction, namely, tolerance and withdrawal symptoms. Tolerance means that ever larger amounts of the substance must be consumed to produce the same desired effect, while withdrawal symptoms refer to the physiological responses and readjustment that occur when the drug is reduced or discontinued. Thus addiction came to mean chemical dependency over which the individual has no control. However, what researchers realized was that even though each of the various classes of drugs is chemically distinct and each drug acts through different neurochemical pathways, the manifestations of tolerance and withdrawal remain the same. In attempting to explain this, researchers moved away from the old concept of addiction as physical dependence to a concept of addiction as psychological dependence. The central issue of drug dependence shifted away from the withdrawal syndrome and instead focused on the rewards and benefits that users get from drugs, namely, that it helps them forget their problems and pain and makes them feel good. This perspective emphasizes the individual's subjective experience with the drug by asking, "What does the drug do for the addict?"

Another piece of evidence that points away from characterizing addiction as a biochemical disease is found in developments in the field pharmacology where there has been an ongoing search for an analgesic, or painkiller, that would not create addiction. Heroin and cocaine were originally thought to be nonaddictive remedies for morphine addiction. What researchers found was that every new pharmaceutical substance that was effective in relieving anxiety or pain or that

had other psychoactive, psychological, or mood effects turned out to have addictive side effects after all. A large number of drugs including the barbiturates, artificially synthesized narcotics, and tranquillizers such as Valium were first welcomed as being nonaddictive but were later found to cause addiction in many, but not all, people.

What this points to is that addiction is *not* a chemical side effect of a drug but rather, a direct result of its psychoactive or psychological effects. Addiction results because of the way the substance alters sensations and feelings. It is the subjective psychological experience itself that the person becomes addicted to. What the research data has shown is that biochemical aspects of addiction are only half the story. Alcohol and other drugs have a powerful impact on both a person's body and feelings, but the point is that these effects do not in and of themselves produce addiction (Peele, 1980). What is at the core of an addiction is how an individual responds to and interprets his/her experience of the drug; it is something that happens inside one's consciousness.

At the same time in recent decades, the concept of addiction has expanded to include more and more behaviors and activities that absorb the person to the exclusion of other important aspects of his or her life. Besides drug and alcohol abuse, addiction could potentially occur with any human activity, including gambling, eating, smoking, sexual activity, love relationships, shopping, exercise, and even religious involvements. The addictive activity virtually becomes a total involvement. But are these activities truly addictions? The trend toward expanding the concept of addiction has highlighted the common features shared between drug addicts and addicts who compulsively pursue certain activities. Here again, the withdrawal syndrome was used to explain what was observed. Whether the addiction was to a drug or to an all-absorbing activity, withdrawal symptoms were common to both. The most intensely felt symptom of withdrawal was not chemical at all but rather "an agonizing sense of the absence of well-being, a sense of some terrible deficiency inside oneself" (Peele & Brodsky, 1991). Thus the same basic question applied to the drug addict also applies to the activity addict: "What does the involvement

do for the addict?"

By looking at the experience of addiction itself, one can determine what it does for the person. "All addictions *accomplish something for the addict*" (Peele, 1989). Addictions serve a purpose. An addiction allows a person to accomplish two things at the same time: first, to seek experiences that satisfy urgently felt needs they are unable to satisfy in other ways; it makes them feel good; and second, the addiction experience successfully, but temporarily, blocks out negative or painful feelings and sensations such as anxiety or uncertainty. Both drugs and compulsive activities have certain effects in common: they are all-absorbing, fast, and powerful in onset; they make the individual less aware and less able to respond to outside influences; and they offer the individual an artificial sense of power and control, of security and calm, of being valued by others. With the compulsive activity, the person does something concrete, material, and orderly in an effort to regulate a highly unpleasant, distressing feeling state, such as an underlying dread, fear, or painful chaos (Weinberg, 1995). There are many kinds of painful feelings that the addiction helps to block awareness of; these may include emptiness, isolation, helplessness, fear, guilt, shame, and hostility. Furthermore, the same drug or involvement can be used by an addict to produce widely differing effects. For example, for some alcoholics, drinking is the route to excitement, while others drink for its calming effects; yet others drink to cope with insecurity or because of an inability to deal with a bad marriage or to get relief from internal conflicts or to escape feelings of depression. By resorting to a substance or a particular activity, the person is attempting to exert control over some significant and painful aspect of his life situation that he feels unable to control and deal with. The addiction serves as a palliative for a chronically distressing, fearful, unbearable internal mental state. Thus the object of the addiction functions powerfully by providing a comfortable buffer against a painful reality and the soothing feeling that all is well.

Thus, addiction can be seen as the direct result of the psychological effects that a drug or an activity provides and it is this *experience itself* that the person becomes addicted to. Any

powerful experience in which people can lose themselves can become the object of an addiction (Peele & Brodsky, 1991). Narcotics provide pain relief, cocaine provides exhilaration, alcohol and gambling produce a sense of power, shopping and eating make people feel they are loved and cared for. All of these addictions allow the person to eliminate or greatly reduce anxiety because they focus the person's attention completely and they produce some positive emotion such as excitement or calmness or the experience of success and power. The drug or activity lets them temporarily escape their misery and find peace or ecstasy. Addicted people repeatedly search out these specific human experiences through their addictive involvements; the addiction then becomes a way of coping with painful feelings and life situations and of artificially acquiring feelings and rewards they feel unable to obtain in other ways. Addiction thus becomes a particular lifestyle that defines the person; it is a way of coping with the world and the self. Thus it is always important to explore the individual's experiential realm and ask, "Why does this particular person, at this particular point in time, find a particular substance or activity so all-encompassing and inescapable?" It is the answer to this question that allows us to understand how ordinary people can find a basic experience so powerful and overwhelming that it takes over their lives and seemingly robs them of their free will.

An essential feature of addiction is its compulsive nature. An addiction is a particular kind of compulsion. A compulsion is a seemingly irresistible, repetitious urge to engage in an act (Nevid, Rathus, & Greene, 1994). It is the compulsive nature of the addiction that makes people feel they have lost control over themselves in relation to the drug or activity. Psychologists have long recognized that what lurks behind compulsions are intense fears, anxieties, or inner conflicts, often experienced as a sense of dread. Compulsions can be seen as a way of dealing with such intense anxieties. The human experience of anxiety is powerfully painful and complex. Anxiety can be "a helpless, sick feeling of guilt; a frantic desperate shaking with no way to grasp the demons that seem to threaten; a confusion that prevents thinking about even simple things; or any of hundreds of experiences" (Martin, 2000). Because anxiety is so painful and powerful, it

provides us with an important principle for understanding potentially destructive and self-defeating behaviors: *self-defeating behaviors and activities become established and are maintained because they function to reduce anxiety; anxiety reduction is an extremely powerful reinforcer of certain behaviors, particularly when the anxiety reduction follows immediately from the behavior and the negative consequences of the reinforced behavior are delayed* (Martin, 2000). This principle has direct relevance and application to all addictive activities and behaviors whose compulsive, driven quality leads so often to self-destructive and self-defeating consequences. Through their ability to focus and absorb attention, compulsive activities help to diminish or annihilate the individual's anxieties and out-of-control feelings; they help the person forget his problems, his fears and anxieties, and his pain.

Another factor in the development of an addiction is the nature of the social environment or the personal life situation of an individual. Often, people will turn to drugs or compulsive involvements during bad phases in their lives, such as a divorce, a death in the family, a job loss, or any other major stresses that come along. This is a time when people loose their moorings, their sense of direction or purpose. Many recover on their own or with the help of family and friends and move on to the next stage in their lives. Others, however, do not and may continue on for years in a progressive downward spiral unless others step in to help or the addict begins to take stock of his or her life at some later point. Adolescence is another phase in which many young people first experiment with drugs, although many of them mature out of this phase as they take on adult responsibilities such as careers, higher education, or parenthood.

Social class differences also account for differences in addiction rates. People who are lower down the social and economic scale are more likely to become addicted to alcohol, drugs, or cigarettes, to be obese, or to have been a victim of sexual or physical abuse in the family. The upper and middle socioeconomic classes also have their addiction and behavioral problems but they are generally smaller in range. Addictions such as shopping, exercise, and bulimia tend to be primarily connected with, and more widespread in, the upper and middle classes.

Certain people seem more prone to developing addictive involvements than others. Many addicts come from more deprived or abusive backgrounds and have more emotional problems, although this alone does not cause them to become addicts. Others from the same kinds of backgrounds and with similar emotional problems do not resort to addictive behaviors. What most addicts seem to have in common is a feeling of powerlessness to bring about the positive feelings they want to feel or to accomplish their goals, without resorting to drugs, alcohol, or some other addictive involvement. As a group, they tend to feel more powerless and less capable of dealing with life than other people, even before they become addicted (Peele, 1989). It is in the addiction that they find their preferred way to obtain their desired feelings such as power, or calm, or acceptance by others - a means that is easier, powerful, and more immediate than other, more ordinary, ways of acquiring these feelings. In this way, their own sense of powerlessness is translated into the belief that the drug or activity is all-powerful because it is the only thing that confers on them the ability to get what they want or need. Furthermore, addicts have not been found to have stronger urges to engage in these activities than other people but rather they exercise less self-restraint in giving in to their impulses and urges; they put fewer brakes on their behaviors.

Table 1: Three Major Factors Involved in Addiction (Adapted from Peele, 1989)

The Person	Social Environment/Situation	The Addictive Experience
Unable to fulfill essential needs	Barren & deprived: disadvantaged social groups; war zones	Creates powerful, immediate sensations; focuses & absorbs attention.
Holds values that support or do not counteract addiction, e.g., lack of achievement motivation.	Antisocial peer groups Absence of supportive social groups. Disturbed or maladaptive family structure	Provides artificial or temporary sense of self-worth, power, control, security, intimacy, accomplishment. Eliminates pain, anxiety, uncertainty, guilt, and other negative sensations or feelings
Lack of restraint and inhibition.	Life situations such as adolescence, temporary isolation, deprivation, or stresses.	
Lack of self-efficacy, sense of powerlessness vis-a-vis the addiction		

The best explanation of addiction takes into account the individual's mind, body, and social or cultural context. The effects of a substance or an activity cannot be isolated from the context of human experience. Thinking of addiction as a "disease" or a chemical dependency fails to take into account the power of the mind in generating the need for a particular substance or activity. Peele (1989) argues against the view of addiction as a disease, that "rather than determining people's conduct, substance use is the *result* of what people believe, value, want." People are active agents in - not passive victims of - their addictions. However, it is also understandable that people want to explain their problems in terms of forces over which they have little or no control. Viewing addiction as a disease allows them to disown responsibility and accountability for their difficulties, to avoid self-reflection, and to avoid looking for causes and finding solutions.

Peele (1989, 1987) argues powerfully and convincingly that the tendency for people to become addicted is intimately tied to their value-driven choices, that both cultural and personal values are crucial in determining who becomes and remains addicted and who chooses not to do so. The finding that practically all college students discontinue using drugs or anything that interferes with their college careers and the fact that hospital patients almost never use narcotics once they leave the hospital shows that people do not invariably succumb to the allure of drugs. Furthermore, most problem-drinkers recover on their own and millions of smokers over the years have given up cigarettes without medical or other treatment. The reasons that people do not succumb to drug addiction are all values issues; it is because these people do not *"see themselves as addicts, don't wish to spend their lives pursuing and savoring the effects of drugs, and refuse to engage in certain behaviors that might endanger their families or careers"* (Peele, 1989).

In addition, more people find shopping, gambling, eating, and sex far more appealing than doing drugs. Chocolate cake and orgasms provide them with far more intense pleasure than drinking or drug taking. Yet only a very small number pursue these without exercising restraint. Most people are able to resist the allure of excessive sweets and sexual indulgences because of

their values: they do not want to get fat, die of heart attacks, make fools of themselves, or hurt others. Rather, they value maintaining their health, their families, their careers, and their self-respect. Yet values such as these play a significant role in preventing addictive behaviors from developing but are almost never taken into account in understanding the nature of addictive behaviors.

Thus, whether a person becomes susceptible to an addiction is determined by a complexity of factors that include not only the values held by the person but also his or her feelings and attitudes about self and life which, in turn, depends on the person's personal history (childhood experiences), personality factors, and the current social environment. To quote Peele again (1980):

> *Addiction is a logical extension of a way of life and its interaction with a drug experience, rather than of the chemistry of one drug or another. Addiction is not a physiological mystery, but rather an organic outgrowth of a person's relationship to the world. To understand any individual case of addiction, we must ask, "What does this person derive from the drug and from experiencing its effects?" In part, our answers will be that it fills time, structures a life, provides a reassuring ritual, and offers an identity. Then we must go deeper, into the addict's own experience of the drug, and find out how and why it reassures, and from what it offers relief. Only by comprehending these problems and how the particular drug creates an escape from them, can we get to the true nature of the addiction for that person.*

Whether or not an addiction exists can be determined by examining four characteristics (Peele, 1980):

1. **Addiction exists on a continuum with ordinary behavior.** Addiction is not an all-or-nothing phenomenon since there is no distinct physiological mechanism that sets off an addiction. Population studies of people with alcoholism, drug addiction, and compulsive involvements regularly reveal that these problems occur along a continuum rather than forming distinct addict and non-addict profiles; there is significant variability in the severity of these problems. People can be more or less addicted to a substance or an involvement, depending on the degree to which it controls his or her life. Total addiction to a drug or an activity is at one end of the continuum and represents only a small part of an addiction problem. Towards the other end of the spectrum

would be milder or lesser versions of substance use and activity involvement, all the way to the point where involvement or use is occasional, sporadic, infrequent or non-existent.

2. **An addiction detracts from all other involvements a person has.** To determine whether an addiction exists, it must decided whether the activity is harmful in the sense of undercutting or diminishing a person's life. Questions to which answers must be considered are whether the person's health will be adversely affected, whether the involvement is the one and only real focus in the person's life, does the involvement detract from other parts of the person's life to the extent that it diminishes the person's ability and interest in dealing with anything else, such as family life. When the individual cannot deal with other areas of his/her life, or gets no gratification from anything else outside the involvement, or cannot live without constant reference to that involvement, then a full-blown addiction exists. However, at some level only the individual can determine how much a particular involvement is harming his or her life.

3. **In time, addiction is no longer a pleasurable experience.** In the beginning the object of the addiction does provide a pleasurable response for a time. However, by the time the person becomes addicted, this experience fades into the background. What the addictive substance or involvement does is eliminate or blunt awareness of emotional pain and negative emotional states such as fear, anxiety, guilt, discomfort, etc. The temporary euphoria experienced with alcohol or gambling, for example, is the euphoria of a sudden releasing of one's cares and woes; the object of the addiction is pursued out of the need to avoid facing and dealing with other things.

4. **Addiction is the inability to choose not to do something.** Addicts are unable to make the decision to stop pursuing the object of their addiction when it begins to hurt, when it ceases to be pleasurable, and even when it results in highly destructive consequences for them, for example, when health, finances, career, or family relationships are jeopardized. Instead, they are compulsively driven by various underlying motivations to continue the involvement; the addict is not consciously aware of these underlying motivations and therefore cannot control his/her behavior with respect to the object of the addiction.

Peele (1987) cites several areas of research that provide evidence that cultural and personal values are essential factors in combating addiction: (1) the large ethnic group differences in the successful socialization of moderate consumption of every kind of substance; (2) the strong intentional aspects of addictive behavior; (3) the tendency for some people to abuse a range of unrelated substances and to display other self-destructive behaviors; (4) developmental studies that repeatedly discover that value orientations play a large role in styles of drug use in adolescence and beyond; and (5) the relationship of therapeutic and natural remission to personal value resolutions by addicts and to life changes they make that evoke values which compete with addiction.

The disease model, on the other hand, assumes the existence of an underlying and inescapable biological source for addictions, some neurochemical or genetic adaptation that explains compulsive behaviors. Furthermore, these neurochemical adjustments lead to predictable and measurable tolerance and withdrawal. Finally, the neurochemical systems underlying addiction are assumed to be irreversible, such that a progressive worsening of the addiction is inevitable and requires medical treatment in order to stop it. However, the universality of sex, food, non-compulsive gambling, shopping, or exercise contradicts such a deterministic model of addiction which requires neuroreceptors and endorphins to explain how daily, ordinary activities implicate fundamental addictive mechanisms. The obvious question is always, "Why then doesn't everyone become addicted to the same activity?" Such neurochemical and genetic theories are readily refuted by standard epidemiological studies that show tremendous variability in a person's tendency to be addicted over time and in different settings. Furthermore, the epidemiologic literature also shows that natural remission is by far the most common path out of compulsive behaviours (Peele, Brodsky, & Arnold, 1991).

This suggests that addicts, rather than having a "disease" for which they cannot be held responsible, are people who have various problems in living or emotional disturbances over which they can exert ultimate control, with or without help from therapists. It also suggests that many

people can and do heal themselves from their addictions or compulsive behaviours, that people are active self-healers who are capable of finding the answers and resources within themselves.

In addition to Peele, Szasz (1972) and Torrey (1974) are two psychiatrists who also have argued long and hard against the medical model as an approach to most of the problems of human behavior. Torrey also believes that as an approach to the problems of human behavior, the medical model produces confusions and absurdities rather than solutions; the categorization of irrational and self-destructive behavior under the medical model of "disease" is neither valid, nor logical, nor accurate and those who use it are required to bend facts beyond credibility. One consequence of the medical or disease approach to social ills is that no human emotional or behavioral disorder is exempt from being categorized as a disease. Everyone is potentially susceptible to being pathologized, no matter how seemingly healthy, good, or in control of themselves they are. Once addictions become treated as diseases, then anything that people do, but should not do, becomes categorized as a disease, from criminal activity to sexual promiscuity to procrastination. Disease notions have come to dominate our way of thinking about major areas of ordinary experience and ordinary problems associated with family life, growing up, conducting personal relationships, and of learning to accept our weaknesses, imperfections, and limitations. "...today, the notion of mental illness is used chiefly to obscure and explain away problems in personal and social relationships. .... We now deny moral, personal, political, and social controversies by pretending that they are psychiatric problems..." (Szasz, 1972). Szasz argues that there is a real danger in viewing difficulties and problems in living as mental illnesses. Mental illness is a disease only in the metaphorical sense and should never be taken literally as a reality. Ultimately, the medical view robs us of our humanity by reducing all our problems to biology.

The baleful consequence of the disease approach to human behaviors is that it leads to the revision of notions personal responsibility and undercuts moral and legal standards of accountability when they are most needed. Seeing emotional/behavioral problems as diseases actually undermines people's self-control by telling them that they have a biological "chemical

dependency" or that they have some genetic predisposition to their behavior and are therefore helpless to overcome it. The disease conception literally undermines the individual's obligation to control his/her behavior and to answer for misconduct. Furthermore, disease notions tend to increase the incidence of self-defeating and destructive behaviors because they excuse, reinforce, and legitimize such behaviors, convincing people, contrary to the evidence, that their behavior is not under their control.

Thus disease conceptions of troublesome behaviors are not only bad science but are also morally and intellectually sloppy. Behavior cannot be reduced solely to biology. It was psychology as a discipline that originally advanced our understanding of human behavior precisely because it fixed the cause of irrational, self-defeating behavior within the control of the individual, within his free will and self-responsibility, rather than in abnormal brain function (Torrey, 1974). The individual has the ability to bring about changes in him or herself, either directly or indirectly. The medical model, however, particularly in the area of addictions, gives short shrift to psychological and environmental factors. It eschews or ignores the very human values that make our lives worth living.

A different metaphor that is perhaps more useful in understanding why and how people develop self-destructive behaviors, emotional disturbances, and problems in living is that of a tree growing towards sunlight in a forest (Bohart, 1990). If the tree grows up in an overcrowded forest, it may have to grow in contorted ways to reach the light. When considered out of context, the tree may look dysfunctional or warped compared to its more fortunate fellows. Yet its "behavior" has arisen out of a positive attempt to adapt, to grow, and to survive. Furthermore, in spite of its "history", if, at any point in time, light is provided in a new, more positive direction, it can positively change its path. The tree has grown in its seemingly distorted manner, not because it has tried to avoid painful truths about itself or because it is clinging to infantile fantasies or because it has some defective gene, but rather because that is the only way it knows how to grow towards the light.

Problems in living and dysfunctional behaviours can be seen as *reactive* in nature. A young tree or a young human being responds and reacts to what is provided by its environment, for better or for worse. Psychological disturbances do not arise from some basic personality defect or a biochemical or genetic defect but rather can be seen as reactions to the human environment. Dysfunctional behaviour emerges from a person's whole life situation, including his/her biology, life history, and current circumstances; all of these have inherent constraints and the person attempts to find a pathway through these constraints (Bohart & Tallman, 1999). Both psychological and behavioral problems develop as attempts to live with an unlivable or unmanageable situation. Defensive solutions and coping devices, which are often themselves dysfunctional, nevertheless emerge as attempts to restore or preserve functioning in response to particular life events. It is in this sense that addictions can best be understood as an individual's attempt at adjustment, albeit a self-destructive one, to his or her environment or circumstances. Addiction is a habitual style of coping, although one that is capable of being modified by the person with changing psychological and life circumstances.

This represents a fundamentally more positive and non-pathologizing view of human beings and the forces underlying dysfunctional behavior. The human being, like the tree, is a process that continues to change throughout its life span. Human beings exist in continual interaction with their surrounding environment. They continue to respond to those surroundings and can choose to change their behavior in order to achieve a more integrated fit or a more functional adaptation. Human beings also have the capacity to profit from feedback, to modify their immediate responses, and to stand back and modify the "programs" themselves. In other words, human beings have the ability to learn from experience and profit from new understanding and knowledge.

This suggests that a learning model for human behavior is more appropriate than the medical model. Much of what actually goes on in psychotherapy is, in fact, a process of education, specifically of learning or re-learning new ways of thinking and behaving that produce

new ways of feeling. Psychotherapy is not a medical procedure but an educational procedure. To learn is to acquire new information, skills, and attitudes; there is learning about oneself and others, about why people react as they do toward certain others, about how attitudes such as an expectation of success rather than failure produces different feelings and outcomes, and about how acquiring certain skills will make handling interpersonal relationships easier. As learning, these are all part of education, not medicine (Torrey, 1974). This is the kind of learning that results in psychological change. Even psychoanalysis can be seen as an educational process in its attempt to correct the deficiencies of early parenting, early learning, or the consequences of trauma; clients are taught to see the interconnections between their private feelings, sensations, and thoughts. In fact, there is strong agreement that the common core of all methods of therapy is the concept of learning.

This is why the application of medicine's disease model to psychology is inappropriate and fundamentally in error, because the source of an emotional difficulty or irrational, self-destructive behavior is far more likely to be found by an understanding of growth and development patterns, and the deficiencies of early learning than by resorting to the concept of mental disease based on a genetic or neurochemical defect. (There are, of course, important exceptions where behaviors can be the result of identifiable biological or neurochemical disorders such as schizophrenia, autism, mongolism, or neurosyphilis.) What is lost with the medical model for explaining self-destructive or emotionally disturbed human behavior is a sense of people's own self-ameliorative powers, their tremendous capacity to heal themselves, with and without the help of psycho-therapy. Self-healing arises from a developmental tendency to integrate information. Self-healing is the human capacity to recover from emotionally injurious experiences, to repair dysfunctional life patterns, and to change ways of feeling and behaving so that the individual moves toward greater coherence and functionality (Bohart & Tallman, 1999). However, the existence of a tendency to self-heal does not mean that it always works, that people will automatically move toward more mature, productive, or actualized ways of acting and being. Often, major self-healing takes place

only when developmental or environmental challenges create a need for individuals to reorganize their lives, i.e., a need for individuals to re-educate themselves about their problems and learn alternative ways of managing their lives.

The Emotional Havoc Wreaked by Addictions, Using Alcoholism as a Paradigm for All Addictions

Alcoholism is one form of addiction that is widespread in North American society. It affects both men and women, it encompasses virtually all age ranges from adolescence to old age, and it occurs in all socioeconomic classes. As such, alcoholism can be seen as a prototype for all addictions, whether the addiction involves another drug or an involvement such as gambling or shopping. Because addictions affect a substantial portion of the population, the consequences of addictive behavior can be seen and felt in those who are in long-term contact with the addict, particularly the immediate family. Therefore, I will examine the psychological effects of alcoholism on the families and children of alcoholics with the understanding that many of these same effects will be applicable to any kind of addiction or addictive family, and indeed, to some degree in all dysfunctional families.

Families with one or more alcoholic members differ not only in socioeconomic or socio-demographic characteristics but also differ significantly in the dynamic and behavioral aspects of family life. In one family, alcoholism may result in members developing a copying style that is designed as an attempt to isolate the alcoholic member, to protect other family members from the adverse consequences of the alcoholic's behavior while intoxicated, and to emphasize the values of independence, self-reliance, and lowered expectations (Steinglass, 1987). In another family, the members may be virtually oblivious or blind to parental drinking or other alcoholic behavior, while a third family might see alcoholism as inevitable or normal, as a built-in, accepted feature of life that is closely linked to the family's cultural or ethnic values. In a fourth family, the members may be fully aware of the adverse consequences that alcoholism is imposing on them but they may

be helpless to come up with effective strategies for dealing with the difficulties presented by the alcoholic's behavior. In yet other families, the members may inadvertently make matters worse by responding in ways that worsen rather than lessen problems.

Kritsberg (1985) identified four major types of alcoholic family systems: (1) the family where active alcoholism is present, usually involving multigenerational alcoholism, (2) the active alcoholic has stopped drinking but the family system continues to operate with the same dysfunctional behaviors, (3) active drinking has stopped for one or more generations but the family dynamics continue to operate in the same characteristic way as an alcoholic family, and (4) a formerly non-alcoholic family becomes alcoholic. All alcoholic family systems are dysfunctional and involve emotional abuse that damages the children in different ways and to different degrees. Often there is cruelty, tyranny, and physical, sexual and/or verbal abuse in these families, making the impact and the severity of the damage that much greater.

Thus, many adults who grew up in alcoholic families will continue to suffer from the effects of parental alcoholism in various ways. Family alcoholism has had a powerful influence on their way of being in the world because of the harmful developmental impact on their growth as human beings; it has frequently changed their thoughts and feelings as well as their attitudes and reactions in significant ways that leave them unable to live productive, healthy lives or to have healthy relationships. Such children have grown up in a home where an undercurrent of anxiety and tension was always present. Their sense of self became distorted and many aspects of their development are missing or distorted. In many ways, these children have lost their childhoods because one or more parents was alcoholic or had some other addiction.

Alcoholism is a family dysfunction that is both personal and systemic; it affects each family member at the individual level and also affects the functioning of the family as a whole. "[F]or many families, alcoholism is a condition that has the capacity to become the central organizing principle around which family life is structured" (Steinglass, 1987); it is when alcoholism becomes an integral part of family functioning that we begin to talk about an *alcoholic family*. In order to

structure their day-to-day lives and to cope with the alcoholic parent, alcoholic families are bound by a number of rules of behavior as well as specific roles for each family member. These rules and roles are designed to keep the system closed. They are rigid and destructive and serve to maintain the alcoholic's agenda, namely, to allow the alcoholic access to his substance, to avoid pain, to protect his defenses, and finally to deny that any of these goals exist. These rules and roles also function as an attempt to bring order and stability to a family that has become increasingly chaotic, unpredictable, and unstable (Wegscheider, 1981; Kritsberg, 1985). It is this dynamic that produces low tolerance for uncertainty and ambiguity in family members as well as an urgent need for stability and predictability which translates into safety.

The alcoholic family is an inflexible, rigid system that cannot adapt to change easily, if at all. The rules that are adopted in the family evolve over time in response to the increasing instability created by the alcoholic's disturbed life style. As the addictive behavior worsens, the alcoholic paradoxically loses power over his own behavior at the same time that he wields more power over the behaviors he imposes on his family. At the same time that he depends on his family to bail him out emotionally, socially, or financially, he controls what they say, do, think, and feel.

The alcoholic family operates in accordance with four general "process" rules that are at the core of their dysfunctional system: (1) the rule of rigidity, (2) the rule of silence, (3) the rule of denial, and (3) the rule of isolation (Kritsberg, 1985). Children learn these rules as they grow up in alcoholic homes and it become their way of responding to the world as adults. They tend to seek out and identify with other people who respond to the world in the same way, according to the same rules.

The rule of rigidity ensures that the family remains inflexible. The family cannot adapt easily to change and members are not allowed to change themselves or to make changes in the family system; the implicit rule is to maintain the status quo at all cost. This rigid structure prevents healthy emotional and cognitive growth in the children who are forced into distorted

perceptions and behaviors to accommodate the alcoholic's agenda. The unpredictable or destructive behavior of the alcoholic forces the other family members to make continual adjustments to accommodate to the consequences of that behavior; in the process they develop increasingly rigid and set ways of responding themselves. As a result, these children develop into adults who have a need to control all aspects of life, including other people, to keep potential chaos, unpredictability, and anxiety at bay.

The rule of silence is another feature of severely dysfunctional, alcoholic families. Neither the spouse nor the children are allowed to talk about what is really happening in the family, nor what anyone is really feeling - neither with each other nor with outsiders. Because the alcoholic him/herself is in so much emotional pain, he or she simply cannot handle the painful feelings of other family members because becoming aware of and attending to the pain tends to intensify his/her own painful feelings. So the alcoholic member needs the other members to deny or conceal their true feelings of fear, pain, confusion, and anger. Children and spouses are simply not permitted to talk about what is seen, heard or felt. This severely hampers communication among family members and creates a kind of disorientation or mystification about what is really happening in the family. Reality checking by talking about what is seen or heard is strongly discouraged. Thus, whatever communication of thoughts or feelings is permitted tends to be distorted and incomplete. When these children grow up, repression, pretense, and denial become lifelong ways of relating to and coping with others. The emotional well-being has been compromised because they are unable to function openly and honestly in the world.

With the rule of denial, the alcoholic family first believes that alcohol is not the cause of the family's problems. When it becomes glaringly obvious that there is alcohol abuse going on and that there is a dependency on it, it suddenly becomes only a complicating factor, not the root of the difficulty. Family members are told, in so many words or in non-verbal language, that what they see, hear, and feel is not true; they are surrounded by denial on all sides as they struggle to pretend that nothing is wrong. As a result, children learn not to trust - neither themselves nor

others. A new belief then emerges that something or someone else is responsible for the alcoholic's dependency and that person or thing becomes the scapegoat. This allows the next step to be instituted: everyone in the family must be an "enabler." This means that in one way or another each family member plays his or her part in protecting the alcoholic's behavior and dependency; they make excuses, cover up, take over others' responsibilities, accept the rules, and protect the status quo - all in the name of love, honor or loyalty to the family - but actually to save the family from shame, embarrassment, guilt and above all to protect them from painful feelings.

Isolation is another rule for the family. No one may discuss what is really going on with outsiders. The myth is created that those outside the system will not understand the family and cannot be trusted. Scrutiny by outsiders is a threat to the family system because they might undermine the alcoholic's control over the family. New information or advice from the outside can create upheaval and change everything. As a result, family members may cling to each other emotionally but never learn to become truly intimate because they are limited in what they can admit to each other about what is going on and what they are really feeling. This emotional isolation of family members from themselves and each other takes its toll in feelings of loneliness and emptiness which run deep. This is what makes adult children especially vulnerable to co-dependency in their adult relationships. Co-dependency refers to the condition of lost selfhood or false selfhood in which an individual loses touch with his or her own inner experience and looks to outside sources (people) in an attempt to feel whole or complete.

Preservation of the rigid alcoholic family system is also accomplished by means of its members taking on a number of roles which are an extension of the family rules. These roles offer individual members some measure of stability and predictability for him- or herself. They allow members to hide their true feelings behind artificial behavior patterns and offer them a particular kind of reward or payoff. Family members do not consciously adopt the various roles but rather take them on as a method of coping - but at the expense of denying reality and dealing honestly with their painful feelings. These roles have been labelled as: the *Enabler*, the *Hero*, the

Scapegoat, the *Lost Child*, the *Placator*, and the *Clown* or *Mascot* (Wegscheider, 1981; Kritsberg, 1985; Black, 1991). It is within these roles that the true self becomes hidden and a false self emerges in its place.

The *Enabler* prevents the alcoholic from experiencing the consequences of his or her alcoholic behavior. The enabler's characteristic symptom is powerlessness and s/he is motivated by anger. The payoff for this role is a sense of self-righteousness and importance but in the process s/he may suffer from the physical or psychosomatic effects of "martyrdom."

The *Hero* ties to make the family look good by achieving success at school or work. This person is motivated by a sense of guilt or inadequacy and resorts to over-achievement to get positive attention as well as a sense of self-worth for him- or herself and also for the family. The hero is often also the over-functioning, take-charge child who takes on too much responsibility in the home. The price for this role is a feeling of compulsion or driven-ness, as well as the need take control of every situation and other people. These individuals are often well-organized and structured but lack flexibility.

. The *Scapegoat* diverts attention from the family by getting into trouble. The person in this role is motivated by feelings of hurt and resorts to delinquent behavior to get attention, although it is negative attention. This serves to divert the focus of attention away from the alcoholic and onto himself but at the cost of self-destructive and later addictive behavior.

The *Lost Child* hides away and tries not to make waves or draw attention to him/herself. This person's role is motivated by feelings of intense loneliness and s/he is usually solitary, shy, and withdrawn. The payoff for this behavior is escape from an unbearable family life, relief for the family at not having to deal with another needy child but at the expense of social isolation with its attendant developmental consequences.

The *Placator* and the *Clown* or *Mascot* all try to reduce conflict and lessen tension in the family by being funny, amusing, clever, or cute and thus smoothing things over. These roles are motivated by fear and serve to get the individual attention by being amusing and making things

fun or funny for the rest of the family. The placator is often a warm, caring, sensitive, listening child who attends to everyone's emotional needs except her own. The price for these roles is often immaturity and any number of emotional disturbances, including an inability to look after one's own needs and wants.

The assignment of these roles is usually a function of family position, rather than personality factors. Typically, the enabler is either the husband or wife, the oldest child is the hero, the second child is the scapegoat, and later children will pick up the roles of the lost child, the clown and the placator. Some roles, such as scapegoat and hero may repeat if there are more children. Sometimes these roles become blended or interchanged as various members grow up or leave or as needs change, but generally they are rigid or fixed. An only child in an alcoholic family generally takes on parts of all these roles, alternating them or playing them simultaneously. In such a case, the confusion and pain are even more overwhelming. These roles and rules allow for some stability and predictability in the family and help members contain their anxiety.

Because alcoholic families are unable to supply their children with consistent love and support, the children in these families experience two major types of abandonment: physical abandonment and emotional abandonment. Both kinds of abandonment create a core emotion of fear which is primal and unverbalized because the child knows or senses that without the adult it cannot survive.

With physical abandonment, the child is left alone too long or too often with its physical needs unmet; this may include missed meals or feedings, extended period of time where the infant or toddler is left in soiled diaper; it may mean leaving the child(ren) alone and unattended for hours and often days, or leaving the infant or young child in the care of older siblings who are still children themselves. Such repeated incidents of physical abandonment leaves the child with a core of fear and loneliness that persists into adulthood (Kritsberg, 1985). The message the child takes away is that s/he is not wanted.

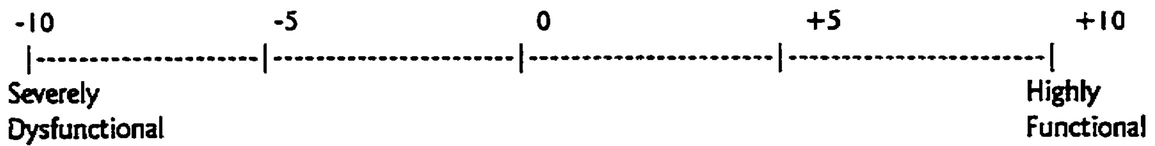
Emotional abandonment is just as devastating. Here the parent cannot provide the child

with enough or consistent emotional support to nurture the child in a healthy way. The child's physical needs may be met but its emotional need for affection, play with the mother, hugging, eye contact and other nurturing behaviors are lacking. The child is left with the same message - that it is not wanted. The emotional abandonment leaves the child with a deep sense of worthlessness and insecurity, forcing the child to struggle with feelings of emptiness, abandonment, hurt, and anxiety which also persist into adulthood. These persistent feelings may result in emotional numbing and an inability to attach or connect emotionally with others; there is no sense of security or belonging. As adults these children use numbing as protection against overwhelming emotional pain that includes profound hurt, anger, loneliness, sadness, resentment, and distrust. Many adult children of alcoholics have said, "I'm afraid that if I ever start to cry, I'll never stop" (Kritsberg, 1985).

Table 2, the *Family System Continuum*, shows that families can range from severely dysfunctional to highly functional (Kritsberg, 1985). Families with alcoholism or some other addiction, or where parents are physically, sexually, or emotional abusive will generally fall somewhere between 0 and -10 on the continuum. However, there will also be degrees or pockets of good functioning for some members or for different members at different times and situations. The chart lists the criteria for the traits and characteristics of an alcoholic or addictive family in comparison to a healthy family.

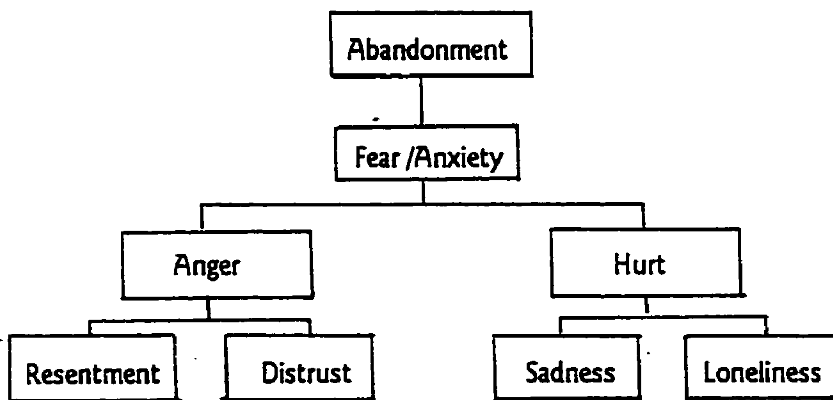
The *Abandonment Matrix* shows that there are two core emotional responses to the anxiety that develops out of the fear of abandonment: the anger route in which the person predominantly develops resentment and distrust and the hurt route in which the person succumbs to a pervasive sadness and loneliness. The alcoholic family also has a layer of shame and guilt attached to these painful emotions because these were used to enforce the family rules.

Table 2: **The Family System Continuum**



Alcoholic/Addictive Family	Healthy Family
1. Rigid rules	1. Flexible rules
2. Rigid roles	2. Flexible roles
3. Family secrets	3. No family secrets
4. Resists outsiders entering the system	4. Allows outsiders into the system
5. Is very serious	5. Has a sense of humour
6. No personal privacy; unclear personal boundaries	6. Members have right to personal privacy and develop a sense of self.
7. False loyalty to the family; members are never free to leave the system.	7. Members have a sense of family and are permitted to leave the system.
8. Conflict between members is denied and ignored.	8. Conflict between members is allowed and resolved.
9. The family resists change.	9. The family continually changes and grows.
10. There is no unity; the family is fragmented.	10. There is a sense of wholeness, of family togetherness.

THE ABANDONMENT MATRIX



Kritsberg, Wayne, 1985. *The Adult Children of Alcoholics Syndrome.* Pompano Beach, FL: Health Communications, p. 30, 34.

Characteristics of Adult Children of Alcoholics

The children who grew up in alcoholic or dysfunctional families become adults who frequently suffer from a variety of mental, physical, and behavioral characteristics. The mental outlook they develop is directly related to having grown up in a family with a chaotic and unpredictable home life in which one or both parents were emotionally unavailable to their children. Some of the mental characteristics they display include thinking in absolutes, an inability to recognize, understand or deal with their emotional states, obsessive thinking, indecision, learning disabilities, confusion, hyper-vigilance, and depression. The physical characteristics may include chronically tense shoulders, back pain, sexual dysfunction, allergies, gastrointestinal disorders, and stress-related disorders. In addition, adult children of alcoholics (ACOAs) also frequently display a number of characteristic behavioral traits and attitudes (Woititz, 1990):

Adult children of alcoholics (ACOAs) guess at what normal is. These adults have no understanding or conception of what normalcy is, what it is like to be in a normal household. A frame of reference for what a normal household would look like simply does not exist, including whether particular feelings and thoughts are appropriate or normal. What adult children do is to look at situations that appear to be normal or appropriate and then try to copy them.

ACOAs have difficulty in following a task through to the end. Adult children of alcoholics have major problems with procrastination or they cannot finish what they start. They struggle very hard at projects and tasks but somehow cannot get themselves mentally organized to follow through and complete them.

ACOAs will lie when it would be just as easy to tell the truth. Lying was basic to the alcoholic family system with its denial of reality, broken promises, coverups, and inconsistencies. Telling lies seemed to make life easier and more comfortable for the children and parents alike. So the truth quickly lost its meaning. Lying becomes so "normal" and natural that it persists into adulthood. These adult children have difficulty telling the truth, even in trivial matters because lying about things has become second nature.

ACOAs judge themselves harshly. Children growing up in alcoholic family systems are often made to feel that no matter how hard they try they are never good enough and are constantly criticized, even for things that make no sense. If something goes wrong, it is the child's responsibility, the child who is at fault. Children finally end up believing the criticisms and internalize them as negative self-feelings and self-images. They load themselves with "shoulds" as adults and judge everything as black and white, as all bad or all good, with no middle ground. Negative self-judgment becomes ingrained in their personalities.

ACOAs take themselves very seriously and have difficulty having fun. They cannot relax enough to just spend time having fun laughing and fooling around. Life was very grim, angry, and serious growing up in an alcoholic family and there was very little experience with relaxation, pleasure or spontaneity.

ACOAs have difficulty with intimate relationships. Having healthy intimate relationships is extremely difficult. Here again, they have no model or frame of reference for what that is because they have never seen one. In addition, these adults carry with them the experience of "Come close, go away" - which was the pattern of inconsistency with which they grew up, a terrible push-pull, approach-avoidance conflict. Their parents loved them one day and rejected them the next. They also grew up with the terrible fear of abandonment, a fear which gets in the way of developing a consistent, day-to-day, healthy relationship with another person. This fear is often coupled with an inability to fully trust another person.

ACOAs over-react to changes over which they have no control. Because of the unpredictable and often dangerous environment in which they grew up, these adults have adopted rigid and controlling ways of relating to others. As children it became very important for them to take charge of the environment to whatever extent possible and therefore s/he learns to trust and rely on him or herself rather than depend on another's judgment. The rigid control helps to allay their fear and anxiety, the fear that they will lose control over their lives if they are not in charge. Consequently they over-react to any imposed changes in plans or a change in the way they

typically do things .

ACOAs constantly seek approval and affirmation. In an alcoholic family the messages that children get are unclear, confused, or mixed. Consequently, even though they seek approval or affirmation, they cannot allow themselves to trust the sincerity of positive statements directed at them. There is always the "but" that might disqualify whatever positive regard they are given. As a result they often sabotage relationships with others because they feel that anyone who would care about them could not be worth much.

ACOAs feel that they are different from other people. Feeling different and socially and emotionally isolated has become part of the make-up of the ACOA. These adults believe that in any social situation, they are the only ones who feel awkward while everyone else feels confident and comfortable. They rarely do a reality check to find out that many other people also have different degrees of discomfort in social situations. It is very difficult for these adults to feel accepted and that they belong.

ACOAs are either super responsible or super irresponsible. These adults have learned to either do all of it or do nothing; they take it all on or give it all up. In their families, they never learned what it is to be a part of a project or task, how to cooperate with other members, share responsibilities, and let the parts come together into a whole. They either took it all on or gave it all up and did nothing. These adults do not have a sense of their own limits and find it extra-ordinarily difficult to say "no." They are afraid of either being found incompetent or being rejected for not doing what someone has asked of them. Their inappropriate sense of responsibility for everything makes them feel they have to take it all on.

ACOAs are extremely loyal, even in the face of evidence that the loyalty is not deserved. Because the alcoholic family home is a closed system, it appears to be a very loyal place where everyone is looking out for and covering up for the alcoholic. The behavior that is modelled for them is that one does not just walk away because the going gets unpleasant or rough. It is important for the family to stick together. This leaves the adult children with the

sense that they should remain in relationships at all costs. Making friends and developing relationships is often very difficult and complicated for the ACOA and once they make the commitment, they feel it must be permanent. The fact that they are treated poorly, emotionally or physically abused, is rationalized away. Somehow, the ACOA finds a way to excuse the bad behavior of the partner and finds him or herself at fault for not having behaved better. The established relationship also provides safety, security, and predictability. And since ACOAs have little conception of what a healthy relationship looks like, they stay with what they have.

ACOAs are impulsive. The more dysfunctional ACOAs tend to lock themselves into a course of action without giving consideration to alternative courses of action or to consequences. If an idea pops into their minds, they act on it. Any other thoughts or options are rationalized away. This is the typical behavior pattern of the full-blown alcoholic who stops at a bar for "just one drink," and readily applies to other kinds of behaviors. Just like chemical addiction, these behaviors also take on a sense of urgency, becoming uncontrolled and compulsive in character. The ACOA often lives from crisis to crisis because he cannot stop himself. The consequences of this impulsivity ultimately leads to confusion, self-loathing, and loss of control over the situation. The person then spends an excessive amount of time and energy cleaning up the mess he created.

Alcoholic families are highly susceptible to the development of other addictive-compulsive behaviors in their children because of the high anxiety and the denial and numbing of painful feelings that is such an integral part of family life. The ACOA is, of course, at high risk for alcoholism itself. Other compulsive behaviors they are highly susceptible to include other drug addiction, eating disorders such as bulimia or over-eating (obesity), workaholism, smoking, gambling, addictive relationships, excessive sexual activity, exercise, and perfectionism.

To summarize, the adult children of alcoholics have accumulated many painful feelings, including pervasive anxiety, and have developed dysfunctional behaviors as well as troubling mental and physical traits, all of which need to be addressed and healed. These same feelings and behaviors are found in other types of addictive and dysfunctional families as well. In each case,

these feelings and behavioral characteristics were developed as a response to the unpredictable, manipulative, abusive, and sometimes dangerous behaviors exhibited by the adult(s) or older sibling(s) in the dysfunctional family, and it was these distorted ways of coping that allowed the child to survive in that situation. The stress and trauma of living in a dysfunctional or addictive family leave their imprint in the form of problems with trust, dependency, control, boundary issues, negative self-concept, substance abuse, low self-esteem, depression, and any number of developmental deficits. The road to healing and recovery for all adults who have grown up in a dysfunctional family may be long and arduous and will take persistence, courage, and commitment.

PART II: THE GROUP EXPERIENCE

Group Therapy: "Women Healing Together"

Addiction, whether one's own, that of a current family member, or in the family-of-origin will have left a strong impact on the individual in some form. The psychological and emotional difficulties and disturbances that lead to an addiction do not disappear or resolve themselves automatically once the addictive substance or activity is stopped. Rather than the end of an addiction and its problems, abstinence marks the beginning of a new phase that requires a healing process. In addition, adults who have been affected by addiction indirectly, by the disturbances created by an addicted parent or spouse who created a dysfunctional family system, also have emotional difficulties that need to be addressed through some form of therapy if recovery and healing are to be achieved. Recovery is a long, difficult, and painful process of radical change that is never easy and rarely smooth for anyone involved.

Group therapy has long been considered an effective way for individuals to deal with a wide range of issues, concerns, and problems in living, including the effects of addiction or of having grown up in an alcoholic or dysfunctional family system. Considerable research over the years has confirmed that group therapy is as effective and as robust as individual therapy (Yalom, 1995). There are certain advantages, however, that group therapy has over individual therapy, especially where a group consists of members of the same sex and with similar broad concerns; these advantages include such factors as (1) finding out that others share the same difficulties and problems (universality) which reduces shame, (2) reducing social isolation which helps women deal with feelings of alienation, helplessness, and/or depression, (3) offering support and safety and the opportunity to express one's true thoughts and feelings , (4) reality testing that enables members to check out their perceptions, feelings, reactions, and life situations and see them from another perspective or more objectively and realistically, and (5) sharing information, resources, and strategies. All of these advantages were readily discernible and played a significant role in the group of women who made up *Women Healing Together*.

<u>**Women Healing Together**</u>

Focus of this Group: Healing from the Effects of Addiction.

Location: St. Raphael Centre, 23 Conifer Crescent, Winnipeg, MB

Duration: The group ran for eight weekly two-hour sessions from April 3 to May 22, 2001.

Therapists: The group was led by two co-facilitators: Janine Ballingall-Scotten, the Group Leader from St. Raphael Centre, and myself, Marianne Willer, Masters Ed. Psych. Student.

Composition of the group: *Women Healing Together* was a closed group made up of women ranging in age from about 40 to 65+ (estimated), and included single, married, divorced, and widowed women. These women had been recruited from a waiting list kept by Janine Ballingall-Scotten of St. Raphael Centre. The core group consisted of 10 members for the first 5 weeks and 9 members for the last 3 weeks, as one member had given notice that she would not be able to attend the last three sessions because of another commitment. One member from the waiting list appeared only once, for the second session, and did not return. Of the core group, 7 of the members already knew each other because they had participated in an earlier 8-week run of this same therapy group. Since I had also participated in the earlier group run as a member, these women also knew me. And since this was a closed group, once it began no new members were allowed in who were not already on the waiting list.

This was an 8-week process for women who were affected by addiction in their own lives, in their family of origin, or by a loved one. Some of the women were recovering alcoholics, some were or had been married to alcoholics. The addictions that affected the remaining women, either directly or indirectly, included eating disorders, gambling, workaholism, and co-dependent relationships. The women in this group came with a number of additional presenting problems and difficulties besides addictions; some of the women were in or had experienced abusive relationships, some were struggling with depression and anxiety; many had painful and disruptive childhoods and a few had been touched by a major illness such as schizophrenia in a parent while

growing up. The purpose of the group was to explore various issues, including self-esteem, loneliness, shame, sexuality, grief, inner child issues, finding one's self, and other issues or concerns the women themselves brought up.

The approach to psychotherapy and recovery was psycho-educational but also included the encouragement of personal disclosures and sharing of painful issues and history, as well as the promotion of appropriate risk-taking in the group with respect to self-disclosures. The goal was to help the women engage in self-disclosure in order to overcome their fears and vulnerabilities, to work through their pain, and ultimately help them acquire deeper understanding of themselves and their situations in a way that would allow them to make significant changes. The format of the session was for the women to take turns in going around and sharing their concerns or difficulties. Each session was based on a theme determined by the co-facilitator who provided hand-outs with information on that particular theme or topic. In addition, the women were made to understand that they could speak to their own issues and concerns if the theme was not particularly relevant to them. The themes and topics for each week were as follows:

Week 1: Self-responsibility

Week 2: Meeting our wants and needs / General Goals

Week 3: Setting boundaries and limits (with an activity)

Week 4: How boundary issues are related to pursuing our wants and needs and to self-esteem

Week 5: Taking care of ourselves in relationships / "How to Make a Complaint"

Week 6: Healing and changing / Shame & guilt

Week 7: Healing and unfinished business

Week 8: Healing and rescuing ourselves / Self-Acceptance

The handouts for each of these themes and topics are in Appendix A.

In addition, members were asked to fill out a feedback sheet after each session and return it to me the following week. The object of this exercise was to have the women reflect on how the session went for them, what they learned or discovered that was relevant and helpful to them, and to express any other feelings, thoughts, or concerns they had about any aspect of the group experience during that session. My purpose for this was to assess how the women were progressing, what they were learning or discovering about themselves, and what aspect of the group experience was helpful or not helpful. A number of women completed and returned the feedback sheets to me on a regular basis while others only did so sporadically.

Group Stages and Process:

There were no clearly discernable stages or phases that the group went through. The initial and the transition stages were barely discernible from the working stage insofar as some of the women began personal sharing almost immediately. The reason for this was probably because most of the members already knew each other from attendance in the previous run of the group and for some members this was their third time. Furthermore, the two new members were already known to the group leader and some of the present members so that a level of comfort was already in place for them. Only one member was entirely new, a true newcomer, to the group and to the facilitators. On the feedback sheets from the first session, many of the members reported how safe and comfortable they already felt in the group.

For the most part, there was a "sameness" in the group's interactional style from session to session that had to do with the format of polite turn-taking by each member. Often there was a period of silence after one person finished and before another finally spoke up and voluntarily initiated her own disclosures and concerns. The polite turn-taking was interspersed with lively or poignantly emotional discussion that was sparked when several other members identified with and responded to what one member shared.

Overall, this group had some characteristics of both a working and a non-working group.

This was a working group insofar as most members had already developed enough trust with each other and the facilitators and a willingness to begin disclosing personal, painful material almost immediately. There was good mutual support as this was going on. The older members already felt familiar with each other and therefore had a sense of inclusion in the group, while the newer members seemed to take their cue from the older members and felt safe enough to also begin sharing their concerns. Communication and feedback among the members fluctuated from session to session; at times the flow was open and clear, with full expression of emotional sharing in response to each other, but at other times, members found it more difficult to open up and make personal disclosures or to respond to a particular member's concerns. There were a few members who typically took up a lot of time in telling their stories or engaged in excessive suggestions and advice giving. There were also a couple of members who were more reserved and tended to observe most of the time, although they did engage in some very deep-felt and painful sharing once they did open up. However, they tended to remain silent for several sessions after that.

One area that was not well developed was in the setting of both group and individual goals. Although the importance of individual goal setting was stressed initially in the first and second sessions when I handed out a sheet that listed 12 general goals with space for members to add their own personal goals, I did not do a follow up in this area by coming back to goal-setting, reinforcing its importance, and challenging group members to set and share their goals in the group. Instead, the heaviest focus was on exploring particular common issues and teaching some specific strategies. It was only during the last session that the importance of moving forward by taking action was again emphasized by the group leader.

Another positive area that indicated this was a working group was the support members gave each other outside the sessions; many of the members met for coffee outside the group, had social contact with each other, such as through church attendance or church activities, or kept in contact with each other by telephone between sessions. This showed the members' mutual interest in each other and the desire to be helpful, caring, and supportive.

Catharsis and emotional expression were also frequent occurrences during most of the sessions. Members were given emotional support and feedback by the facilitators to help them make sense of their emotional experiences. Another strong feature of the women in this group was their willingness to accept responsibility for their lives, to no longer be victims, to actively find new directions they wanted to go in, and to make needed changes, albeit slowly and tentatively. Most members expressed optimism and seemed to be very hopeful that making constructive changes in their lives was possible.

One aspect of the group process that was not developed or did not emerge, with one exception, was interpersonal conflict or confrontation between members because of hidden negative feelings. Again, because of the format of taking turns to speak, and limited feedback from other members except by invitation, interpersonal interactions between members tended to be muted, sympathetic, and gentle. However, there were usually one or two members who were the exception and spoke out more often and more forcefully in terms of advice-giving, commenting, or initiating feedback. Thus, there was only one occasion during which a member who had been harboring negative feelings was encouraged to bring this out in the group. The group leader dealt with this member's negative feelings towards the other member by challenging her to examine her own issues more closely, to help her see how she was projecting her feelings of rejection onto others. In addition, judging from some of the responses on the feedback sheets at different times, there was a suggestion that members also had various negative and positive feelings towards other members that often went unexpressed in the group process.

For the final session, or termination, the group members put together a pot-luck luncheon prior to the formal group session. They spent this time socializing and sharing their experiences. During the final group session, time was spent on reinforcing the importance of taking action on whatever level was needed to move themselves forward; it was not enough to just have the knowledge or information. It was important to take the time to process and consolidate what was learned and then put that knowledge and understanding into action. It was recognized that

healing was not complete and many understood that this group experience was only a stepping stone along the path to recovery. The responsibility for continued growth rested on them. This was a sad time for members because they would no longer be coming together at a regular time and place, but on the other hand, new friendships seemed to have been forged or strengthened.

As co-facilitators of this group, we (a) explored common themes that provided the women with some universality, (b) provided on-going emotional support and feedback to the members, (c) helped members learn how to express clearly what they want from others, especially from other people in their lives outside the group, (d) focused on the importance of translating their knowledge and understanding into action, (e) encouraged members to practice new skills and to consider new or alternative behaviors in order to improve their self-assertiveness and self-esteem, (f) provided a balance between support and confrontation or challenge,

Summary Writeup for Each Two-hour Group Session

Session 1, April 3, 2001

Attendance: 8 members

Theme: Self-responsibility

Summary of the Session:

The session began with introductions and going over ground rules for how members would conduct themselves, with an emphasis that feeling safe in the group was critical. The co-facilitator read a meditation from Melody Beattie's book on taking responsibility for our selves and our lives. Ground rules and group norms were established as follows:

- show up on time and attend regularly
- use "I" statements to own your feelings, thoughts, and opinions
- feedback is only to be given with permission from the person, if it's wanted
- no use of substances or addictive activities during the 8-week course
- listen

- no advice, no criticism, no judgment
- risk opening up and sharing
- confidentiality: what is said in the group stays in the group

With respect to giving feedback, members were to state

- what you saw
- what you heard
- what you feel

The member receiving the feedback is to sit with it, rather than react or respond.

The co-facilitator spoke to the issue of trust and the need to respect others' confidentiality in the group; this was important to allow members to feel safe. Outside the group, it was okay to discuss or share your own feelings and issues with friends or one's partner, but not those of other members. What was important was for members to explore their own feelings, issues, concerns, and problems and to discover their own needs. The focus for each member was to be on the Self. She stressed the importance of taking responsibility for parts of our lives in ways that perhaps we had not done before. We don't want to do more of what does not work. And we need to face our fears, whatever they are, our fear of facing truths about ourselves, our true thoughts and feelings and behaviors - and maybe also facing truths about other people in our lives. Revealing our true self can be very scary, but in order to benefit from the group experience we have to take risks. The idea is to confront our own feelings and fears and deal with them in the group, in a safe setting.

The group leader discussed the different kinds of substance abuse and addictive activities or obsessive-compulsive behaviors that people use to deal with painful emotions. The range of activities and behaviors that could fall within the scope of "addiction" is quite large and can include: love, sex, work, drinking coffee, gambling, eating, chewing gum, exercise, and even religion. Anything that serves to alter one's mood as a way of escaping from life and from one's

problems, from not dealing with reality, constitutes an addictive activity.

Members were invited to start sharing their stories and concerns. There was a good start as most members already knew each other from participation in one or more previous runs of the same group and therefore felt more comfortable and at ease.

<u>Session 1 Feedback: Theme of Self-Responsbility</u> (7 feedback sheets)

- Members reported feeling very comfortable and safe being in the group, especially because they had participated in the same group with the same women before. One of the new members related that first sessions are always difficult for her but she was confident that with time she would share more.
- Several members reported liking the smaller size of the group compared to the last group-run because it allowed more time for feedback on everyone's situation.
- Hearing others share their own painful stories was very helpful for members; it helped some members see their own problems from a new perspective; several members realized that they have been making progress.
- Some members recognized how they had been abused but were beginning to take responsibility in seeing their own part in permitting the abuse.
- Members expressed hope and confidence that their futures would become better and that they will become stronger individuals.

Most members identified strongly with the theme of self-responsibility and related it to their own lives and also identified for themselves what they need to work on:

- All members recognized that they had more work to do.
- Many expressed that they still wanted to know themselves better.
- Identifying one's feelings of loneliness, pain, fear, sadness, emptiness was important. One member commented: *"Feelings are just feelings. Do I have to change them or fix them?"*
- Respecting one's own choices, feelings, and decisions and accepting one's limitations and

imperfections.

- The issue of differentiating one's own from others' feelings hit home for several members who commented on the need to learn to own their own feelings and to let others keep their feelings; they identified with the struggle of how to keep themselves separate from others at the emotional level.
- Members also realized that they often inappropriately carry the responsibility or burden of other people's thoughts and feelings and responsibilities and are realizing that it is important to respect other people's choices and decisions and let them take responsibility for their own lives and choices; it was often difficult to define where one's own decisions and responsibilities ended and another's decisions and responsibilities began.
- One woman related how overwhelmed she was with feelings of hurt, sadness, emptiness, and sympathy, not just for herself but for the others, stating she wished she had the magic power to heal her sisters.
- Learning how to develop healthier relationships with family was another common theme.
- One woman expressed concerns about having to be perfect and pursuing perfectionism in order to be accepted.
- There was also the issue of appearing "selfish" by focusing on oneself and one's inner self instead of others, and a recognition that there is such a thing as healthy self-love.

Session 2, April 10, 2001

Attendance: 10 members

Theme: Meeting our wants and needs

Summary of the Session:

Two meditations provided by the co-facilitator were read by two different group members; these continued the theme from the first week on how we can learn to take responsibility for ourselves, how to listen to ourselves, and how to identify our wants and needs. Members were

then encouraged to share their experiences and feelings in this area. There was a good response and many members opened up, took risks, and began to tell their stories and reveal their personal feelings or troubles in a meaningful way. Existential concerns and humour also emerged. Issues such as abuse, loneliness, the need to tune into ourselves and listen, "who am I," finding our own meaning in life, self-empowerment, control issues with others, and how life is an exciting journey all emerged. This showed that there was trust in the group. Various members also gave each other good feedback, and showed support and caring. One member in particular was supplied with a number of resources for follow through in regard to a specific problem.

This session showed that trust, safety, and confidentiality had been established and group cohesion was a strong factor during this session. What was particularly helpful in establishing these group features was the fact that most of the members already knew each other from having participated in the same group previously .

Session 2 Feedback: Theme of meeting our wants and needs (6 feedback sheets)

The members echoed each other considerably in their comments:

- Realization that no one has the answers to how our own lives should be lived; we have to find those answers and the solutions to our problems for ourselves.
- Realization that we are all unique and need help to heal ourselves.
- Realization that not only the solutions to our problems but also our happiness are to be found through making changes and getting encouragement from others; it is our own responsibility to take charge of our lives and to find peace.
- We all struggle with something - either internal or external difficulties and problems and we can learn from each other and find out how others have coped with their problems.
- Several women again said they felt better in realizing that they were not alone or unique in their problems and feelings because others shared some very similar problems (" I am not a freak"); but they also recognized their differences and that they each have their unique struggles and circumstances.

- There was also sympathy and empathy expressed for others in their lives who were also struggling but were too ashamed or proud to reveal it.
- There was an on-going recognition again of the need to not take on the emotional burdens and struggles of other members, to keep one's boundaries clear.
- Some women realized that they had already struggled with and come to terms with issues that other women are just beginning to struggle with; they felt they had made their peace with certain issues and this has given these women more self-confidence.
- Realization that we are responsible for our own burdens and struggles and we can learn to listen compassionately but do not need to take on the emotional burdens of others. It's just as important that we learn to listen to our inner selves, to learn to trust our own beliefs, perceptions, and thoughts.
- Again, there was an appreciation expressed for feeling safe enough to open up and share personal and painful life situations and relationship difficulties. It was also important to learn and experience how others cope with their problems.
- A few women expressed feelings of discomfort in the group; one found it a heavy session in terms of what was shared.
- One woman expressed feelings of frustration and disconnection from the group and stated that she felt uncomfortable with one particular member who, she felt, looked down on her.
- A few women said how the feedback from the co-facilitator was helpful and that the type-written hand-outs were helpful.
- One woman expressed a need for acquiring some communication skills to use in dealing with a difficult, angry family member.

Session 3, April 17, 2001

Attendance: 10 members

Theme: Setting Boundaries & Limits

<u>Summary of the Session:</u>

After announcements, the group members were asked to do a very quick check-in consisting of a single word or phrase to say how they were feeling. I then gave a brief presentation on the topic of boundaries, emphasizing the importance of and need for setting boundaries and limits for oneself. I provided a handout for the meditation which included 3 activity questions for members to consider.

Members formed into 3 groups in separate rooms and were asked to discuss this issue in terms of the activity questions given with the meditation reading. After approximately 25 minutes and a short break, the groups reconvened and were asked to share their personal experiences in this area with the larger group. It turned out that Easter had been a very difficult time for many members in terms of the difficulties they had had with their families or lack of family life due to death or alienation. The rest of the session was taken up with discussion and elaboration of concerns that emerged from the smaller group exercise.

<u>Session 3 Feedback: Theme of Setting Boundaries & Limits</u> (6 feedback sheets)

Members reported:

- Boundary setting and self-respect were very important issues for all the women. They saw this as part of practicing self-care, putting oneself first instead of last.
- There was general acknowledgment that setting boundaries is very difficult; some women realized they had been operating with "peace at all cost" in their families but they began to realize this was not working; they were just being volunteers for abuse.
- The topic helped some to verbalize what they were going through..
- Several members reported how they had been or were being abused physically, verbally, emotionally, or financially by spouses and realized the need to take care of themselves.
- Breaking into smaller groups in which members shared their experiences was very helpful; members reported that it was most helpful and instructive to learn how other members practiced and rehearsed setting their boundaries.

- Learning how to say "no" graciously, respecting oneself, and practising self-care were difficult to practise without feeling guilty.
- One member saw the boundaries issue as an invasion of her own privacy by others; she also felt she was not receiving enough feedback from the group. However, another woman wrote that she appreciated the group's input and how the facilitator kept the group on track.
- One member reported how she had already been working on this issue for some time in her family. Another woman wrote how she has learned to leave a situation in which she becomes uncomfortable instead of feeling she has to stay.
- There was a realization that they control the present and only they can change themselves but it's a matter of taking one small step at a time; women are coping the best they can under the circumstances. Some women are still finding it very difficult to handle what is going on, but most seem to have at least one way of coping that allows them to have peace of mind, at least one boundary that they do not allow others to violate.
- One member reiterated how helpful it was that she knew most of the members from the previous run of this group.
- Some members reflected on the difficulties they had over the holidays with various family members.
- There was appreciation for seeing that other people have similar problems, fears and disappointments - that there are other lonely people out there - but also that there are others out there who are also looking for companionship, so one doesn't have to be alone or lonely.

Session 4, April 24, 2001

Attendance: 8 members

Theme: How boundary issues are related to pursuing our wants and needs and to self-esteem.

Summary of the Session:

I gave a short talk on the need for self-assertion and risk-taking in our lives:

- how assertive people tend to like themselves and feel good about themselves;
- self-assertion means being neither aggressive nor submissive
- the extent to which you assert yourself determines your level of self esteem;
- that self-assertion fosters fulfilling relationships and releases positive energy
- self-assertion can greatly reduce your fear and anxiety
- you get to live your own life, and the chances of getting what you want out of life improves greatly - when you let people know what you want and stand up for it

However, there may be a price to pay for changing onself and making improvements in self-assertion:

- it may cause disruptions in your life
- it's a hard struggle to change your own habitual behavior
- there is pain associated with honest and caring confrontation
- making changes forces you to reappraise your basic values
  - there is no more "peace at any price"
  - giving up the role of peacemaker for the sake of the relationship or the family

Recommended reading Harriet Lerner's book *The Dance of Anger*.

After this brief presentation, members were invited to comment and/or relate this issue to their own lives; there was a good response from several members who identified strongly with the theme of "peace at any price" in their lives. There were poignant self-disclosures when several women revealed how being a peacemaker had impacted their lives in the past and present. Other members spoke about their ease or difficulty with setting boundaries with others so as not to be taken advantage of or abused and how much of a struggle this is or has been for them, especially in terms of dealing with guilt that is evoked when they make the effort to change their behavior. Members gave each other some good feedback that included support and encouragement for

these efforts, so that again members became aware of how much this is a struggle for everyone, not just a few members. Different members are at different stages of the healing and recovery process and some have become better at setting limits over time; two women at different levels of recovery shared their difficulty with setting limits, with one woman showing how she had become progressively better and stronger at doing this. This allowed others to see that progress is possible but can be uneven with occasional setbacks, and that people can change and improve over time by their own efforts and with the support and encouragement of group members. During a break in the discussion, the three-part self-assertion message was put up:

a) When you ____________________ [description of the behavior]
b) I feel ______________________ [disclosure of the feeling]
c) because ____________________ [the effect it has on you]

The Group Leader suggested that her own preference for the last part of the statement would be to replace it with:

"and I prefer, need, want, desire ____________________"

Such statements need to be made with firmness but without hostility or guilt. A couple of members asked for additional examples of assertive statements and were given:

"No."

"This does not meet my expectations."

"This is not what I want."

Personal stories and discussions continued around this theme, with a reiteration of the need to identify and focus on one's own needs and wants.

Session 4 Feedback: Theme of how boundary issues are related to pursuing our wants and needs and to self-esteem. (7 feedback sheets)

With this session, more women began to write about less generally and more specifically about their personal issues and feelings. It became evident that many were reaping new insights and

beginning to understand themselves better:

- Overall, the members expressed their awareness again for the need to work harder on setting boundaries.
- Some related how their experiences with verbal and emotional abuse left no physical signs but left emotional scars; how a spouse can been seen as a wonderful person by outsiders but at home he is a stranger to the family, and how he is helpful to everyone else but the spouse.
- How verbal abuse damages the spirit and has closed the door to true communication and intimacy with the spouse; how verbal abuse robs one of joy and vitality in one's life.
- One woman wrote about how she identified with another women in the group because they had both been raised in large families where everything had to be shared. She related how sense of ownership was inappropriately transferred into her marriage, how her spouse had changed dramatically after they were married and how her boundaries were quickly violated; she related how ownership became a huge problem, a control issue, at both the property and spiritual level because everything became his property, and how this robbed her of her personhood. She was made to feel like a nothing and had nothing. Both her privacy and physical space were violated. However, this group member also related how for the first time she has been able to set limits around keeping her own thoughts and feelings private from her spouse,-to keep her thoughts, feelings, and behaviors from being invaded and manipulated.
- One member felt that perhaps she talked too much. She realized that everyone has pain which can be faced or ignored. To face it means that you can then choose to live with it or to change it. Changing it means taking a chance that things may get worse or better.
- One member identified with another member who had similar issues and felt she understood what the other woman was going through. This gave her a sense of belonging in realizing that she was not alone and others had the same problems and issues. She also

realized the need to be firmer in setting boundaries, to say "no," and to take care of herself.

- Several members expressed appreciation for the handout on boundaries, finding the information very helpful.
- Members again expressed the helpfulness of getting input or feedback from other members when relating their personal experiences, and hearing their stories.
- The importance of putting into practice what was discussed - such items as how to be self-assertive in a healthy way, without aggressiveness; how to counteract people who are aggressive, abusive, overbearing or controlling and how difficult it is to stand one's ground.
- One woman left the session feeling sad and uneasy about some of the communications in the group; she was particularly uncomfortable with one member's angry tone and felt she was giving uncalled for advice to another; she felt one of the facilitators should have stepped in and stopped her or told her to use "I" messages. This woman also felt that another member had not shared enough details about how much abuse she was experiencing. She liked the feedback that the group leader gave to this woman in terms of some alternatives and choices this woman could exercise.
- One member wrote about her discomfort with another woman in the group and that she had discussed this privately with the group leader who recommended that she bring this up in the group session. However, she had reservations because of her own fear of confrontations. She went on at length describing exactly how she felt about the other woman and the attitude and beliefs she felt this woman had about her as shown by her behavior during interactions in the group. She had many questions about the kind of feedback that was and was not permitted in the group; she felt that she was giving good feedback to the other woman (some "truth") at times and felt that she also expected others to tell her the truth, that she needs help and that's why she's in the group.

Session 5, May 1, 2001

Attendance: 9 members

Theme: Taking Care of Ourselves in Relationships

Summary of the Session:

The co-facilitator began the session with a short reading on relationships, on how we can take care of ourselves in relationships. She commented on how we can learn to stop others from abusing or mistreating us and how that is related to our self-respect. She stressed that if we do not like the way we have handled ourselves or responded to a person in a particular relationship, we can practice or rehearse how we would like to respond when this kind of situation arises again. The co-facilitator provided a handout to members entitled *"How to Make a Complaint."* Members were invited to relate their personal experiences in this area and several did so; there was a good discussion with personal sharing of stories among the women. One woman read a short fable relating to how a person can use emotions to manipulate others, to instill guilt and induce others to behave or act a certain way. This theme resonated strongly among many of the women who strongly identified with each other in relation to this experience in their lives. This session showed that group cohesion was well-established among the women who participated in the discussion and openly shared their experiences and feelings. A couple of members shared very little or not at all, but no pressure was applied as these women had shared during other sessions. One woman who shared on-going difficulties with family members was given a number of resources and agency names through which to get additional assistance and to mobilize her.

After a short break, one member took an enormous risk to confront and verbalize her own fears in the group, her sense of disconnection from the group, and her feelings about one particular group member whom she was afraid to confront. She felt that she was being ignored, was disliked, disapproved of, and judged by this particular member; in addition she also expressed uncertainty about the limits and boundaries around giving feedback, stating that she felt she had been slapped down or censured for doing so on one occasion. The group leader then personally

intervened to deal with this member's issues which were laden with guilt and shame; later feedback was invited by other group members. The session ended shortly after the feedback was given.

<u>**Session 5 Feedback: Theme of Taking Care of Oneself in Relationships**</u> (7 feedback sheets)

What members reported:

- One member felt encouraged by the feedback she received which included a number of resources and agencies for her follow up with regarding her personal problem.
- Recognition of how problems can be passed from one generation to the next and still not be resolved; how it is important to break the cycle so as not to perpetuate the problem.
- One member was helped by another member's "reversal of roles" in that the other member reflected the same bewildered feelings she had felt about her spouse because he had changed so quickly once they were married; for her, this represented a validation of her perceptions. This helped the woman understand more objectively how domestic abuse happens behind closed doors and how that serves to hamper one's perceptions of a situation; she also became poignantly aware of how a spouse can present a different face to the outside world compared to what is presented to the family. However, she felt she was learning important social skills, especially how to confront, by observing the confrontation that took place in the group. She learned that it is important to confront and to come to some resolution.
- One member reported that she learned a lot from this session about boundaries and how one can have both self-respect and also show respect for others.
- Many members reported feeling emotionally drained, raw, stressed, overwhelmed, or emotionally shaken by the painful "confrontation" that took place between two members - because it triggered their own painful memories and feelings. Some members felt anger, pain, and frustration; several members strongly identified with the person or issue behind the confrontation, stating that they shared the same pain and shame of the confronter.

- One woman reported that she found herself sitting in the shoes of the confronter and identifying strongly with her deep pain. She felt that she could not control her tears and was ashamed about it.
- One woman described how she felt the need to be comforted and had to take time to calm herself down when she came home because she felt as though she had been through an emotional shakeup.
- One woman recognized that the confrontation was the product of a projection; this member recognized that we are all attracted to some people more than others, that some people may not like us nor we like them.
- One member reported being helped by this confrontation in terms of social skills - how to confront and come to some resolution.
- One member reported feeling horrified at the "stunt" with the confronter and wrote that she would not be surprised if the person who had been confronted did not return to the group; she felt the person had been devastated. This woman also expressed frustration and a fear that the group was in danger of falling apart, partly because of the kind of feedback that another member was also getting. She also felt that some members should not be in a group therapy setting.
- One member reported that as a result of the confrontation she gained some insight into herself in terms of both the envy and dislike she felt for the other member.
- The member who did the "confronting" reported a whole host of mixed and conflicted feelings about the session, including reservations she had about revealing her true feelings and fears about confronting the other woman, the intervention by the group leader, and the outcome. She stated that she would still have liked to be able to address the other woman and find out what this woman truly thinks of her. However, even though she still feels uncomfortable, she is committed to continuing her participation in the group.

Session 6, May 8, 2001

Attendance: 9 members

Theme: Healing & Changing / Shame & Guilt

Summary of the Session:

The co-facilitator opened the session with a reading on healing and changing and invited members to make comments or share any aspect of healing that they had experienced or were struggling with. Several women responded and shared their experiences, either in relation to changes they had made or to their current, on-going difficulties. One woman brought up the topic of shame and how she felt extremely uncomfortable facing the co-facilitator after a private conversation after the last session that left her feeling vulnerable because of what she had revealed about herself in such an intimate fashion; she almost did not come to this group session because of the shame she felt. This courageous woman was able to confront her feelings of shame in the group and appeared to work through some of it. The co-facilitator had prepared a separate hand-out on "Shame and Guilt" which she handed out and then spoke briefly on the topic, touching on the origin of shame, the difference between shame and guilt, and how we can heal shame by acknowledging that we have it, and allowing ourselves to reveal it and overcome the secrecy around it. The group leader stressed that shame carries a core message that we need to listen for. The subsequent discussion in this area was very meaningful to the members and productive.

Following this discussion, an exercise was carried out in which each member had brought a picture of herself as a child. The pictures were placed on a table for everyone to examine and so that people could try to match up the picture with the group member. The group leader invited the members to identify what qualities they saw in the various pictures of the children; some of the qualities that were identified were innocence, hope, a sense of expectation, vulnerability, etc. The leader then followed this up with a 10-minute guided relaxation and visualization exercise for connecting with the inner child in which the members were led to access their inner child and become acquainted with it. [A copy of this exercise, "*Imagery and Meeting Your Inner Child*" is

in Appendix B.] When the imagery exercise was finished, the members drew on paper with colored markers whatever they had experienced during this visualization. After this, there was extensive personal, poignant, and deep-felt sharing of what this whole experience had been like for each member. This ended the session.

Session 6 Feedback: Theme of Healing & Changing: Shame & Guilt (5 feedback sheets)

This session included two exercises, one involving reflecting on childhood pictures which members had brought for display, and another that involved a guided visualization in which members re-visited their inner child, as young girls. Members reflections often included references to previous weeks' themes or issues; reports were as follows:

- One member reported that after many years of pain, she began to look at her denial and has been learning new ways of living and feeling; recovery, however, was a slow process but a healing, spiritual journey. She reported that she is starting to feel better about herself, is becoming more self-accepting, is finding a sense of self-worth and self-importance, and recognizing that risk is necessary for change and growth. This member also reflected on how during her long healing process when she had been able to speak of her shame, she was then able to let it go and continue the healing process for herself. She also recognized that her only real limitations in life were those that she placed on herself. With the help of her Higher Power she realized she would/could become a better person and her pain would diminish.
- Another member reported how the meditation/visualization at the end of the session made her cry and that this was good for her. She was touched by what many of the other group members shared, but also felt deeply stirred in her own soul for her own pain and loss. She felt she received personal insight that contributed to her own growth and healing by sharing her own experience of woundedness with others in the group; there was a feeling of common ground in these shared experiences, that she was not alone, and felt less frightened because she was not so alone. Looking at the pictures elicited deep emotions

that revolved around how small, innocent, and unmarred young children were and how it made her angry how parents were unable or unwilling to nurture them properly and how so many of the children had been harmed physically, emotionally, and spiritually. She noted poignantly how her own experience had left a gaping hole in her soul, and grief at the unfairness of it all. She recognized how it takes great courage to want to heal, to find the emotional and other resources that it takes. This woman, however, also complained that certain members talk too much and take too much time away from others, suggesting that the facilitator(s) could encourage the overly talkative members to come back to the point of the sharing, rather than wandering off topic.

- Another member reported that this session was good for her because it helped her recognize her poor boundaries with her family members/siblings. The picture session left her with mixed emotions; she found herself thinking more of her brother and the pain she feels for him. Looking at herself at her young age she realized how much damage she had sustained and how that could never be changed; the clock cannot be turned back; she questioned why she was born. She reflected on how difficult it is to walk away from the only family you know because there is no one else there, that it is frightening to be truly alone.
- Another member reflected on loneliness - how a couple of other members had talked about their deep feelings of loneliness, but that she herself did not suffer from this kind of loneliness; rather, she enjoyed her solitude. However, she did feel loneliness when she was among certain people or groups, "lonely in a crowd," but realized that it was really boredom. This member also believes shame is a prime motivator for negative behaviors such as perfectionism and addictions; shame is the result of being exposed as something inferior because of abuse or mistreatment; but she also recognized that there is healthy shame. She finds that the way out is to learn our limits, to become self-accepting, to keep growing and learning, to allow room for error, and "to thine own self be true." The

meditation affected her deeply. She was able to connect with her inner child, to comfort her and reassure her that she would not be abandoned or left alone again.

- Another member reflected on a physical disability she has had all her life, how it has affected her, and what she has done and is doing to change how she deals with it in relationship to other people and their attitudes toward her. She described how miserable and hurt she had been during her childhood because of this impairment and how she had felt it necessary to isolate herself, both as a child and as an adult. She decided to overcome this barrier, overcome her shame, remove her mask and trust that people will come to accept her as she is. She is proud of herself for what she has accomplished in the last four years.

Session 7, May 15, 2001

Attendance: 7 members

Theme: Healing & Unfinished Business

Summary of the Session:

After some preliminary announcements, the co-facilitator began by giving a short review of the general feedback that had been received from members, that the comments on the feedback sheets were important in terms of reflecting what was going on for those members who filled them in. The co-facilitator mentioned that earlier the feedback sheets had been more general and various members were echoing each other in the same kind of global or general concerns they had and that the later, or more current, feedback forms reflected more specific and personal material. The co-facilitator then referred to the May 1st session during which the confrontation had taken place, advising members that their feedback sheets reflected that many of them had had strong emotional reactions at the time, feeling overwhelmed, shaken, raw, or stressed. She then asked if there was any unfinished business about that session that someone would like to address; she also asked members what unfinished business there is for them in their own lives, what have they not

attended to. She also let members know that this confrontation was not a bad thing, that is what groups are all about, that things do and should get stirred up during such a confrontation, but then need to be worked through and resolved by all members affected by it. She stressed that if members are too comfortable or only comfortable in the group, it means they may not be taking personal risks to disclose their true feelings and the group may not be very useful or productive for them, that it was important to be challenged as well as supported by other members. One member commented that she was always anxious and felt uncomfortable in the group because she has great difficulty disclosing; this member, however, had shared a number of personal difficulties over the course of the meetings in spite of her discomfort.

After this, the co-facilitator commenced with the prepared reading on "Healing and Unfinished Business." She then invited members to speak to any issue related to the reading or to check in and say where they are in their personal lives. With this, the go-around began and there was again some very intimate disclosures and sharing by all members. Several members shared a common theme of how they had been or were being shut down by other family members who did not want to talk about more personal family issues or discuss the past and what it all meant. The group leader then commented that there was a myth about families being close to each other or bonded, that it was only with some family members that one can have a close or intimate relationship, that we need to let go of the need to bond and let others live their lives the only way they know how. Other women discussed how they had been accessing and working with their inner childhood hurts, or how they were coming to terms with a failing or abusive marriage. The group leader responded by asking how the group can support them.

After the break, there was a lively discussion about using four-letter words in situations when there are intensely felt emotions, how many women had overcome their inhibitions in using these words, and how liberating it felt to be able to use these words in these circumstances, including within the group. The remaining women then continued to share their personal experiences and struggles with respect to family and relationship matters. Here again, several

women talked about how they cannot speak about childhood events or other feelings with family members because the family does not want to hear about it. One member related how difficult it was for her to look at the past herself because it was still too painful.

At the end of the session, the group agreed that there would be a pot-luck lunch at 12:00 next week, just prior to the final (8th) session, as part of a farewell celebration.

Session 7 Feedback: Theme of Healing and Unfinished Business (4 feedback sheets)

This was the last session for which feedback sheets were collected. Although only four members turned them in, these women wrote at great length about their experience and their thoughts and feelings:

- One member reported this as the most painful session for her as it was her wedding anniversary but a very unhappy one; there were many deeply conflicting and painful feelings attached to the event. She affirmed that the feedback I had given her rang true, that she felt a sense of failure with the marriage, that the past was lost. The family members on her husband's side are now lost from her life - which she has to grieve and needs to come to terms with. Her question was: What was the lesson in all this? There was also the issue Jan had brought up for her, of choosing life versus choosing spiritual death in deciding whether the marriage will continue as it is. She had given up all her hopes and dreams for the sake of the marriage to an alcoholic and life has passed her by. However, she feels that she has been getting stronger over the past few years, improving herself thanks to the work she has done in various groups and thanks to her Higher Power. In asking why her life has evolved as it did, she found her own answer in realizing that because of that experience, she has been taught a number of things; she has learned to face shame and guilt, to grieve, to listen to her inner self, to accept herself and regain her self-esteem, learned honesty and humility, and the 12-steps. She feels that she has met a number of "angels" along the way who have moved her along the path to her own healing and recovery.

- Another member reflected about her introversion, her shyness, which makes it a challenge to be involved in this group of women. Even though she finds it hard work to be in the group, she finds she appreciates herself more as a result. Some years ago she took her first steps towards healing by becoming involved in outside activities and a support group which became a source of guidance and insight into some of the problems she was experiencing. What she needs the most is to have someone who can listen to her and understand her story and her experiences. As a result of these activities she was able to discover and develop some of her hidden talents, namely writing poems and prose in the form of journals. This has become the main avenue for releasing her grief and exploring her turbulent emotions. She also acknowledged the presence and guidance of God in her life which has given her the strength to survive and go on despite her tribulations. Her suffering has enabled her to create an honest and true relationship with people and with God. Recognizing her personal value and dignity gave her the ability to continue growing through her pain and suffering. She recognizes that healing is an ongoing process and that she still needs to address the unfinished business in her life, particularly in her family life with a husband who continues to put her down; in spite of this she continues to fight to take better care of herself.
- One member had been encouraged to bring in a quilt she had made to show the other women and had done so even though she felt apprehensive about how the women would react to it. Her apprehension centered around the idea that they would think, how could she have the temerity to even attempt this kind of thing. All her life she had lived with the belief that she was a nothing and was good for nothing, that she was worthless and useless. However, the women marvelled at the beauty of the quilt and affirmed her for having done such a beautiful job. She had never heard the words, "I am so very proud of you" from anyone. She realized how she had been shamed for her feelings, her needs, and her talents, first by her own family while growing up and now again by her husband's

reactions. This time, however, she was able to counter the negative reactions because of the positive reactions she received from the women in the group. She realized that no one can change the fact that she had made this beautiful quilt which is tangible proof that she is good for something. This woman also reminisced about the fact that she had been a "barren women" because she could not bear a child. However, she had dealt with this many years ago by asking herself what she really wanted, which was to raise a child and watch it grow and learn, to raise a family. She realized that in order to do this, she did not need to bear children herself but that she could adopt, which is what she did. As a result she felt that she did not miss out on anything or that she was less of a woman. The fact that she did not conceive was an act of God. This woman concluded that she had worked very hard in the last five months and was saturated for now, needing to process a lot of the material and experiences in the group. She feels more at peace than she has in a long time.

- Another member reflected on her own difficulties with speaking up, understanding that somehow she needs to learn to speak up in a certain way and that sometimes the communication may not be received well by others. The other person may walk away and that would be difficult to take. This member also expressed a lot of difficulty with the idea that this group was structured by a religious institution and she admitted that she has trouble with religion. She felt that unless you were a religious person, a Christian, a certain other member made you feel that you were nothing, especially if you challenged any religious belief. She feels that she was prevented from speaking at times, from challenging another member because she was opening up their wounds. She had opened up her own wounds and felt that others were feeling what she was feeling but that yet others in the group did not appreciate or like this opening of their wounds. But why then are they there, she asked. She appreciated the co-facilitator's disclosure to the group of the feedback from the confrontation session, that there had been very strong feelings and reactions about what had happened. This member felt that some of the members still want

to hide and not deal with their issues. Nevertheless, this member felt that she got some positive feedback from certain members.

Session 8, May 22, 2001

Attendance: 9 members

Theme: Healing & Rescuing Ourselves

Summary of the Session:

The final session was preceded by a celebration that included most members bringing food to make up a pot-luck lunch during which the women could eat, talk, and socialize. Only one or two women were unable to come for the lunch but did come in time for the regular group session.

The co-facilitator began the session by passing out the handout "Healing & Rescuing Ourselves" and reading it aloud. One woman then launched into a repeat of the same set of problems and complaints which she had presented during her first session but had not taken any action on, despite being given resources and suggestions. The group leader addressed her directly on how this was a time for taking action, making hard choices, and doing some hard self-examination. This was generalized to the issues and difficulties that all the group members were dealing with in their lives. The group leader then spoke to the fact that this was the final session and it was a time to go away and process what we have learned, a time to take action on whatever level was needed to move ourselves forward; it was not enough to just have the information. She named a number of other resources agencies for members to follow up with such as the 12-step program, Christie House, and other programs and groups offered by St. Raphael Centre. With endings there are new beginnings. The co-facilitator reminded the members, "If you always do what you've always done, you'll always have what you've always had." The co-facilitator then extended a personal thanks to the entire group for allowing her to take part in the facilitation and for sharing themselves as shown by their trust and willingness to provide her with some excellent written feedback and personal reflections on what they were experiencing.

One member had been encouraged to bring in her own book of prose and poetry, "Spiritual Awakening," which she had started as a journal toward self-healing some years ago; the co-facilitator had picked out a couple of short selections from this book that were relevant to group issues and read them aloud to the group. The remainder of the session was taken up with more deep-felt personal sharing by most of the members with respect to on-going difficulties, and the saying of good-byes. Reference was also made by two of the members to some of the unresolved issues and emotions between them which had also had an impact on other members' reactions in relation to both the process and content of the issue. There was the realization of a lot of unfinished business for many members at different levels and areas of their recovery. Members knew that the healing and recovery process had just begun for some of them and there was much work yet ahead before they found themselves in a better place.

The session ended late with the women forming a circle, holding hands, and reciting the serenity prayer: "God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

Final Session 8 Feedback: Theme of Healing and Rescuing Ourselves

No Feedback sheets were given out as this was the final session. Instead, the **Therapeutic Factors Questionnaire** had been handed out during the 7th session and members were asked to return them for the last session; these questionnaires were to be anonymous with no names on them. This questionnaire was made up of 35 items and designed to assess which factors members found helpful as part of their healing and recovery process. Each question was answered on a scale of 1 to 5 with 1 equating to extremely helpful and 5 equating to barely helpful. Eight questionnaires were returned; only one member failed to turn in a questionnaire.

Overall Assessment of the Feedback Sheets:

The reflections on the feedback sheets were rich and abundant in information on how the women described their issues and concerns and how they were struggling and feeling. It was evident many times that the women were comforted and helped by knowing that others were also facing problems and struggling with emotional and relationship difficulties much like their own. The women were very closely aligned in terms of the similarity and commonality of their concerns. They all felt comforted by the knowledge that they were not alone or unique in their problems and feelings, but they also recognized their differences, that they each had their own unique circumstances. For most of them, their disclosures in the group allowed them to feel accepted by the rest of the group. This allowed some members to recognize their isolation and to let go of their shame and guilt when they disclosed their painful stories; at the same time, it invariably made them more compassionate and sympathetic toward others, often stirring up strong feelings of mutual identification with each other's pain and suffering.

From the women who did fill out the feedback forms, it was evident that they were working hard at processing their various thoughts, feelings, and issues. At various times, through their self-reflections, they showed how they arrived at poignant new insights and understanding of their situations. They began to understand what their constraints were and how they often limited themselves on the one hand, but also how they faced the limitations they did have, on the other hand. For a few, there was a sense of relief that they could come out of hiding and isolation, effectively remove their masks, and see through the veil of denial behind which they were living. They came to the realization again and again that they had work to do and new skills to learn. They had to find their own answers and solutions to their difficulties; no one else had the answer to how they should live their lives except themselves.

The women wrote about how they struggled with various issues such as setting limits and boundaries; learning not to carry other people's emotional burdens or responsibilities; dealing with painful emotions such as loneliness; abuse in the family; perfectionism and doing too much for

others at their own expense; grieving the loss of family relationships; and coming to terms with the loss of illusions about marital relationships. Several of the women also indicated that they felt they had already found peace and resolution with some of the issues raised by other women or that they had made significant progress in certain areas. Many felt that they were finding inner strengths and talents they did not see before. The women learned to trust themselves, to validate their own perceptions and feelings. Some were setting limits and boundaries for the first time. They felt they were acquiring important social skills and finding self-worth and self-acceptance. A number of the women saw themselves as courageous and wrote about how they became proud of what they had accomplished. They saw themselves as learning, making progress, experiencing set-backs, overcoming obstacles, and constantly renewing their commitment to growing stronger and healing.

In addition, the women were not afraid to express their thoughts and feelings about the group experience. They consistently stated what in the group they found personally helpful and meaningful, for example, the information and issues presented, the feedback and support they received, and the skills they learned. They also freely stated how any particular meeting or session affected them - whether they came out of the group feeling good, confident, and energized or overwhelmed, distressed, emotionally drained, frustrated, or disconnected. They also voiced complaints from time to time about how some members talked too long, how the facilitators should/could have constrained these members and kept them on track, and how some felt they did not get enough feedback.

There was an on-going difficulty with one of the women who did not feel accepted by and connected with the group because of her sense of rejection and disapproval from another member, but she was unwilling to bring this to the group initially and waited for several sessions. When the confrontation did finally take place, there were some very strong emotional reactions and mixed responses among the group members, with some feeling very uncomfortable and even distressed for various reasons, while others felt that they learned something valuable about the need to

confront and how to confront. This was an incident that left a number of members with unresolved or unfinished business.

Overall, this remarkable group of women took on the challenge of working hard at their own recovery and growth, of taking active steps and risks to make positive changes, and came to appreciate their own efforts and struggles at making changes for the better. Despite their pain and suffering, their courage, confidence, and sense of commitment to their own healing shone through.

PART III: THE HEALING PROCESS

Therapeutic Factors in Healing

Yalom (1995) identified a number of therapeutic factors that operate in groups and promote therapeutic recovery or healing. These factors consisted of 12 general categories; ranked in order of importance, they were: interpersonal input, catharsis, group cohesiveness, self-understanding, interpersonal output, existential factors, universality, instillation of hope, altruism, family re-enactment, guidance, and identification. It was group members in long-term, interactive psychotherapy groups who themselves assessed these factors as most relevant to their improvement. However, Yalom (1995) also makes the observation that the differential value that group participants place on the therapeutic factors is strongly dependent on the type of group they are in, the stage of the therapy, and socioeconomic, intellectual, and personal variables associated with the members.

The therapeutic factors that I placed in the form of items on the questionnaire were a limited and modified version of Yalom's 12 original factors. For this group, *Women Healing Together*, I dropped the category of altruism as not relevant; this item refers to helping others, forgetting oneself in favor of thinking of others first, and putting others' needs ahead of one's own. It turned out that this characteristic was one that the women in this group had taken on too strongly in their lives, at their own expense. It is not that thinking of others and their needs is unimportant but that there seemed to have been no real balance in many of these women's lives between looking after themselves and looking after others' needs. I also combined interpersonal input and output into one category of interpersonal learning and included two additional categories for my own purposes: psycho-education and emotional support. The results of the questionnaire are in the following table:

Table 3: Ranking of Therapeutic Factors in Group Therapy for "Women Healing Together"

Factors were ranked in order of importance and scored by 8 group members. Ranks were determined by taking the average score for each question, based on a scale of 1 to 5 as follows:

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

I developed three average range groups for helpfulness of therapeutic factors as follows:

Most helpful: 1.0 - 2.4 *
Mid-range: 2.5 - 2.9
Less helpful: 3.0 - 5.0

	Factor	Question No.		Average Score For Question	Factor Average
1.	Psycho-education	31	*	**1.6**	1.6
2.	Universality	1	*	**1.86**	2.036
		7	*	2.25	
		8	*	2.0	
3.	Emotional support	32		2.75	2.12
		33	*	**1.5**	
4.	Instillation of Hope	2	*	2.37	2.23
		24	*	2.0	
		25	*	2.14	
		26	*	2.43	
5.	Family-Re-enactment	19	*	2.25	2.31
		20	*	2.37	
6.	Existential Factors	27		2.75	2.37
		28	*	2.0	
7.	Self-Understanding	21		2.71	2.42
		22		2.71	
		23	*	2.14	
		29	*	2.12	
		30	*	2.43	
8.	Interpersonal Learning	9		2.75	2.5
		10		3.0	
		34	*	2.25	
		35	*	2.0	

	Factor	Question No.		Average Score	Factor Average
9.	Group Cohesiveness	3		2.5	2.68
		4		2.87	
		5		2.87	
		6		2.5	
10.	Guidance	12		2.75	2.68
		13		2.62	
11.	Catharsis	11		2.75	2.75
		14	*	2.25	
		15		3.25	
12.	Identification	16		4.57	3.48
		17		3.0	
		18		2.87	

Therapeutic factors and questions adapted from Yalom (1995), p. 74-78.

Table 4: Questions Organized by Therapeutic Factors

Psycho-Education:

31. Receiving written handouts with information about specific issues.

Universality:

1. Learning that "*I am not alone*" or "*I am not the only one with my type of problem; others are in the same boat as I am.*"
7. Learning that others have some of the same thoughts and feelings that I do.
8. Learning that others had parents and backgrounds as unhappy or messed up as mine.

Emotional Support:

32. Emotional support received from other group members.
33. Emotional support received from one or both of the group facilitators.

Instillation of Hope

2. Optimism and hope that I can get through this difficult time in my life by participating in the group.
24. Seeing others getting better was inspiring to me or gave me hope.
25. Knowing others had solved problems similar to mine.
26. Seeing other group members were improving or had improved encouraged me.

Family Re-enactment

19. Being in the group somehow helped me to understand old hangups that I had in the past with my parents, brothers, sisters, or other people in my life.
20. Being in the group was, in a sense, like being in a family, only this time a more accepting and understanding family.

Existential Factors

27. Recognizing that life is at times unfair and unjust.
28. Learning that I must take ultimate responsibility for the way I live my life no matter how much support and guidance I get from others.

Self-Understanding

21. Learning that I have likes or dislikes for a person for reasons which may have little to do with the person and more to do with my hangups or experiences with people in my past.
22. Learning that I react to some people or situations unrealistically, with feelings that somehow belong to earlier periods in my life.
23. Learning that how I feel and behave today is related to my childhood and development.
29. Receiving information that helped me expand my knowledge and understand myself better.
30. Being able to identify problematic themes and patterns in my relationships.

Interpersonal Learning

9. Improving my skills in getting along or dealing with people.
10. Feeling more trustful of groups and of other people.
34. Learning ways to handle issues or settle differences.
35. Learning social skill techniques, such as how to set boundaries or limits .

Group Cohesiveness

3. Finding a sense of belonging, togetherness, and acceptance in the group.
4. Being able to open up and express strong feelings and not worrying about how others will perceive me.
5. Revealing embarrassing things about myself and still being accepted by the group.
6. Belonging to a group of people who understand and accept me.

Guidance

12. A facilitator suggesting or advising something for me to do or giving me definite suggestions about a relationship or life problem.
13. Group members suggesting or advising something for me to do or giving me definite suggestions about a life or relationship problem.

Catharsis

11. Being able to say what was bothering me instead of holding it in.
14. Learning how to express my feelings.
15. Expressing negative or positive feelings toward another member.

Identification

16. Trying to be like someone in the group who was better adjusted than I was.
17. Finding someone in the group whom I could pattern myself after.
18. Seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same.

Following is a description of each factor and an analysis of how these factors operated in this group based on personal observation, comments on the feedback sheets, and responses to the questionnaires. What is critically important to remember is that all of these therapeutic factors are highly interdependent; none of them stand in isolation to the others.

1. **Universality.** Many individuals-who have come from severely dysfunctional families often believe they are alone in their misery, that they alone have frightening thoughts, feelings, fantasies, or personal difficulties. In this therapy group, *Women Healing Together*, particularly in the early stages, the women began to hear other members disclose painful or distressing feelings and problems similar to their own. This disconfirmed their uniqueness, that they were not the only ones with problems, that they shared common concerns and feelings. This realization alone often brings an enormous sense of relief and comfort, a sense that "we are all in the same boat." This was precisely what was found in this group

of women. Universality was rated very high on the questionnaire (3 items), as very and extremely helpful, by the majority of the women. This was also strongly reflected on the feedback sheets by the women who did give feedback, indicating that this was a potent healing factor for the women.

2. **Instillation of hope.** The belief, expectation, or conviction that members can be helped to overcome their problems and difficulties through participation in a therapy group is another crucial factor that contributes to healing. Sustaining hope and confidence in the therapeutic process helps to keep members in the group so that other factors can take effect. Group members are invariably at different points along a coping continuum and some members often find it helpful to see how others have improved their circumstances or their functioning. This also instills hope for future recovery. Instillation of hope was also highly rated as a healing factor for the women in this group. All four of the items received scores of very and extremely helpful by the majority of the women; some members scored a few of the items as helpful but there were no scores worse than helpful. This indicated that the hope of getting better, improving, and solving problems was a potent therapeutic factor for these women. A strong sense of hope was also very evident on the women's feedback sheets.

3. **Existential factors.** These factors include a recognition of some fundamental humanistic or philosophical issues that bear-on one's life. These include ultimate responsibility for one's life, basic isolation, the capriciousness of existence, and letting go of the trivialities in one's life in the face of more basic issues such recognizing one's mortality and therefore concentrating on leading a more meaningful life. Certain of these items often connect at a deep level for members and are ranked highly as an important factor. For the members of *Women Healing Together* this was no exception. One of the two existential items in the questionnaire, "learning that I must take ultimate responsibility for the way I live my life no matter how much support and guidance I get from others," was scored as either

extremely helpful or very helpful by six of the seven members who answered this question; only one member scored this item as somewhat helpful and one member failed to score the item. The second item, "recognizing that life is at times unfair and unjust" was also scored as helpful, very helpful, or extremely helpful by six of the eight women, while two scored this item as somewhat helpful. A few women also expressed strong existential themes on their feedback sheets. Existential factors seem to help members come to terms with their basic sense of aloneness in terms of choice and decision-making in their lives.

4. **Self-understanding.** Both therapists and group members generally have an urgent and deep-rooted need for intellectual understanding of themselves and their place in the world. Members in particular have a great need and want for self-knowledge and for a deeper understanding of their difficulties. It is the motives behind this need that help to bring about positive change. What drives the desire for self-knowledge is the need for a sense of control and mastery as well as safety. Through knowledge and understanding, the unknown and the unexplained are rendered harmless; information removes ambiguity and reduces anxiety. Knowledge gives us the ability to explain things and explanation allows us to order the events in our lives into a coherent, predictable pattern. In this sense, knowledge is power because it removes fear of the unknown and once we understand the self better or can explain and understand our difficulties, they become more manageable and under one's control; we can then make better choices that permit us to act in our own best interests. Three of the five items on the questionnaire that related to self-understanding were rated primarily as extremely or very helpful by the women in this group; the other two items were also rated from helpful to extremely helpful by most of the members, indicating that this was a potent factor. Self-understanding was another factor that came through on the feedback sheets the women submitted and came through in the strong desire to make sense of their problems.

5. Family re-enactment. The majority of people who participate in groups come from a background of highly unsatisfactory childhood experiences in dysfunctional families-of-origin. *Women Healing Together* was no exception. Long-term therapy groups invariably bring out many of the same dynamics and problems that existed in the individual's original family. There are authority/parental figures, peer siblings, strong emotions, deep intimacy, and sometimes hostile, competitive feelings. In time, some members begin to interact with others members or with the leaders in a way that reflects how they interacted with their original family members. Some members may display helpless dependence on the leaders, some may admire or try to appease the leaders or others, some compete for attention and caring, some complain about favoritism or may seek to become the favorite, some look for allies to defend themselves against others, and some are wary or fearful of the leader(s). All the roles that adult children of alcoholics exhibit may be replayed by the various members of the group and indeed there may be competition for some of these roles. In the group, these fixed roles can be explored and challenged. Working out problems with other members or with a leader is also working through unfinished family business from long ago. However, in this group, *Women Healing Together*, many of these dynamics did not have time to fully surface or be played out because of the 8-week time limit and the fact that a certain amount of time during each two-hour session was devoted to the elucidation of particular issues in a general way rather than being related to members' specific, individual issues, although the women did disclose many of these personal issues. There was only one occasion when one member was encouraged to disclose to the group the reservations and negative feelings (hostility) she had about another group member. This "confrontation" was handled by the group leader and took up a good portion of the group's time. There were a number of very strong reactions reflected by the women on their feedback sheets in response to this event, some positive and some negative. It also stirred up many more hidden or unaddressed issues for some members, including shame.

As one psychotherapist (Gans, 1989) explained it:

> *One of the most frequent causes of hostility in the early phase of group development is narcissistic injury (although narcissistic injury is a potent source of hostility in all phases of group development). The potential for injury to self-esteem, while a painful fact of group membership, is not bad. Much of the healing in group takes place by the growing capacity and willingness of its members to acknowledge and deal with their respective hurts and slights at each others' hands. These include being unappreciated, excluded, [snubbed,] forgotten, stereotyped, cheated, disappointed, shamed, and exposed. Initially, responses to such emotional injury are angry and hostile; however, as members gradually are helped to see that there are "no innocent bystanders" and that, to some degree, they have the power both to change what is happening in group and to take responsibility for how others respond to them, the emotional tone changes. Eventually, a sense of collaboration replaces power struggles, sibling issues, and destructive competition.*

It is doubtful that the issues between the two women were resolved satisfactorily for either one, primarily because of the time limitation. In my opinion, many more sessions would have had to be devoted to truly working through the emotional difficulties for both women. However, as a therapeutic factor, the two family re-enactment items on the questionnaire were scored as helpful, very helpful, and extremely helpful by most of the women. These two items, however, were related more to acquiring an understanding of old hang-ups from past family relationships as well as feeling that the group itself was like a more accepting and understanding family. So this factor in this group was more closely intertwined with gaining self-understanding.

6. **Interpersonal learning.** This refers to social learning that is acquired as a result of group members interacting with each other during sessions. Within the social microcosm of a psychotherapy group, members can acquire certain social skills such as managing conflict, learning how they impact each other, what impressions they make on others, learning to trust, and how to handle issues or settle differences. Psychological symptoms and interpersonal difficulties have often developed from disturbed interpersonal relationships earlier in life. Therapy groups can create a social universe within which these disturbances can be uncovered, explored, and changed through interaction with and feedback from other members and the therapist. However, in this group, again because of

the more structured format of the group and the fact that it was time-limited, interpersonal learning was not as pronounced; inter-personal interactions were more limited because the format called for feedback from others only on request and others were waiting for their turn to check-in and to relate their concerns or difficulties. Certain social skills such as how to set limits and boundaries and how to be self-assertive were taught in a more explicit and generalized instructional manner as part of psycho-education, although a number of the women were able to relate how they personally had learned how to handle and negotiate some of these issues. However, after the "confrontation" a number of women stated in their feedback sheets that they had learned something about how to deal with conflict and come to some kind of resolution. The results of the questionnaire showed that two of the four items for interpersonal learning were rated from very to extremely helpful, while the other two were in the mid-range for helpfulness. This indicated that interpersonal learning was still an important and valued factor for the women in this group.

7. **Group cohesiveness.** Cohesiveness refers to the members' relationship both to the other group members as well as to the leader; it pertains to the sense of "we-ness" or group spirit the members share. It also includes all the forces that hold the members together as a group such as a sene of belonging, feeling valued, accepted, and supported as well as a sense of being warm, safe, and comfortable. Cohesion, however, is not a fixed quality of the group but can fluctuate over time. In addition, cohesiveness does not always mean total comfort at all times but can include feeling safe enough to disclose strong negative emotions toward others in the group at times. Group cohesion is a powerful therapeutic factor in its own right but its real importance is that it is a necessary condition for augmenting other therapeutic factors. Good cohesiveness promotes healing because it allows for deep emotional sharing of one's painful or shameful inner world, followed by acceptance by other members. To be accepted by others means that one can no longer

sustain the belief that one is basically unlovable, unacceptable, or worthless. Members who internalize this experience learn to accept themselves, which itself is a critical step toward healing. The overall rating for this factor fell into the mid-range, but individual scores for these items spanned the entire range of the scale from barely helpful to extremely helpful. In looking at the sets of individual scores for the four items that made up this factor, it can be seen that there was consistency within the scores for each member; that is, each member consistently felt group cohesion at some point on the scale; for example several members scored cohesion as extremely helpful across all four items, while several other members scored all the items as helpful or somewhat helpful; no member scored these four items at the different extremes. This indicates that for some members all aspects of group cohesion were important and played a healing role, while for other members the group cohesion was either not felt, or they did not feel ready for deep sharing, and therefore this did not provide them with a healing experience.

8. **Guidance.** Guidance is the explicit asking for and/or giving of advice or suggestions for handling a personal difficulty, but can also include providing cognitive strategies for handling specific kinds of difficulties. Advice can come from the therapist/facilitators or from other members. Even though it is well-known that advice and suggestions are rarely followed, advice-giving nevertheless serves its function as a group process because it implies and conveys interest and mutual caring. For the members of *Women Healing Together*, this factor fell into the mid-range for helpfulness. In looking at the two questions that made up this factor, the different members rated this factor along the entire range from barely helpful to extremely helpful. The most likely reason for this is that only some members wanted and received specific advice for their difficulties, while others who did receive advice and suggestions found it very helpful.

9. **Catharsis.** Catharsis is the full expression or ventilation of strong emotions, whether negative or positive. As a therapeutic factor, emotional expression alone is not enough to

produce positive change, but rather requires some form of cognitive re-learning to go along with it, i.e., the person must undergo some kind of shift in the way she typically reacts to something, or some kind of change in basic attitude or perspective as a result of the emotional experience. Often, being able to feel the emotion along with being able to find the words to say what could not be said before satisfies both these requirements for positive change. In a group, catharsis becomes more helpful once supportive bonds have been forged with group members. Most of the members of *Women Healing Together* disclosed personal information that often led to the shedding of painful tears, generating caring, concern, and empathy from others who identified closely with the pain of those members. On the questionnaire, the item that was valued most was learning how to express feelings. The item relating to the expression of negative or positive feelings toward another member was rated as less helpful most likely because there was very little of this kind of exchange in the group with the exception of the confrontation that took place during week 5 and was not resolved for either member. Being able to say what was bothering a member, instead of holding it, in was rated as moderately helpful. Much of the emotional expression by group members seemed to be a pure ventilation of pain and unhappiness with abusive situations in the past and present and did not involve a great deal of inner exploration; new insights or changes in attitude or perspective did not develop until later sessions.

10. **Identification.** This refers to imitative behavior in which a group member tries to pattern herself or some aspect of her behavior after another group member. This was regarded as the least helpful factor by participants in both long-term therapy groups and among the women in *Women Healing Together.* However, there is another level of therapeutic benefit that members may experience through being spectators and watching how other members reveal their inner worlds and deal with their problems. Even though some members may participate minimally or passively, they nevertheless acquire some self-

understanding and knowledge by watching how others interact, reveal their painful situations or feelings, and work through some of their difficulties. There was at least one woman in this group who was relatively quiet and passive and may have benefitted this way. Attending the group sessions and simply observing may allow her to become more aware of the possibilities for action at a later time, after termination of group sessions, when she could become more fully engaged with others by taking risks and making changes when she is ready. Thus, identification was the least helpful of all the therapeutic factors, with an overall rating in the less helpful range. Most members rated these items individually as barely helpful, somewhat helpful, or helpful.

11. **Emotional support.** This included members and facilitators providing empathy, sympathy, acceptance, understanding, and a non-judgmental attitude and atmosphere in the running of the group. Specific emotional support, however, was valued very highly when it came from the facilitators, much more than when it was provided by other members of the group, as indicated on the questionnaire. Emotional support from a facilitator had the highest therapeutic factor rating on the questionnaire.

12. **Psycho-education.** This was the imparting of information relevant to the issues identified by the women in this group in the form of weekly hand-outs (see Appendix A). This factor is intimately connected to self-understanding and really belongs in that category. However, I made this into a separate item for my own purpose which was to identify specifically whether the hand-outs I was providing were something that the women wanted, found helpful, and welcomed. I received a great deal of verbal encouragement from the women almost from the beginning to continue making the information on specific topics and issues available in written form on hand-outs. This allowed the women to follow along, to highlight what they found most relevant and applicable to themselves, and it gave them something to take home and re-read and think about. On the questionnaire, psycho-education emerged as the factor with the second best average score as a single

therapeutic item, after emotional support from the facilitators, which was first. Psycho-education was unanimously valued and appreciated by the members of *Women Healing Together*. Most of the women seemed to have a thirst for knowledge in attempting to get a better understanding of themselves and their difficulties and how they might be able to make changes. As is true of self-understanding, psycho-education serves an important function in imparting information that members are often desperate for. Explanation and clarification can function as an effective and powerful therapeutic force for change because most people abhor uncertainty and ambiguity. Hearing an explanation for a phenomenon that provides understanding is a first step toward its control.

Women Healing Together was a time-limited therapy group consisting of 8 weeks of two-hour sessions, once per week. Thus, in comparison to long-term, interactional psychotherapy groups, this group was more limited with respect to interpersonal interactions because feedback was primarily given only on request and because the main focus was not on here-and-now interpersonal interactions but rather on personal disclosures; it was also not psychodynamically oriented in that the 8 week period did not lend itself to the deep and extended explorations of internal conflicts and hidden motivations that make up personal interactions. Instead, the group was structured so that each individual member would have an opportunity to check in and share her own personal story, difficulties, and feelings; feedback was provided in terms of emotional support, personal reactions to what a member said, and resources or information offered by the members and facilitators. The main thrust of the group besides psycho-education was to increase self-awareness and self-understanding through risking self-disclosure and subsequent exploration of commonly-shared issues and concerns.

It was expected, therefore, that the therapeutic factors Yalom identified might not be valued in the same way by the members of *Women Healing Together* that longer-term, interactive therapy groups did and thus not be ranked in the same order. As expected, the rank orderings for

Women Healing Together versus long-term, interactional therapy groups differed. Following is the comparison, ranked in order of importance:

Table 5: Comparison of Rankings of Therapeutic Factors between Long-Term Therapy Groups and "Women Healing Together":

Long-term Therapy Groups	*Women Healing Together (8 weeks, 8 members)*
1. interpersonal learning-input	1. psycho-education (handouts & explanations)
2. catharsis	2. universality
3. group cohesiveness	3. emotional support
4. self-understanding	4. instillation of hope
5. interpersonal learning-output	5. family re-enactment
6. existential factors	6. existential factors
7. universality	7. self-understanding
8. instillation of hope	8. interpersonal learning
9. altruism	9. group cohesiveness
10. family re-enactment	10. guidance
11. guidance	11. catharsis
12. identification	12. identification

As Yalom (1995) pointed out, the least valued therapeutic factors are not necessarily unimportant so much as they are simply valued less relative to the other factors. The factors that the members of *Women Healing Together* chose as most helpful coincided closely with a number of the factors that Alcoholics Anonymous and other time-limited, self-help groups employ and encourage, namely imparting of information which equates with psycho-education, universality, and some aspects of group cohesiveness. Interpersonal learning is often not possible in time-limited groups because relationship difficulties, which often contribute to symptoms and long-standing problems, cannot be worked through within the shorter time frame of those therapy groups that have specific goals to accomplish.

Differences in the individual characteristics of the group members also contributed to the individual variation in the rankings of the individual questions or items that made up the therapeutic factors categories. Yalom (1995) describes research showing that an individual's level of functioning is significantly related to the ranking of therapeutic factors, with higher-functioning

members valuing certain factors more than lower-functioning members. Higher functioning individuals tended to value interpersonal or vicarious learning, self-understanding, and deeper insight into their interpersonal relations, while lower-functioning individuals placed more value on items that offered more safety and required less risk such as universality, instillation of hope, advice, and guidance from members and group leaders (Yalom, Tinklenberg, & Gilula, 1968; Leszcz, Yalom, & Norden, 1985). However, these needs and values are highly variable, changing with stages of therapy and recovery, as well as members' individual characteristics; these personal characteristics include ego strength, motivation, developmental deficits, degree of progress, goals, and specific characterological difficulties such as narcissistic versus self-effacing personalities. Thus different group members will select and value different aspects of the group process accordingly. Undoubtedly, although not explicitly assessed or analyzed, it can be assumed that most of these variables also applied to the members of *Women Healing Together*. Group experiences will address specific deficits and therefore will create a better fit for those members whose needs in this area are congruent with whatever is being dealt with in the group.

Thus, the question of the relative potency of therapeutic factors is complicated. Different factors and the strength of the therapeutic factors may be valued by different kinds of therapy groups, by the same group at different developmental stages, and by different members within the same group depending on their individual needs, strengths, and emotional difficulties (Yalom, 1995). Variables such as age, sex, or education appear to make little difference.

Another related question that has been looked at with respect to therapeutic factors in group therapy for individuals recovering from addictions is whether the same therapeutic factors apply to different clinical populations who have not been affected by addiction. The assumption has been that adult children of alcoholics, or ACOAs, are a distinctive population with special therapeutic needs because alcoholic families develop distinctive symptoms, behaviors, and patterns of needs as a consequence of their common experiences (Kritsberg, 1985). A study done by Mahon and Kempler (1995) suggests that the therapeutic needs and factors do not differ in

these two kinds of groups. This study used Yalom's 12 therapeutic factors and compared two clinical populations who participated in ongoing psychotherapy groups; one group consisted of adult children of alcoholics, or ACOAs, and the other group consisted of non-ACOAs. The finding was that there was no significant difference among ACOAs and non-ACOAs in the perceived importance of the therapeutic factors. The most valued factors in both groups were self-understanding, cohesion, catharsis, and interpersonal learning, while instillation of hope, altruism, guidance, and identification were less important factors for both groups.

One explanation for both ACOAs and non-ACOAs in psychotherapy needing the same therapeutic factors is that they have all experienced growing up in a dysfunctional family. In this sense, alcoholism or any addiction is simply one of the potential problems that plays a role in creating a dysfunctional family. Many of the behaviors and symptoms associated with ACOAs are also found in families in which one or both parents suffered from a chronic illness, whether physical or psychiatric (Miller & Tuchfeld, 1986). It is a dysfunctional family of any kind, rather than alcoholism or addiction per se, that creates the psychological and emotional difficulties in individuals who seek psychotherapy as adults. However, it is also too sweeping an assumption to say that all those who seek group therapy must come from dysfunctional families. The term "dysfunctional" can be retrospectively applied to almost any family system by any individual who experiences emotional difficulties or problems in living. Such a position simply assumes too much and discriminates too little. However, the evidence does support the same therapeutic needs for both ACOAs and non-ACOAs.

Other Healing Factors Operative in "*Women Healing Together*"

What heals us? What is healing and how do we heal? These are challenging questions because there are different kinds of healing, different levels of healing, and different degrees of healing. Healing involves experiencing changes that may affect emotional, cognitive, physical, sexual, and spiritual aspects of people's lives. The need to heal emerges because of the many

different kinds of psychic wounds people have suffered as infants, as children, as adolescents, and also as adults. What is common to all these wounds is the experience of pain, of deprivation, lack of loving and nurturing, fear, confusion, and helplessness. To heal means to make whole again by filling in the holes in the soul.

For *Women Healing Together*, a number of additional therapeutic factors besides the group factors, also played a role in healing:

1. Helping a member stay with her painful feelings and discomfort is part of the healing process; it allows a person to continue the search process on a deeper and fuller level by drawing attention to the immediate experience and facilitating awareness (Yalom & Bugental, 1997); this was done on a number of occasions for members of this group by both facilitators.
2. An important aspect of healing is the need to identify and label emotions appropriately and accurately. Many individuals have grown up in homes where emotions were not talked about or where certain emotions were condemned as bad and unacceptable (e.g. anger or sadness) and had to be suppressed. Sometimes a person can be overwhelmed with conflicting and painful feelings which they cannot make sense of or name; sometimes it is the accompanying situation or issue that is difficult to understand and put a label on. Validating, clarifying, and normalizing the women's emotions, perceptions, and issues was done throughout these sessions, as needed, by the co-facilitators. At times, this kind of validating and clarifying helped clear up cognitive distortions that had muddied ongoing experiential processing for the person in the past.
3. Providing validation and acceptance of emotions is also healing in another sense; it allows the person to feel entitled to her feelings, rather than ashamed of them and needing to hide them from others.
4. Disclosing painful emotions or material that has been locked up inside is typically healing. When painful material is kept inside and unexpressed, the person cannot examine it,

explore it, work it through or resolve it and she continues to suffer with it. Disclosure generally releases the person from its grip because the need for secrecy is gone and the shame or horror of the event and the emotions can be released.

5. Repetition in telling one's story, rehashing one's issues, problems and concerns, are all vital aspects of the healing journey. Individuals need to revisit their emotional hurts and pains and concerns many times before they begin to see their way clear to making changes and improvements in their lives. Such repetition does not mean that a person is necessarily stuck or not making progress. People generally have a need to explore and rework a difficulty from many angles; other details and facets need to emerge and be allowed expression before the person can move on. This was also true for most of the women in this group who covered the same ground many times and may still need more time for this.

6. Metaphors, fables and imagery can also highlight issues or experiences that are sometimes difficult to articulate or formulate in abstract words; this promotes healing by bringing such subtle or poignant experiences into the light and strengthening the emotional understanding of its meaning. During a session, one woman to whom the co-facilitator had given a particular fable, read this story from *Friedman's Fables* that related to her situation and with which she identified in a profound way. After she read this fable, many of the other women were also able to identify with the issue that the fable captured.

7. Restoring a sense of control in one's life is a healing experience. Acquiring important new social skills, self-understanding, and knowledge all contribute to the acquisition of a sense of control over one's life. Understanding the source and nature of one's difficulties often provides a tremendous sense of relief and becomes a first step in mastering those difficulties. A sense of control gives the individual the psychological benefits of reducing helplessness and restoring balance, predictability and safety. It becomes part of making one's life more manageable and allowing one to make more conscious choices. It was

evident that all the women in the group were, in one way or another, struggling with this issue and that knowledge, self-understanding, and specific, concrete skills all contributed to giving them a sense of control.

8. Journalling is an exercise that promotes healing. Some of the women in this group kept their own private journals. The feedback sheets that many of the women filled out after each session can also be seen as a form of journalling because it required them to pour out and clarify some of their deepest thoughts and feelings onto paper. It gave them a means of exploring their own issues further and gaining greater self-understanding and new insights. Journal writing also has the potential to heal by providing emotional release, by allowing distress, anger, anxiety and fears to flow freely (Pennebaker, 1990). Writing about troubling or traumatic events allows the individual to uncover strengths and solutions that may be lying unburied within. Often, if pursued consistently over time, journalling results in new awareness and growth. There was much evidence of this happening in the journalling the women did on their feedback sheets.

How does a person know when she has experienced healing? Healing involves change, growth, development, and integration. Healing has taken place when a person can think better, live better, and feel better about herself, when she attains clarity about herself and what she wants. Healing has occurred when the hurt, the pain, and the shame of the past have been faced and resolved, or when they can be managed better. Healing has taken place when women learn to face painful issues, solve their problems and become better at the *process* of problem-solving. It occurs when the past is no longer blindly repeated, when hard and unpleasant realities are dealt with, when women can make conscious choices about how they want to live and behave, and when they can decide what kinds of relationships they want and on what terms. Healing means women know what their wants and needs are, know what they are entitled to, and can then pursue their wants and needs without guilt or reservation. It means living a life of integrity with the

courage of their convictions and values. Healing means achieving a greater sense of autonomy, a sense of wholeness, and a more authentic way of relating to self and to others. With healing comes a sense of acceptance - acceptance of self and of others; it also comes when women realize that they only have the power to change themselves, not others. Healing is an ongoing journey in which individuals learn to live their lives at a new level of awareness; it means realizing that they will always be a work-in-progress. Healing means mending one's tattered wings so one can learn to soar again.

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APPENDIX A

WOMEN HEALING TOGETHER

General Goals: (Decide which ones are right for you.)

1. To increase my self-esteem
2. To know myself better
3. To learn new or better coping skills
4. To share my issues, feelings, and struggles so that I can understanding myself better
5. To recognize that others struggle too
6. To learn how to ask others for what I want
7. To resolve personal problems
8. To be come more open and honest with selected others
9. To learn the distinction between having feelings and acting on them
10. To become both independent and inter-dependent
11. To accept the reality of my limitations
12. To reduce behavior that prevents intimacy
13. To learn how to trust myself and others
14. To increase my self-awareness and thereby increase the possibilities for choice &action
15. To clarify my values and to decide whether and how I need to modify them
16. To increase my capacity to care for myself as well as others
17. To learn to ask others for what I want
18. To support and challenge others
19. To confront others with care and concern
20. To become sensitive to my own needs and wants and feelings, not just those of others
21. To learn to make choices in a world where nothing is guaranteed

My own goals:

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Women Healing Together
Meeting Our Wants & Needs
April 10, 2001

Part of taking responsibility for ourselves means taking responsibility for what we want and need, and knowing that's okay to do.

Learning to tune-in to ourselves, learning to listen to ourselves, is an art. It takes practice. We can use our ability to guess what others want and need, and apply that skill to ourselves.

What does it sound like we might want and need? What would we guess would help us feel better? What are our feelings telling us. Our body? Our mind? Our intuition? If we ask, then listen closely; we'll hear the answer. We are wiser than we think, and we can be trusted.

What we want and need counts. It's important, and it's valid. It's okay to learn to participate in meeting our own needs.

We can learn to identify what we want and need and be patient with ourselves while we're learning.

Today, I will pay attention to what I want and need. I will not discount myself.

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So many of us have been brainwashed to think that we can't have what we want in life. That is the belief of the martyr. It is born of deprivation and fear.

Identifying what we want and need, then writing it down, sets in motion a powerful chain of events. It indicates that we are taking responsibility for our selves, giving God and the Universe permission to supply our wants and needs.

The belief that we deserve to have a change in character, a relationship, a new dimension to an existing relationship, a possession, a certain level of health, living, loving, or success, is a powerful force in bringing that desire to pass. Often, when we realize that we want something, that feeling is God preparing us to receive it.

Listen. Trust. Empower the good in your life by paying attention to what you want and need. Write it down. Affirm it mentally. Pray about it. Then, let it go. Give it to God and see what happens. The results may be better than you think.

Today, I will pay attention to what I want and need. I will take time to write it down, then I will let it go. I will begin to believe I deserve the best.

Women Healing Together
Setting Boundaries
April 17, 2001

When we own our power to take care of ourselves - set a boundary, say "no," change an old pattern - we may get flack from some people. That's okay. We don't have to let their reactions control us, stop us, or influence our decision to take care of ourselves.

We don't have to control ***their*** reactions to our process of self-care. Their reaction is not our responsibility. We don't have to expect them to not react either.

People will react when we do things differently or take assertive action to nurture ourselves, particularly if our decision in some way affects them. Let them have their feelings. Let them have their reactions. But continue on your course anyway.

If people are used to us behaving in a certain way, they'll attempt to convince us to stay that way to avoid changing the system. If people are used to us saying "yes" all the time, they may start mumbling and murmuring when we say "no." If people are used to us taking care of their responsibilities, feelings, and problems, they may give us some flack when we stop doing that. That's normal. We can learn to live with a little flack in the name of healthy self-care. Not abuse, mind you. Flack.

If people are used to controlling us through guilt, bullying, badgering, and emotional blackmail, they may intensify their efforts when we change and refuse to be controlled. That's okay. That's flack too. We don't have to let flack pull us back into old ways if we've decided we want and need to change. We don't have to react to flack or give it much attention. It doesn't deserve attention. It will die down.

Today, I will learn to disregard any flack I receive for changing my behaviors or making other efforts to be true to myself and to take care of myself.

Activity:

1. Is somebody in your life using you, or not treating you appropriately or respectfully now?
   Are you complaining, angry, whining, or upset about something?
   What's preventing you from taking care of yourself? What do you think will happen if you do?
   What do you think will happen if you don't?

2. In the past, what have you been willing to lose for the sake of a particular relationship?
   What are you willing to lose now? What are you willing not to lose?

3. What are the most difficult kinds of boundaries for you to set and enforce?

- Adapted from "The Language of Letting Go" and "Beyond Codependency" by Melody Beattie

Women Healing Together
April 24, 2001
Boundaries / Meeting our Wants & Needs / Self-Esteem

Do you have a hard time standing up for yourself?
Do you keep agreeing to do things that you really don't want to do?
Do you tolerate rude comments or pushy people because you can't handle conflict?
Do you take things personally?

Boundaries tell us where you end and where I begin.
We need boundaries to protect ourselves and to take care of ourselves.
Boundaries can be internal and external.
Boundaries can be physical, sexual, emotional, and intellectual.

External boundaries are needed protect our bodies; this includes setting physical & sexual limits.
Internal boundaries are needed to protect our thoughts and feelings.

How were our boundaries violated when we were children?
Did anyone here grow up with healthy boundaries where you were taught to set limits on what you would accept or allow to be done to you?
How do we allow others to violate our boundaries now?
What keeps us from setting appropriate boundaries now?

There are four kinds of impairments in boundaries:

87. No boundaries at all
88. Damaged boundaries
89. A wall instead of a boundary; can be a wall of anger, fear, silence, or words
90. Movement back and forth between a wall and no boundaries at all

Examples:
- when we have trouble saying no
- letting others take advantage of us in some way
- not standing up for ourselves when we are abused
- property violations, lending or borrowing personal possessions without setting a limit
- allowing ourselves be pressured when we want or don't want to do something
- letting others touch us inappropriately, or take liberties with us
- when we always respond to other people's demands without *ever* checking in with ourselves

Healthy boundaries:

- need to be firm but flexible
- leave us with self-respect and respect for others
- allow us to balance vulnerability and self-protection in a healthy way

A healthy boundary means we know how to

- set limits
- say no
- take care of ourselves

<u>Healthy responses to maintain our boundaries:</u>

"I'll think about it and let you know tomorrow." - one of the most useful lines of defense.

Realize that always being nice or always appeasing other people means that you are not being respectful to yourself or to others.

You do have the right not to answer the telephone or the knock on the door.

You have a right to your own privacy in your house, in your bedroom, in the bathroom; have a boundary around your own house and your yard, exercise the right not to be intruded on.

You have a right to your own time, to do with your time what you want.

Learning About Boundaries

Boundaries are the lines and limits we establish to mark our personal territory - our SELVES. Our boundaries define and contain that territory: our bodies, minds, emotions, spirit, possessions, and rights.

Many of us have developed a high tolerance for pain, for abuse, for mistreatment, for craziness and for boundary violations of all kinds. Sometimes it's difficult to discern when someone is hurting us, when we're hurting them, or even when we are hurting ourselves. Sometimes we have to hurt long and hard before we even notice that we're hurting. And many of us don't have a frame of reference for what is normal and appropriate.

Shame is connected to our boundary issues. We may feel ashamed when we allow people to invade or trespass on our boundaries. Shame can block us from setting the boundaries we need to set.

Having a Boundary Issue means we have a difficulty defining where another person ends and where I begin. We do not have a clear sense of ourselves and our boundaries are blurred. People with weak boundaries seem to pick up or absorb other people's feelings, almost like a sponge absorbing water.

Healthy Boundaries

Having boundaries doesn't complicate life; boundaries simplify life. We need to know how far we'll go and how far we'll allow others to go with us. Once we understand this, we can go anywhere.

Setting reasonable, healthy limits in all our relationships is a prerequisite to love and relationships that work for us. Boundaries are the key to loving relationships. We can learn to make appropriate choices concerning what we are willing to give in our relationships - give of ourselves, our time, our talents, our knowledge, and our money. When we have a solid sense of ourselves we will be able to experience closeness and intimacy.

Developing healthy boundaries means that we learn to respect ourselves and others. We don't use or abuse others or allow them to use or abuse us. We stop abusing ourselves. We don't control others or let them control us. We stop taking responsibility for other people and stop letting them take responsibility for us. We take responsibility for ourselves. If we're rigid, we loosen up a bit. We develop a clear sense of our self and our rights. We learn we have a complete self. We do that by learning to listen to and trust ourselves. What hurts? What feels good? What's ours and what isn't? And what are we willing to lose?

Developing healthy boundaries gives us back our self-esteem. We learn to recognize the difference between appropriate and inappropriate treatment. We come to believe that we deserve to be treated well and with respect by other people, including by our children. We don't allow others to use us, talk down to us, or talk ugly to us. We don't have to do everything people ask to tell us to do. We don't have to be touched when we don't want to be touched, or be touched in certain ways we don't like. We can say "no" and "stop that." We don't have to let people use us. We can make our own decisions about what we want and need to do in particular situations. We can stand up for ourselves.

Setting boundaries does not mean that we build thick walls around ourselves to keep others out.

Unhealthy boundaries developed for many reasons:

- when healthy boundaries aren't role modeled or taught to children
- when children's boundaries and rights are invaded or violated
- when children are forced into improper roles with others
- when children are emotionally or physically neglected or abandoned
- when children are sexually abused
- when children aren't nurtured
- when children grow up without appropriate discipline and limits
- when children are forced into caretaking a parent

Setting Boundaries

When we identify the need to set a limit without another person, we do it clearly, without angry words and without argument. We avoid apologizing, rationalizing, justifying, or over-explaining. We offer a brief explanation if it makes sense to do that.

We will probably feel ashamed or afraid when we set boundaries. Do it anyway.

People don't respect people that allow themselves to be used. People take advantage of people they can use and they respect people they can't use.

We cannot simultaneously set a boundary or a limit and take care of another person's feelings.

If you are in a **lot of anger, rage, or complaining and whining** - these are clues that you need to set boundaries. The things we say we can't stand, don't like, feel angry about, and hate - may be areas screaming for boundaries. Recovery means that we learn to listen closely to ourselves to hear what we're saying. These things are like flashing red alarms that indicate there's a problem. But shame and fear may be the barriers we need to break through to take care of ourselves.

Other clues that we need to set boundaries are feeling threatened, suffocated, or victimized by someone. We need to pay attention to what our bodies and our feelings are telling us. We may need to get really angry to start setting a boundary, but then we need to set that boundary without anger; we need to be calm and firm and definite about it.

We will be tested when we set boundaries. Plan on that happening. It makes no sense to set a boundary unless we are ready and willing to enforce it. The key to setting boundaries isn't to convince other people we have limits - it's convincing ourselves.

Boundaries are to take care of ourselves, not to control others. If we set a boundary not to be around a practising alcoholic, it isn't to force him or her to stop drinking. They can choose to drink or not. Our boundary gives us a guideline to make our choice - whether we want to be around the alcoholic, or drug abuser.

Boundary setting can also be fun. Besides learning to identify what hurts and what we don't like, we learn to identify what we like, what feels good, what we want and what brings us pleasure, satisfaction, and even joy. This can be an exciting discovery where we learn who we really are. That's when we begin to enhance the quality of our lives.

SETTING PERSONAL BOUNDARIES (Taken from the Oprah Show)

Step One: Self-Awareness
Step Two: Setting Your Boundaries
Step Three: Strengthen Your Internal Boundaries

The first step in learning to set boundaries is self-awareness. For example, pay close attention to the situations where you lose energy, feel a knot in your stomach, or want to cry. Identifying where you need more space, self-respect, energy, or personal power is the first step.

Another way to identify your boundaries is by completing these three sentences with at least 10 examples.

1. People may not __________.

   Examples

   Go though my personal belongings
   Criticize me
   Make comments about my weight
   Take their anger out on me
   Humiliate me in front of others
   Tell off-color jokes in my company
   Invade my personal space

2. I have a right to ask for __________.

   Examples

   Privacy
   A new hairstyle from an old stylist
   Peace and quiet while getting a massage
   Help around the house
   More information before making a purchase
   Quiet time to myself

3. To protect my time and energy, it's OK to _______________.

   Examples

   Turn the ringer off on the phone
   Take my time returning calls or e-mails
   Change my mind
   Bow out of a volunteer activity
   Cancel a commitment when I'm not feeling well
   Reserve a place in my home that is
   off-limits to others

Step Two - Setting Your Boundaries

Start setting simple but firm boundaries with a graceful or neutral tone. This will feel uncomfortable at first but, as you take care of yourself, the personal power you gain will make it easier.

1. Be sure to have support in place before and after each conversation

2. Vent any strong emotions with your partner before having your boundary conversation.

3. Use simple, direct language. Here are some examples:

To set a boundary with an angry person:
"You may not yell at me. If you continue, I'll have to leave the room."

To set a boundary with personal phone calls at work:
"I've decided to take all personal calls in the evening in order to get my work done. I will need to call you later."

To say no to extra commitments:
"Although this organization is important to me, I need to decline your request for volunteer help in order to honor my family's needs."

To set a boundary with someone who is critical:
"It's not okay with me that you comment on my weight. I'd like to ask you to stop."

To buy yourself time when making tough decisions:
"I'll have to sleep on it, I have a policy of not making decisions right away."
"I want you to know that I won't be making a decision today. I'd like to gather information"

To set a boundary with a hair stylist:
"I love what you've done with my hair, but I'm ready for a change. I'd like to talk about a new hairstyle."

To back out of a commitment:
"I know I agreed to head up our fund raising efforts, but after reviewing my schedule, I now realize that I won't be able to give it my best attention. I'll need to bow out. I'd like to help find a replacement by the end of next week.

To set a boundary with an adult child who borrows money:
"I won't be lending you money anymore. I love you and you need to take responsibility for yourself."

4. When setting boundaries, there is no need to defend, debate or over-explain your feelings. Be firm, gracious and direct. When faced with resistance, repeat your statement or request.

5.Back up your boundary with action. Stay strong. If you give in, you invite people to ignore your needs.

Step Three: Strengthen Your Internal Boundaries

One of the reasons that women take things personally is because they have weak "internal boundaries." An internal boundary is like an invisible shield that prevents you from taking in a comment without checking it out first. For example, when someone accuses you of being arrogant, you stop and consider the statement ***before*** taking it in.

When you use this internal shield (especially with difficult people like an ex-spouse or critical parent) it gives you time to ask yourself the following three questions:

How much of this is true about me?
How much of this is about the other person?
What do I need to do (if anything) to regain my personal power or stand up for myself?

This last question is very important. Too often women neglect to stand up for themselves by avoiding confrontation and end up weakening their internal shield, making it harder to set boundaries at all. So, if someone offends you, it may be necessary to let them know in order to protect and strengthen your internal boundaries.

Women Healing Together
May 1, 2001
RELATIONSHIPS

If we are unhappy without a relationship, we'll probably be unhappy with one as well. A relationship doesn't begin our life; a relationship doesn't become our life. A relationship is a continuation of life.

There is a gift for us in each relationship that comes our way. Sometimes the gift is a behavior we're learning to acquire; it may be detachment, self-esteem, becoming confident enough to set a boundary, or owning our power in another way.

Some relationships trigger healing in us - healing from issues of the past or an issue we're facing today. Sometimes we find ourselves learning the most important lessons from the people we least expect to help us. Relationships may teach us about loving ourselves or someone else. Or maybe we'll learn to let others love us.

Recovery is not done apart from our relationships. Recovery is done by learning to own **our** power and to take care of ourselves in relationships.

Sometimes we aren't certain what lesson we're learning, especially while we are in the middle of the process. But we can trust that the lesson and the gift are there. We don't have to control this process. We'll understand when it's time. We can also trust that the gift is precisely what we need.

Today, I will be grateful for all my relationships. I will open myself to the lesson and the gift from each person in my life. I will trust that I, too, am a gift in other people's lives.

When we fail to object to what we feel is another's disdainful or abusive treatment of us, then we sanction that person's right to mistreat us and that sanction is likely to harm us even more than the mistreatment itself. What we permit, we promote. Many people choose never to complain because they mistakenly believe that anyone who objects to behavior is a troublemaker or a selfish person. So they would rather suffer almost any abuse than risk standing up for themselves. Others withhold their complaints out of fear that they will not be loved and that they are worthwhile to the other person only on the condition that they act compliantly and agreeably.

If a close friend or acquaintance belittles you by the way she or he talks to you, it becomes your responsibility to tell him or her precisely how s/he is doing so, and to give the person the opportunity to show good faith by being receptive to your complaint. When you want to preserve a relationship, being able to object fairly, in a kind or caring way, to behavior which you feel is damaging to you becomes a necessity.

Each of us must discover the actions, behaviors, or activities that intensify and promote our self-respect. We must learn to act in those ways that produce love of ourselves and love of other people if that is what we want to feel.

There is a tremendous advantage in rehearsing precisely what we want to say or do if a given situation arises again. If we don't like the way we handle ourselves in a relationship, we can ask ourselves what would we like to have said or done and what we would say or do if the same situation came up again.

HOW TO MAKE A COMPLAINT

From "The Action Approach" or "Self-Creation" by Dr. George Weinberg.

1. **Complain to the person you think is harming you, and not to anyone else.**

2. **Try not to object to your spouse's or friend's behavior in front of others.** To most people, being criticized feels like being personally attacked because criticism is so often used as a vehicle for personal assault. In fairness to your spouse, friend or acquaintance, wait until you are alone with that person, unless waiting would be costly for some special reason.

3. **Don't compare the person's behavior with that of other people.** No one wants to be described as inferior to anyone else. Comparisons will nearly always predispose other people not to listen to what you say, even when the complaint is justified.

4. **Make your complaint as soon as you can; that is, as soon as you're alone with the other person and can articulate it.** Speaking up, like any task, becomes more difficult when you postpone it. Waiting allows your anger or resentment to build and increases the likelihood that you'll make irrelevant comments. If you criticize someone for what he or she did long ago, you will look like a brooder. The impression will be accurate, and the other person will feel less comfortable with you afterward.

5. **Don't repeat a point once you've made it and the other person has carefully considered it. This means, don't expect a signed confession after you've spoken.** The reward for patiently listening to a criticism or complaint ought to be exoneration from having to hear the same crime discussed again. A person's action against you either warrants ending the relationship with him or her, or it doesn't. If it doesn't, be a sport and quit rehashing the other's violations of your relationship.

6. **Object only to actions that the other person can change.** Your comments will be constructive only if they pertain to behavior the other person can change. You may ask a person not to shout, but if you ask him not to be angry with you, you're probably asking too much.

7. **Make your complaints vocally, not facially.** Facial expression of all kinds are outward complements of the spirit. Our expressions may be rich and various, but they cease to be when we use them as devices to convey messages we are reluctant to put into words, when we use them to manipulate others into behaving differently with us so that we can get what we want from them without being forthright about it. Facial expressions sometimes succeed in getting people to do what they don't want to do, but we don't look forward to meeting the people who bully us by sighing or acting disappointed with us.

8. **Try to make only one complaint at a time.** If you make more, you'll demoralize the other person and perhaps obscure your major point.

9. **Rehearse your presentation of your complaint if you need to.**

10. **Don't preface your complaint.** *"Listen. There's something I've wanted to tell you for a long time. It may hurt you badly, but please don't feel offended by what I'm going to say....." OR: "I want to tell you something, and it's for your own good. Now listen carefully to what I'm going to say...."*
What could be worse than a preface like these? Instead of inoculating your listener against the pain of what you are going to tell him, you are stabbing him to death with your hypodermic needle. By using prefaces, you convince both the person and yourself that he or she won't be capable of receiving it with the same friendly spirit that you feel while making it. There are perhaps as many people killed by such prefaces as by complaints.

11. **Don't apologize for your complaint after you make it.** Telling the person you're sorry you had to disagree with him or her is apologizing for what you said in good faith. Apologizing is asking the other person to brace you so that you won't fall down under the stress of disagreeing with him/her. Doing so imposes an unnecessary burden on him/her; it will detract from the merit of your accomplishment in making the complaint, in your own mind, and it will renew your conflict about whether you had the right to say what you did.

12. **Avoid sarcasm.** Among the invariable motivations for using sarcasm are contempt and fear. Your contempt will predispose the other person not to listen. Being sarcastic is snivelling, no matter how clever your turn of phrase. Sarcastic people have no dignity; they are cowards.

13. **Don't ask people *why* they are doing something to which you object. Ask them to stop, if that is the underlying wish or request you want to express.** "Why are you interrupting me?" "Why are you putting your feet on my chair?" It's obvious that the speaker wants the other person to stop an activity. Probably, s/he doesn't feel strong enough to make the request openly and directly, so s/he disguises it as a scientific inquiry. It would be easier for the other person to stop what he was doing than to search for his motivation and report it accurately to you. Many people regard serious questions about their motivations as obnoxious invasions of their privacy.

14. **Don't talk about other people's motivations when objecting to their behavior.** Tell them simply what they are doing; and if it is relevant, why you feel they ought not to do it. Examples of statements that are objectionable because they include irrelevant speculations about the motives of the offender:
"You never <u>want</u> me to finish what I'm saying." [How do you know what they want?]
"You <u>don't care</u> how long I wait for you." [How do you know the person doesn't care?]
"Quit <u>trying</u> to make me angry." [Are you sure the person was trying to make you angry?]

If you stop playing psychoanalyst with people and just tell them how they're offending without giving them diagnoses, they'll become much more receptive to what you say. Statements like these are irritating invasions of the listener's privacy. Hardly a person alive doesn't feel the difference between, "*Please don't interrupt me*," and "*You never want me to finish what I'm saying.*" Also, look out for the tendency to confuse the consequences of an action and its intention. The fact that someone is stepping on your foot doesn't automatically imply that his intention was to hurt you. It may or may not be.

15. **Avoid words like "always" and "never" because they contain implicit references to the past.**
Exaggerations intended for emphasis when making an objection or complaint rob you of accuracy, and of all the psychological advantages that go with it.

16. **If you never compliment the other person, don't expect him or her to remain open to your criticisms or complaints.**
There was supposedly a little girl who didn't talk till she was eight. Doctors, social workers, and psychiatrists were all consulted but couldn't figure out why. Then one day at breakfast she cried out, "This oatmeal is lumpy." When asked why she had never spoken before, she answered that up till then everything had been all right.

    Don't be this little girl. Complaints ring loud and long when they're the only sounds that are ever made. If you want to make occasional objections, you have the obligation to compliment or praise the person at other times for specific things that you like. And I recommend the practice of thanking people for listening to your criticisms.

Women Healing Together
May 8, 2001
HEALING AND CHANGING

As many of us have already experienced, we begin our journey of recovery with a lot of hurt, pain, sadness, shame, and anger. We blame everyone else for our unhappiness and our misery. Things happened to us a long time ago and they happened more than once. They hurt us deeply. And we protected ourselves the only way we knew how. But as we get deeper into recovery, as we confront ourselves, we find these feelings and beliefs and attitudes changing. Healing and recovery are often painful. Recovery means moving from shame and blame and anger to self-respect and healthy self-love when we begin to take care of ourselves, when we take responsibility for meeting our own wants and needs and making important changes in our lives. As we heal, we begin to remove our veils of denial and to learn new ways of living and feeling and sharing and being. We learn to be functional.

Healing means change and change involves struggle and a new kind of pain: ***growing pain***. Change can be a change in behavior, a change in feeling, a change in self-awareness, a change in knowledge, or a change in attitude. Healing takes place when we can think better, live better, and feel better about ourselves. But all healing comes with a price attached and that price is effort, work and always some discomfort or pain. Healing is taking place when we learn to solve our problems by changing our behaviors, our attitudes, and our thinking. Healing means we have learned to become better at the *process* of problem solving, at *how* we go about it. Healing has occurred when we attain clarity about ourselves and our lives and we no longer blindly repeat the past, by repeating the same old behavior patterns. If we can now make conscious and different choices about how we want to live and behave, if we can decide what kinds of relationships we want and decide on what terms, then we have begun to heal and become more functional. Healing means we have faced and resolved our old burdens of hurt, pain, and shame. We are healed when we start to relate more authentically and with fuller awareness of ourselves and others. With healing comes a sense of acceptance - acceptance of self and others; it also comes with the realization that we only have the power to change ourselves, not others. Healing is an ongoing journey in which we learn to live our lives with greater self-awareness. Healing means that we will always be a work-in-progress.

Shame and Guilt

Guilt

Guilt is the realization that you have done something wrong or have harmed someone. With guilt, if you have done something wrong, you can repair it or make amends or make a commitment never to do that again. Guilt is good for you if it lasts no longer than five minutes and brings a change in behavior. It really is mentally healthy to experience guilt over harmful actions. Guilt, if briefly sustained, can make people think more clearly about how to behave next time. Guilt is a healthy warning system that tells us we have transgressed a value and we need to get back to living up to our values or standards.

But it is pointless to feel guilty over the workings of one's own mind. If people learn to understand the workings of their mind, they are better able to behave in a manner that works for them in the long run. But this does require an examination of your own values, standards, and attitudes, as well as those of others around you. Perfectionism and never making a mistake are not healthy standards to try to live up to.

Shame is the feeling or the sense that you are fundamentally bad, flawed, evil, defective, or inadequate; there's something really wrong with you. Shame is among the most destructive and devastating of human emotions. Because of its painfulness and its terrible impact on self-worth, shame inclines one toward suppression, walls and denial. Denial causes dehumanization, a loss of the capacity for empathy for one's partner or for others, and can manifest itself in a variety of insidious ways. Shame invites masochism: "I deserve to suffer" or sadism: "I must make you (the other) helpless out of fear of your power over me. I cannot feel safe unless you (the other) are helpless." It is the basis for scape-goating, prejudice and projection. It invites others to abuse you and prevents you from setting appropriate boundaries.

Shame also shuts out other people. It builds barriers in relationships. "How can I let you know me if I am full of shame? I am unworthy." It elicits self-hate, more shame, and humiliation. In creating distance, it prevents intimacy, leading to isolation, loneliness, and depression, along with hatred and distrust of others. It elicits envy and jealousy of others seeming well being. It cannot allow love or pleasure. Being ashamed, we cannot trust others' positive efforts and don't feel deserving. Shame must reject overtures of caring from others. At the extreme, it becomes paranoia.

Confiding is the ability to allow ourselves to be known, is largely dependent upon feeling "good enough and lovable" in order to trust another with our truths and our vulnerabilities. The ability to confide is essential to and dwells at the heart of bonding and intimacy. Shame sabotages this ability.

To believe we are good enough despite our mistakes is essential to confiding, to acknowledging our own humanness. It is essential to self-worth and to the ability to appreciate the worth and humanness of others. Shame precludes love, pleasure, closeness and intimacy. Along with creating walls, it can also create monsters. "I am not lovable, I am not good enough" often becomes the invisible script for addiction, depravity, scapegoating, persecution, failure and abuse.

It is important as an adult to own responsibility for one's behavior, to be able to acknowledge mistakes, to accept criticism or complaints, to be willing to make atonement, to express genuine regret or remorse in order to be free to take in love and pleasure.

Healing the Shame we Carry

In our culture, shame is something we are not supposed to talk about. It is just too shameful! Because of this, many of us are out of touch with the experiences of shame we carry around inside us. It is too painful to look at. Shame is extremely powerful, more powerful than anger in the effects it has on us. But it is also hard to heal and recover when the one thing we need to talk about is not supposed to be looked at or discussed. What we can't feel, we can't heal. We start to recover when we can reveal our shame, feel it, face it, acknowledge it, talk all about it, and share our experiences with others who care. We heal when we stop disowning our painful feelings, especially shame.

When we begin to feel our shame and look at it with new knowledge and understanding, then it begins to lose its power over us - because secrecy is what keeps shame locked up inside ourselves. Letting go of secrecy about our shame, putting it out there for caring others to see, is very scary and threatening, but it ultimately sets us free again. When shameful thoughts and feelings can be verbally expressed and exposed to the light of day, our anxiety and pain begin to diminish and we begin to feel better. Once we begin to feel better we can think about our problems and difficulties with more intelligence and clarity. And we begin to reclaim our lives from the shackles and restrictions that shame and secrecy have impose on us, on our lives and our relationships. We begin to heal.

Women Healing Together
May 15, 2001
HEALING & UNFINISHED BUSINESS

When you don't deal with your pain, it waits for you.

Unfinished business refers to your unresolved life experiences from the past or the present, to some problem or difficulty that is not being addressed; whatever issue remains unresolved will continue to distort your responses in the present. Unfinished business is a blockage of your maturational and recovery process. If some of your unfinished business relates to the more distant past, you need to be prepared to experience the pains and hurts and neglects of your childhood. Only when you are prepared to feel the pain and when you can give comfort and understanding to the child within for what she never had, for the things that were done to her that were not her fault, only then can you complete the unfinished business of your past and move into a freer, unencumbered adulthood. This may require a period of mourning, of allowing yourself to feel the pain you never acknowledged before, a time of talking in fantasy to the child within. This will lead eventually to the point when you can finally lay the past to rest - really lay it to rest. To grow up is to assume responsibility for parenting the child within.

> *One has to return again and again to weep the tears which are still unshed. We cannot feel all the grief of our many losses at the time we suffered them. That would be too crippling. But if we would really gather our whole lives into a single whole, no emotion that belongs to us should be left unfelt.*

As children and even as adults we struggle to escape from our painful feelings. Often, the legitimate fear, shame, anger and rage we would normally feel are so painfully intolerable that we do not allow them to be experienced and expressed; it's just too dangerous and threatening - because of what might happen if we did. Instead, these feelings go underground and are expressed in other ways. Sometimes these emotions become frozen into the body and barricaded behind walls of muscular and physiological tension. Sometimes we choose depression. We remain prisoners of that which we do not confront. Why do we work so hard to deny our emotions, especially concerning other people? We deny our feelings of frustration, anger, or fear toward our friends or children; we may deny a whole range of feelings toward our spouse or our parents. We talk ourselves out of our feelings sometimes, saying that it doesn't really matter when it *does* matter. We say "I don't get angry. I'm a Christian, so I forgive and forget." So we run away from our emotions because we don't know what else to do with them. But if we own and accept these feelings and stay with them, often that is all that is needed to make them go away. And sometimes our emotions are giving us a message that says we need to take action, to change something in our lives. We need to deal with unfinished business in the present. Unfinished business also refers to current difficulties and problems that we are afraid to face and deal with. Making needed changes in ourselves and in our relationships is a difficult and scary business. It is here that we confront ourselves, who we really are, and what we are up against inside and outside ourselves.

If you listen to your emotions, what do they tell you? Your emotions orient you to what is important in your life. So pay attention. Your emotions focus your attention on what your needs and goals are. If you do not pay attention to what you are feeling you cannot organize your life or deal with your problems with yourself or with others. ***Our emotions are like an internal compass; they tell us what matters to us.*** Without that compass it is very difficult to become powerfully self-directive in our lives.[3] If we are being abused or mistreated by a parent or by a spouse or our children or our friends, our emotions tell us that we need to do something, to take some kind of action to change things. Our hurt tells us that we need to find ways to defend and assert ourselves. Our anger tells us the same thing: that we need to do something to take of ourselves. Our feelings of helplessness may tells us that we are morally superior to others, or that this is how we control others around us to get them to do things for us that we are unwilling to do for ourselves; it may be how we emotionally blackmail others or how we let others blackmail us, or how we keep ourselves from taking financial responsibility for ourselves. Our painful emotions may tell us that we are playing a victim or martyr role. Emotions have a world of meaning behind them; they give us information about who we are, if we pay attention. Confronting the truth about yourself is always painful at first, but then it liberates you because with knowledge and insight you acquire the possibility of taking action.

It is important to acknowledge that you have negative feelings and to allow yourself to experience them. Acknowledging to yourself that you are someone who envies others, who is fearful and hostile, who is capable of hatred and rage, of jealousy and vindictiveness, is central to mature self-responsibility. So, too, is acknowledging that those feelings will exist in the people you love or care about and that part of loving them is accepting the reality of those "imperfections." What matters in terms of your self and other relationships is not that you are capable of both positive and negative emotions, but that you do not hide from knowing this about yourself. [2] You do not have to act on each and every feeling; you only need to find appropriate ways of reacting to them or dealing with them.

Our emotions tell us where our battle lies. Passivity, doing nothing, keeps us safe in our misery; it keeps us stuck, and it keeps us from taking responsibility for our lives. Recovery is hard work; it is emotionally painful work. Every form of healing has a help/hurt ratio - healing gives something to the person and it extracts a cost; no form of therapy or healing is entirely without pain or negative consequences.[4]

Anxiety is inherent in growth and healing. Growth requires your ability to tolerate anxiety, discomfort, and pain as you make changes to yourself and your life. But one of the forms of psychological heroism is the willingness to live through anxiety, uncertainty, and ambivalence while going through personal growth and development.[1] Be a hero in your own life. The rewards are enormous.

Today I will listen to myself as I go through my day. I will not judge myself for what I am feeling; I will accept all my feelings; I will accept myself.

1. Branden, Nathaniel, 1989. *Honoring the Self: The Psychology of Confidence and Respect*, New York: Bantam Books

2. Dowrick, Stephanie, 1995. *Intimacy and Solitude: Balancing Closeness and Independence*, New York: W.W. Norton & Co.

3. Johnson, Susan & Schwartz, Richard, 2000 AAMFT Annual Conference. *Beyond Touchy Feely: Emotion and Change in Couples Therapy.*

4. Langs, Robert, 1993. *Empowered Psychotherapy: Teaching Self Processing, A New approach to the Human Psyche and Its Reintegration*, London: Karnac Books.

Women Healing Together
May 22, 2001
HEALING & RESCUING OURSELVES

No one is waiting.

No one likes a martyr. How do we feel around martyrs? Guilty, angry, trapped, negative, and anxious to get away.

Somehow, many of us have developed the belief that depriving ourselves, not taking care of ourselves, being a victim, and suffering needlessly will get us what we want.

It is our job to notice our abilities, our strengths, and take care of ourselves by developing and acting on them. It is our job to notice our pain and weariness and appropriately take care of ourselves. It is our job to notice our deprivations, too, and begin to take steps to give ourselves abundance. It begins inside of us, by changing what we believe we deserve, by giving up our deprivation and treating ourselves the way we deserve to be treated.

Life is hard, but we don't have to make it more difficult by neglecting ourselves. There is no glory in suffering, in only suffering. Our pain will not stop when a rescuer comes along, but only when we take responsibility for ourselves and stop our own pain.

Today I will be my own rescuer. I will stop waiting for someone else to work through my issues and solve my problems for me.

- Melody Beattie, *The Language of Letting Go.*

SELF-ACCEPTANCE

Life Lesson: *You cannot change what you do not acknowledge.*

Practicing self-acceptance means being willing to own, experience, and take responsibility for our thoughts, feelings, and actions, and to do so without evasion, denial, or disowning; self-acceptance does not mean that you allow yourself to collapse into self-hatred and self-repudiation. It means giving yourself permission to think your thoughts, experience your emotions, and look at your actions without necessarily liking, endorsing, or condoning them. Self-acceptance means accepting yourself as you are at the moment and acknowledging this is how your life really is.

However, we often allow our fears to paralyze us and stop us from taking action; there are many fears that will do this:

- Fear of facing truths about ourselves (our thoughts, feelings, or actions) truths that we deny or disown in order to protect our self-image.
- Fear of facing truths about another person that, if acknowledged, would put pressure on us to rock the boat of the relationship or even destroy it.
- Fear of not knowing how to deal with the realities we are acknowledging.
- Fear of being overwhelmed by our inner world, fear that once we open up the door to it, we may lose our mind or the ability to cope with what comes out.
- Fear of losing face in the eyes of significant others if certain truths about ourselves are exposed, so we dread to expose them even to ourselves.
- Fear that our thinking will not prove to be correct; fear that we might make an error, fear that we will realize how fallible we are.
- Fear that if we act on our judgment and are wrong, it will be our fault; there will be no one to blame but ourselves, and others may hold us accountable.

What you will discover if you find the courage to face your fears and accept the truth about yourself or your life is that rather than becoming permanently stuck with the "awful truth," just the opposite is true: self-acceptance is the foundation of growth and change. To accept whatever you are, that you are weak or unassertive for example, does not mean that you will end up staying that way forever; but unless you recognize these things and acknowledge them in yourself, you cannot change them. To accept yourself as you are now does not prevent the possibility of change; on the contrary, self-acceptance is the precondition of change.

Knowledge of what is possible is the beginning of happiness. —George Santayana

Do you want to be positive or negative? Do you want to be a self-starter or wait around for others to push you into action? Do you want to advance in life with your face eagerly turned to the wind, or trudge forward grimly gazing at the ground?

Ask yourself the following question, "How seriously do I want to pursue growth and positive change in my life?" The difference between longing for a better self or a better life and committing to self-improvement is the difference between daydreaming and action. Many people say they want to be better, lead better lives, develop better relationships. But most remain stuck on life's shore, seldom if ever moving to the midstream where they can move forward. This is largely because their longing is not tied to specific methods of action. their dreams remain unfulfilled. Their lives trudge along in the soft sands of passivity.

It's one thing to "intellectualize" a commitment to a goal and a mode of action. It's quite another to grapple for and grab the actual, relevant skills. It requires an act of choice, but it also demands awareness and acceptance of the inevitability of both failure and frustration. It calls for resiliency and determination. ***It requires a basic decision to persist in spite of dark and daunting odds.*** Sustained and sometimes intense pressure from family members or society often blocks the way. Above all, it demands a steadfastness to persist in the face of your own internal problems, including confusion, isolation, self-doubts, feeling overwhelmed, or procrastination.

The Holy trinity of psychological health and well-being is:

- self-awareness = knowing
- self-responsibility = choosing
- self-assertiveness = acting & doing

Self-awareness means learning to know what you feel, think, need, and want. When you become aware of these things, when you can admit them and name them and claim them, then you open up the possibility for choice and action. Then you open up the possibility for a new way of being and living. It takes enormous courage to admit that your life has partaken of error and self-deception. However, it is not just the truth that will make you free and strong, it is *going through the process of finding that truth in yourself,* as you struggle with yourself, as you pursue your growth and development.

No one is waiting to rescue you. It's up to you.

Adapted from:
website: www.objectiveamerican.com - by E.G. Ross
The Art of Living Consciously, Nathaniel Branden
The Disowned Self, Nathaniel Branden

APPENDIX B

IMAGERY AND MEETING YOUR INNER CHILD

Sit in an upright position. Feet firmly on the floor. Close your eyes. Relax and focus on your breathing. Be aware of the air as you breathe it in and as you breathe it out. Trusting that each new breath will be there for you. Notice the difference in the air as it comes in and as it goes out. Focus on the difference.

I want you now to imagine a beautiful summer day. You are standing in an open field or a meadow. A gentle breeze is blowing and you feel the warm sunshine on your face. Notice the colours and sounds around you. As you look across the meadow you see a house. It is a warm and inviting place and you go there. Notice the room, the colour of the house and the windows and doors. You feel welcome as you go through the front door and enter a sunlit room. The room is warm and safe. You see a comfortable chair and go and sit in it. Relax. Be at peace. Look up at the door and you see a child. The child is you. How old is the child? How do you look? How is the child dressed? The child comes into the room. Invite the child over. Tell the child that you know better than anyone else what she has been through. What happens? Do you speak? Does she speak? What happens? Spend time with whatever happens. (5 minutes)

It is nearly time for you to leave. Tell you child you want to come back and visit. It is OK. Tell your child you will return soon. Say your good-byes. Leave the house and return to the field or meadow. When you are ready, return to this room.

Exercise:

Without talking, take paper and crayons and draw your experience (10 minutes).

Or

Write/talk about your experience. What happened? What feelings did you have towards this child? (10 minutes)

APPENDIX C

Questionnaire

Which of the following factors do you feel helped you or played a part in your healing / recovery process, realizing that your healing and recovery may not be complete at this time.

1. Learning that "*I am not alone*" or "*I am not the only one with my type of problem; others are in the same boat as I am.*"

   1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

2. Optimism and hope that I can get through this difficult time in my life by participating in the group.

   1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

3. Finding a sense of belonging, togetherness, and acceptance in the group.

   1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

4. Being able to open up and express strong feelings and not worrying about how others will perceive me.

   1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

5. Revealing embarrassing things about myself and still being accepted by the group.

   1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

6. Belonging to a group of people who understand and accept me.

   1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

7. Learning that others have some of the same thoughts and feelings that I do.

   1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

8. Learning that others had parents and backgrounds as unhappy or messed up as mine.

   1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

9. Improving my skills in getting along or dealing with people.

   1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

10. Feeling more trustful of groups and of other people.

    1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

11. Being able to say what was bothering me instead of holding it in.

    1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

12. A facilitator suggesting or advising something for me to do or giving me definite suggestions about a relationship or life problem.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

13. Group members suggesting or advising something for me to do or giving me definite suggestions about a life or relationship problem.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

14. Learning how to express my feelings.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

15. Expressing negative or positive feelings toward another membr.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

16. Trying to be like someone in the group who was better adjusted than I was.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

17. Finding someone in the group whom I could pattern myself after.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

18. Seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

19. Being in the group somehow helped me to understand old hangups that I had in the past with my parents, brothers, sisters, or other people in my life.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

20. Being in the group was, in a sense, like being in a family, only this time a more accepting and understanding family.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

21. Learning that I have likes or dislikes for a person for reasons which may have little to do with the person and more to do with my hangups or experiences with people in my past.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

22. Learning that I react to some people or situations unrealistically, with feelings that somehow belong to earlier periods in my life.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

23. Learning that how I feel and behave today is related to my childhood and development.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

24. Seeing others getting better was inspiring to me or gave me hope.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

25. Knowing others had solved problems similar to mine.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

26. Seeing other group members were improving or had improved encouraged me.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

27. Recognizing that life is at times unfair and unjust.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

28. Learning that I must take ultimate responsibility for the way I live my life no matter how much support and guidance I get from others.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

29. Receiving information that helped me expand my knowledge and understand myself better.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

30. Being able to identify problematic themes and patterns in my relationships.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

31. Receiving written handouts with information about specific issues.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

32. Emotional support received from other group members.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

33. Emotional support received from one or both of the group facilitators.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

34. Learning ways to handle issues or settle differences.

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

35. Learning social skill techniques, such as how to set boundaries or limits .

1 = extremely helpful 2 = very helpful 3 = helpful 4 = somewhat helpful 5 = barely helpful

APPENDIX D

Detailed Results of the Scoring on the Therapeutic Factors Questionnaire

1=extremely helpful 2=very helpful 3=helpful 4=somewhat helpful 5=barely helpful

	MEMBERS DESIGNATED BY LETTER							
QUESTION NO.	A	B	C	D	E	F	G	H
1	2	2	1	-	2	3	2	1
2	3	3	2	3	2	2	2	2
3	4	1	1	4	2	3	3	2
4	2	3	1	5	1	4	4	3
5	3	2	1	5	2	4	3	3
6	2	2	1	4	2	3	3	3
7	2	2	2	3	3	2	2	2
8	2	2	3	3	-	1	1	2
9	2	2	3	4	3	3	2	3
10	3	2	1	5	3	4	3	3
11	2	3	2	3	2	3	4	3
12	2	1	1	5	1	5	3	4
13	2	2	1	3	1	3	4	5
14	2	1	2	3	2	3	3	2
15	3	2	2	3	4	3	5	4
16	-	4	4	4	5	5	5	5
17	-	2	3	1	2	5	3	5
18	4	3	3	3	2	3	3	2
19	2	2	1	1	4	3	2	3
20	3	2	1	3	3	3	2	2
21	2	2	1	3	3	-	5	3
22	2	2	1	3	5	-	4	2
23	2	2	1	1	4	-	3	2
24	-	2	1	1	2	3	2	3
25	2	2	2	3	2	-	1	3
26	-	3	1	3	2	3	2	3
27	2	4	1	3	4	3	2	3
28	1	2	1	4	2	-	2	2
29	1	2	1	3	3	4	2	1
30	2	2	2	3	3	-	3	2
31	2	1	1	1	2	2	3	1
32	3	2	1	4	3	3	3	3
33	3	1	1	2	1	1	1	2
34	3	1	2	4	3	2	2	1
35	3	1	1	3	2	3	2	1