# A FEMINIST PERSPECTIVE ON GROUP TREATMENT OF ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE

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by

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# A FEMINIST PERSPECTIVE ON GROUP TREATMENT OF ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE

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A Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

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To my parents and family. Your love and support I cherish more deeply each passing year.

# Abstract

This practicum reports on a time limited structured group program for women who were sexually abused as children. The program utilized a humanistic growth development model within a feministic perspective to provide treatment to this client population. The feminist perspective was chosen to provide the women with support and a paradigm to examine their life experiences. Within this report the long term consequences of sexual abuse are presented. The selection of group participants is explored. The objectives and rational for the group intervention are discussed. The therapeutic tools and measures used to evaluate the group members are examined. The results of the practicum illustrates the success of this short term treatment approach, with women who were sexually abused as children and highlights the benefits accrued by the women who participated in the group.

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# CHAPTER 1

## INTRODUCTION

During the past century, Western European Society has denied the pervasiveness of sexual abuse, specifically the rape and molestation of female children by their adult male caregivers. Sexual abuse relates directly to the power men have held in a patriarchal society that dismisses the needs and rights of children. Indeed, many past and current psychological theories blame women for their own sexual abuse.

In the late nineteenth century, Sigmund Freud postulated that female hysteria was the result of sexual abuse by male relatives. Prior to this, it was generally held that sexual abuse did not occur. The dichotomy of the widely held belief was that when sexual abuse did indeed occur, the male perpetrator was not responsible for his actions; rather the responsibility was shifted to his victim.

Freud changed his initial findings on the sexual abuse of women, due to male social standards of his time. At present, feminist theory concurs with Freuds' initial findings, nevertheless what is more important is that feminist theory focuses on the damage created when Freud recanted and chose to follow the social norms.

It was because of this change in attitude, that this project was undertaken to explore feminist social work practice within a group treatment program for women sexually abused as children. The objectives developed for this practicum were the implementation and evaluation of a group treatment program. These are to provide the student with valuable educational benefits.

The group treatment plan followed by the student was developed by the Womens' Post Treatment Centre. The student was given the opportunity by the Womens' Post Treatment Centre to plan and initiate new group exercise, within the agency's fourteen week program. The benefits to the student

were to provide the opportunity to develop and run a hospital based group treatment program. Such a program would be oriented towards women who had experienced childhood sexual abuse.

Implementation of the group treatment program increased the student's clinical skills in the area of group therapy. The student especially benefited from the staff's practice wisdom and expertise in running a group therapy program, as this was the student's first experience in co-leading a women's therapeutic group.

Evaluation of the group treatment program allowed the student to determine whether or not the treatment program would be effective and the desired results achieved. It also allowed the student to assess what changes might be needed to improve the program's viability in the future. It helped the student to determine whether or not current theories regarding the long term effects of childhood sexual abuse were substantiated by her practicum program. Most importantly, the review of the literature of the long-term consequences of childhood sexual abuse and the knowledge gained by exploring women's reality through the lens of the feminist perspective, provided the student with an expanded vision to use in her future practice.

Julie Brickman, (1984) a feminist psychologist, states that it is only within the feminist perspective that the pain and humiliation female children suffer at the hands of their male caregivers can be validated and healed. Therefore the student's approach to a group program for adult survivors of sexual abuse was to incorporate many of the basic feminist tenets of therapy for women within the group model so the female experience could be acknowledged and supported within the therapy process.

This chapter will look at the incidence of childhood sexual abuse, society's denial of childhood sexual abuse, and how the use of conventional psychological theory has placed the onus of blame on the victim.

The women's movement that has pushed for equal opportunities for women to pursue educational and career choices, has also brought to the public's attention issues of sexual violence in the work place, the street and in the home. If it were not for the feminist movement, the violence towards women might continue to be hidden.

Rape was the first type of sexual violence towards women that was publicly acknowledged. As rape was more openly discussed, women began to admit to sexual violence within the family. The fear of speaking out about incest was broken. The family is the unit within society that sexual abuse is often initially experienced. Incest teaches women that their role in society is to be subservient to men. Incest teaches women that their bodies do not belong to them. Incest teaches women that their sexuality is first to be expressed in humiliation and pain. The fact that molestation and rape occurs within the family with supposedly trustworthy adults seriously affects the child's ability to trust herself and others and causes long term effects in the social functioning of the woman.

Investigations of sexual offenses against children in Canada (Badgley, Allard, McCormick, Proudfoot, Fortin, Ogilvie, Rae-Grant, Gelinas, Pepin, Sutherland 1984), found that thirty-four percent of female children in Canada are victims of childhood sexual abuse. Russell, (1986) found the following statistics - possibly twenty percent of the female population has experienced incest abuse, twelve percent of which occurred before the age of eighteen. The majority of the victims are female and the majority of the abusers male. The usual pattern of incestuous activity begins when the girl is prepubescent usually between the ages of seven to twelve, although it may occur earlier. The average duration is approximately four years.

There are a number of definitions of incest. Canada's law on incest is stated in the Criminal Code as Section 155 (1). "Everyone commits incest who, knowing that another person by blood relationship is his or her parent, child, brother, sister, grandparent or grandchild, as the case may be, has

sexual intercourse with that person." This legal definition is limited as it excludes any activity other than sexual intercourse and it excludes social relationships of step-families, foster families and adoptive families.

> Two other definitions are Benward and Densen-Gerber (1975) and Butler (1985).
>
> Incest refers to sexual contact with a person who would be considered an illegible partner because of his blood and or social ties to the subject and her family. The term encompasses then several categories of partners including father, stepfather, grandfather, uncle, siblings, cousins, and in-laws, and what are called quasi-family. The last category includes parental and family friends (eg. mother's sexual partner). Partner represents someone from whom the female child should rightfully expect warmth and protection and sexual distance. (p.326) Sandra Butler (1985) defines incest as..."any sexual activity or experience imposed on a child which results in emotional, physical or sexual trauma. The forms of incestuous assault are diverse, the acts are not always genital and the experience not always a physical one" (p.5).

Children involved sexually with adults may be said to submit rather than to consent to the activity and to be unable to give informed consent due to their immaturity, dependence and powerlessness (Courtois, 1988).

Susan Brownmillar (1975), in Against Our Will states:

> The unholy silence that shrouds the intra-family sexual abuse of children and prevents its realistic appraisal is rooted in the same patriarchal philosophy of sexual private property that shaped and determined the historic male attitude towards rape. For if woman was man's corporal property, then children were and are wholly owned subsidiary. (p.281)

Florence Rush (1980), gives a historical perspective on how sexual abuse of children has been condoned by past and present societies. She traces the sexual victimization of female children back through Judaic and Christian traditions.

> The Biblical female no matter what her age was property, and as such stripped of all human attributes, and because the female was a sexual property, all heterosexual relationships were defined as financial transactions. Marriage was the purchase of a daughter from her father, prostitution was the selling and reselling of a female by her master for sexual services and rape was the theft of a girl's virginity which could be compensated for, by payments to her father (p.18,19).

According to Talmudic law, Hebrew children of three years and one day could be betrothed by sexual intercourse. Christian girls were routinely married at age seven or younger. Both traditions allowed female children to become virgins again at a certain age. The Hebrew age was three and the Christian age was seven. Therefore, no matter how often a child has been penetrated vaginally before age three or seven, it was of no legal consequence and her value in market was not decreased. Further in Biblical law, a man was forbidden to have sexual involvement with his father's wives, concubines or his mother or step-mother as they were his father's property. However, there is no Biblical taboo against father-daughter incest.

Thus it appears (Courtois, 1988, p.7) "that child sexual abuse has been embedded in and covertly allowed in most cultures, while being overtly and publicly decried and denied."

Between 1900 and 1970, less than 100 studies were completed on incest. The studies suffered from serious methodological flaws and often involved only the most serious cases that came to the attention of social agencies. These studies based on Freudian theory perpetuated many myths. Incest was often blamed on the seductive daughter (Bender & Bleu 1937, as described by Meiselman 1978;

Lukianowicz, 1972) or the cold rejecting, colluding mother (Henderson, 1976; Geiser, 1975; Kaufman, Peck & Taguiri, 1954) whereas the abuser appeared to be a poor fellow who was manipulated by his wife and/or daughter.

Brickman (1984) states,

> with respect to women all models of therapy can be classified as traditional in some if not all their basic tenants. However divergent theoretically, their definitions and treatment of women are alike sexist...and dangerous to the health of the women. (p.49)

The female is judged not by herself but in relation to male needs and self-interest. When working with incest, traditional theories do not work because of the belief that sexual victimization does not cause long term consequences. This results in the female pain being hidden. The pain of the incest victim "is suspect of being motivated to affect the offender, destroy his comfort, his reputation or to get even with him for some slight" (p.55).

In traditional theories, Brickman (1984) reiterates that the victim's pain disappears. She states the issues in traditional therapy become the girl's desire for the father, her seduction of him and the belief she has not been affected by the assault. When the family is viewed, it's a cold rejecting mother who has destroyed the emotional development of her son and/or a wife who deprives him of his sexual rights therefore unconsciously allowing him to sexually assault his daughter.

In the feminist model, Brickman (1984) emphasizes that women are the important central figures. "When working with incest a victim's pain and its consequences are the central feature of the incest" (p.63).

The offender is considered more a daughter-raper or a niece molester than as a father.

The fact that he is also a father or relative is viewed as intensifying rather than

> mitigating the betrayal and the trauma. Mothers are not automatically held partially responsible for the incest, but are viewed as potential allies for their daughters. It is recognized that daughters will feel abandoned and unprotected by them but their mothering problems are additional issues. (p.64)

"While victims are assumed to suffer, offenders are assumed to benefit from the occurrence of incest. The most obvious payoff is sexual gratification" (p.65).

To counter the denial of a woman's reality, as held by traditional therapeutic models, and to emphasize women's needs, a feminist perspective of therapy has been developed and can be used within various treatment approaches. Chapter two outlines major feminist beliefs and principles of feminist therapy, which were used to provide treatment to the women participating in the practicum group.

# CHAPTER 2

# FEMINIST PERSPECTIVE

## An Introduction to Feminist Beliefs

Feminist therapy grew out of the women's movement and a critical analysis of sexism inherent in the theory and practice of the helping professions (Levine, 1983). Feminism is not only a philosophical perspective and a way of visualizing and thinking about situations but also an evolving set of theories attempting to explain the various phenomena of women's oppression (Collins, 1986, p.214). Cox (1976) defines feminists as "women who agree that we live in a male dominated culture in which women remain unacknowledged and invalidated as sources of power" (Sturdivant, 1980, p.43).

In western society women have been defined as existing to meet the needs of men; women have been excluded from any position of power or authority in society. This exclusion has been maintained by men in a number of ways. Sturdivant (1980) refers to Polk's definition of the types of power differentials between men and women in society. These include:

1. Normative power. Because "of their sex and their control of traditional sex-role definitions, men are able to manipulate women's behaviour by ignoring, misrepresenting, devaluing and discrediting women or their accomplishments especially when women deviate from traditional roles."
2. Institutional power. Men have various types of access to money, education and positions of influence and "they use this control to limit life options for women and to extend life options for men".
3. Brute Force. "Not only are most men stronger then most women....Men physically dominate women by beating them and by rape and threat of rape." (pp.112-113)

The women's movement also asserts that women's lives and experiences differ from men's not only due to biological factors but also due to sociocultural factors that maintain the sex roles. These sexual roles oppress women and prevent them from functioning and contributing to society according to their potential (Sturdivant, 1980). Feminist therapy assumes female socialization and female sex roles not only prevent women from self-actualization but also directly cause psychological problems in women and perpetuate women's minority status in society. Sturdivant (1980) refers to Suzanne Keller's description of the core elements of the female sex role. These are summarized as:

1. A concentration on marriage, home and children.
2. A reliance on a male provider for sustenance and status.
3. An expectation that women will emphasize nurturance and life preserving activities.
4. An injunction that women live through others rather than for self.
5. A stress on beauty and eroticism.
6. A ban on the expression of direct assertion, aggression and power.

A review of these core elements illuminates the perspective that women's socialization emphasizes dependency and affiliation while discouraging social, economic or political power. Sturdivant (1980) states the main result of the female sex role is the exchange of autonomy for (supposed) economic security. Foremost, women are socialized to be the physical and emotional caretakers of others. Levine (1983) states:

> Men become husbands, fathers and workers. Women are not supposed to aspire to such an integration of life if it is in any way disruptive to others, if in any way it impinges significantly on men's needs and aspirations, or on the lives of children. This is partly what patriarchy is all about. Women have been directed to be loyal, first and foremost, to individual men in their lives and to blame themselves or other women

when trouble emerges. Under such conditions, solidarity among women in pursuit of change has been profoundly undermined. (p.75)

Sturdivant (1980) cites Beauvoir (1961) who states, "representation of the world, like the world itself, is the work of men; they describe it from their own point of view, which they confuse with absolute truth" (p.91). Unfortunately traditional psycho-therapies have also viewed women's lives and experiences from this point of view.

Levine (1983), notes Erikson devotes seventeen pages to the identity development of the adolescent boy and one paragraph to the development of the adolescent girl. He states that a young woman cannot have an identity before she knows whom she will marry and most of a young woman's identity is defined by her attractiveness and in her selectively of the man she wishes to marry.

Traditional therapists have continued to demean women who are sexual victims, by labelling them as "castrating woman" or "angry woman" without seeing that assertive behavior is healthy and adaptive for these women's personal development. Perhaps what is most horrifying is the assertion by many male therapists that it is therapeutic for women to engage in sex with them

Feminist therapists assert that traditional therapy serves as a form of social control. In that it does not acknowledge the effects of sociocultural factors in the etiology of women's emotional problems. Feminists charge that the adjustment model of mental health is oppressive to women (Sturdivant, 1983). This model perpetuates the myth of male dominance and authority and does not allow women to examine the appropriateness of the various types of roles assigned to them.

**Feminist Therapy : A Humanistic Growth/Development Model**

Feminist therapists believe women's emotional problems stem from external sociocultural factors and internal psychological states. Feminist therapists encourage women to become more self aware, autonomous and self nurturing. Berlin (1973) states that,

> feminist-therapists want women to have a clear and individualized standard of personal value and to communicate honestly and clearly from a position of self-respect and self-centredness. Feminist therapists want women to actively influence the course of one's own life by taking action on one's own behalf. (pp.493,495)

Feminist therapists believe in feminist humanism; a positive belief in the capacity of women to self actualize based on their own self-knowledge and human potential. Sturdivant (1980) relates this to Kluchhohn's (1956) value orientation that views women as mutually good and values people living in harmony with one another and with nature. This style also focuses on the present time while planning for the future and it emphasizes the personality type of Being-In-Becoming, which is reflected in feminist therapy's emphasis on growth and change for women. It is a developmental approach that perceives women as able to move forward in a life long process of self-realization in social functioning.

Feminist therapists believe that the emphasis on adjusting to stereotyped sex roles is unhealthy for women. Levine (1983) states:

> By and large, women have found that helpers stress adjustment rather than change; individual not collective or political solutions; personal pathology, weakness rather than strength; the psyche unrelated to economic and social hazards in women's lives; and the authority of male experts, male management, and male decision makers in and beyond the home. (p.77)

Sturdivant (1980) in her model for feminist therapy states personal and social change, not adjustment is the goal of feminist therapy. She presents a growth/development model of therapy rather than the illness/remediation model of traditional therapies.

Within this model, the social conformity goals of traditional therapy are replaced and women are encouraged to examine social roles and then choose whether these roles reflect their personal needs

and lifestyles rather than accept these roles as offered by society. This places a strong emphasis on personal self-definition and self-determination by women in shaping their own identity.

Levine (1983) states that "The mandate for feminist counselling includes a healing process, an education process and a political process" (p.79). A basic principle in the feminist approach is the "personal is political". The political context of personal experience is a critical aspect of feminist counselling. Feminist therapists believe it is crucial to make the connection between personal experiences and social factors to women clients. Russell (1984) states this is the skill of social analysis.

Social analysis is a skill of assessing social and cultural restraints that impinge internally and externally in a client's behavior and of helping the client recognize these restraints. This skill can also help clients to cognitively restructure their world. Clients often tell therapists their difficulties are entirely self-imposed. Traditional therapists often support this perception by looking at the intrapsychic dynamics as causes of actions and attitudes. Social analysis looks at the social restraints that contribute to problematic situations. Most women are socialized into submissive, passive roles. Quick speech, frequent smiling, allowing for interruptions, fostering of male leadership, avoidance of decision making, and failure to exercise power are behaviours that reinforce women's subordinate position. Once clients recognize these forces, they can acquire perceptions and behaviours to protect them against manipulation by such forces. Social analysis places the focus of therapy outside the client as well as within the client. Social analysis identifies individual problems with those of women as a group and stresses the commonality of women.

**Tenets of Feminists Therapy**

Feminist therapists encourage women to find a sense of personal power beginning with the choice of the therapist. Clients are encouraged to shop around and take a consumer approach to their counselling. Therapists are expected to make their values explicit during the therapy process while

providing the client the opportunity to accept or reject the orientation. The focus of the therapy is on the client's goals and not the therapist's goals (Sturdivant, 1980). The client is viewed as the expert on her feelings and experiences. The therapist helps to increase the client's feelings of power and autonomy through validating the client's experiences and perceptions. Trusting her own decisions, problem-solving skills and refusing to allow others to make decisions for her is a significant sign of personal growth for women in therapy (Sturdivant, 1980).

Feminist therapy encourages therapists to view the relationship between therapist and client as egalitarian rather than a subordinate relationship which may parallel the client's experience of other important relationships in her life (Russell, 1984). Information and knowledge is to be shared during the therapy process. Levine (1983) states the commonality between two women makes understanding and working together a natural part of the helping process. However, it is important to acknowledge that therapy cannot be a totally equal relationship. Any professional helping relationship carries within it an unequal power structure (Russell, 1984).

This unequal power structure can be minimized by the therapist through emphasis on the commonality of women's experiences and demystifying the therapeutic process with the client. In this manner, self-disclosure by the therapist can be helpful to the client in selective areas but it always requires sensitivity in terms of timing, depth and appropriateness.

Another important skill is behavioural feedback. Russell (1984) writes that behavioral feedback is the skill of providing the client with accurate and concise feedback regarding her behavior or behavioral manifestations of feelings. It requires clear and unambiguous communication by the therapist that can be easily understood and verified by the client. It is communication based on what is seen and heard rather than inferred, construed or suggested. If therapists are viewed as experts, clients can then be passive recipients with no responsibility for direction or self-assertion in the interaction. Clients are

thereby absolved of self-scrutiny, of analysis of behavior patterns, and of the task of changing habitual patterns and learning new skills. In short, the client's role in such interactions parallels the traditional passive female role that lay at the root of the distress in the first place. The skill of behavioral feedback encourages a more active and direct participation by the client in the therapy.

Perhaps one of the most important goals of feminist therapy is to encourage each woman to develop every asset of her personality that might increase personal effectiveness.

Before achieving this goal, women must be encouraged to explore their own needs and desires without the need for the approval of others. A woman must feel entitled to spend time and attention on herself, must feel the legitimacy of attending to her own needs and desires, and must feel the right to look after herself in the face of conflicting demands from others. Many women neglect themselves while endlessly trying to please others, or take care of others. The tragic results are few personal rewards. Often women who attend to themselves are frequently characterized by derogatory terms such as demanding, pushy and self-centered. Women need to be disabused of the legitimacy of these notions and encouraged to care for themselves first and foremost. This self-nurturing is often the most difficult therapy goal to achieve.

As women are encouraged to nurture themselves and value other women, they commonly become angry. They often express rage at the societal injustice against women. Anger is one of the most prohibited emotions for women and learning to experience and express it is essential for personal growth (Sturdivant, 1980). Greenspan (1983) states anger is a sign of increasing strength. Sturdivant (1980) refers to (Leidig & Mueller, 1976) therapeutic steps to help women express their anger as an important goal in feminist therapy. These steps are:

1. Recognition of anger.
2. Realization that there are external reasons for this anger.

3. Identification of the source and specifically what about that angers her.

4. Validation of her expression of anger.

5. Encouragement of her attempt to gain power over some areas of her life about which she feels angry.

6. Mellowing out after she has faced her anger (p.79).

Feminist therapists define women's sexuality in terms of women's needs and desires. Feminist therapists stress women are in charge of their own sexuality. Sturdivant (1980) cites Childs, Sachnoff and Stocher (1976) who state a woman has the right:

1) To engage or to initiate sexual activity or to refuse;

2) To enjoy her body apart from other;

3) To experience and experiment with different sexual relationships, and

4) To have her own standards and to use herself as a measure of her own experiences. (p.99)

Feminist therapists do not view bisexuality and homosexuality as pychopathalogical, but as an alternative lifestyle based on individual preference.

According to Russell (1984), feminist therapists choose to help women obtain a positive evaluation of their gender. The therapist counsels the client to value her strengths and attributes of being female. Female traits of affiliation, nurturance and compassion, which are essential to the maintenance of societal functioning, are to be valued in spite of a social system that devalues them.

**Feminist Groups**

Women's groups look specifically at womens' issues: menstruation; pregnancy; childbirth; rape; and physical and psychological abuse, issues which are generally not discussed around men. Feminist therapy groups arose from the consciousness raising groups of the 1960's and 1970's, but they are not consciousness raising groups. Consciousness raising groups were the first groups that allowed women

to explore their commonality of experience, receive social and emotional support from one another and examine the political and economic restraints imposed on their lives by society. Due to feminists questioning the exploitation of women by the traditional therapeutic approaches, by the 1980's, therapy groups run by women, for women emerged. These groups focused on the specific problem areas of battered women, sexually abused women including rape victims and incest survivors and women who suffered from eating disorders.

Feminist therapy groups adhere to three basic principles. They emphasize political, economic and social factors as having a significant impact on women's personal problems.

Isolation may lead women to believe they are alone with their problems. Feminist therapy groups encourage women to build supportive relationships among each other to decrease their feelings of social isolation and to learn from the commonalities of their experiences. Burden and Gottlieb (1987) cite Gottlieb, Burden, McCormick and Nicarthy (1983) who state "in this way women learn to trust and value other women and by extension to value themselves" (p.32). Feminist therapy groups encourage women to focus on their own personal identity apart from their relationships with others, and often provide the first social experience where women are encouraged to nurture themselves.

Sturdivant (1980) states all female groups convey a message not conveyed by mix-sexed groups. This message is: women exist apart from men. Women are persons in their own right; that it is permissible and desirable for women to band with other women, not just men; and women are worthwhile and make valuable contributions to each other.

Walker (1987) states feminist therapy groups are distinctly different from traditional therapy groups in terms of "group development, goals and structure, leadership dimensions, interpersonal relations and communication patterns" (p.4).

There are no covert agendas in feminist therapy groups. Group development involves the group

therapist making the process explicit from the beginning. This is accomplished by discussing the objective and motivation for the group and then sharing this with the group members so they can have clear expectations of how the group experience can help them with their personal goals and growth. Group members are also encouraged to discuss the content and structure of the sessions and to give on-going feedback to the therapists.

Feminist therapy groups are often quite structured and time limited. Structured group sessions help to provide a safe atmosphere for group members to explore their issues and concerns. Time limited groups help to decrease dependency on the group experience and therapist (Burden & Gottlieb, 1987).

Feminist therapy groups value the exploration of the realities of being female and promote self-disclosure about personal feelings and significant relationship. Walker (1987) states group discussions often focus on (Carlock & Marlin, 1977) "interpersonal issues such as establishing independence, resolving conflicting role expectations...eliminating self-hatred and repression of ones abilities" (p.8). In women's groups, touch promotes feelings of closeness and support with the result that non-verbal forms of communication, such as tears are more acceptable. Feminist therapy groups appear to be more conducive to the expression of anger where its expression can be encouraged and supported (Walker, 1987).

Men are not the best therapists for female therapy groups. The belief is that a male therapist reinforces sexual stereo-types and undermines female issues (Walker, 1987). Burden and Gottlieb (1987) believe the presence of men lessen women's abilities to express themselves freely, especially feelings focusing on sexuality and anger. Female and male therapists have different leadership styles. Men have a competitive style with groups and tend to be authoritarian and task oriented. Women leaders demonstrate greater concern for relationships among people than male leaders do (Walker, 1987). Women minimize distance and increase affiliation. Walker states, "female therapists are more sensitive

to issues facing women, are better able to empathize with feelings, provide a positive role identification model, and may be able to facilitate the resolution of role conflicts by utilizing their own experiences" (p.7).

Feminist therapists assume that the relationships among the various group members are as important as the group members relationship with the therapist. The therapist and the group members all serve as role models. In a feminist therapy group, the therapist is viewed as a resource person and a consultant to the group, as well as a person who helps group members achieve their goals.

An education process and a skill building process are important components of a feminist therapy group. This allows group members to request information on issues and learn skills that may have been denied them during the socialization process (Burden & Gottlieb, 1984).

Feminist therapy groups hold positive expectations for women. These groups express the beliefs that women are capable of taking charge of their lives and with the support of other women can solve their problems and reach their personal goals.

Feminist therapists believe the process of change is helped by cognitive restructuring of basic ideas about oneself, other women and society. Feminist therapists also believe that group support and validation for behavioural change may help to motivate women to participate in political and social action that will improve their status and power in society (Sturdivant, 1980).

**Discussion**

When implementing the practicum group, it was essential that the women had the opportunity to explore the political and social factors that contributed to their sexual abuse. This was accomplished by examining women's roles in society, by the use of group exercises, discussions and handouts. Equally important was to encourage the women to express their goals at the beginning of group and throughout the therapy sessions, thus emphasizing the therapist's roles as a group facilitator. This sense of safety

permits the women to begin to attend to their own needs and to become aware of issues that are inhibiting personal growth. By providing direct behavioural feedback, encouraging a more assertive communicative style and providing validation for the anger, fear and grief, group members achieved measurable personal growth. Throughout the group program, the therapists encouraged the women to trust in their own intuition and to value themselves and other women.

**Feminist Perspective and Social Work Practice**

Social work's set of values are major factors in defining social work as a distinct profession. These values act as a guide defining the goals and purpose of the profession. Perhaps the most important value is the belief in the inherent dignity and worth of all human beings and the assumption that people best realize their humanity through effective social functioning.

> Collins (1986) states social work perceives the human condition as not in stasis, but as part of an interactive open system, not as undimensional, but as immersed in, affecting and affected by the social and physical environment. Social work values provide a perspective that enables the practitioner to visualize the interdependence of individuals and the many significant systems of which the individuals are a part. The person-in-environment paradigm that results from this perspective is a guiding principle for social work practice, knowledge and research (p.216).

The feminist perspective is guided by the belief in the women's personal experiences reflect social and political norms. A number of assumptions underlying feminist social work practice were developed by the Feminist Practice Project sponsored by the Committee on Women's issues of the American Association of Social Workers in the mid-1980's. These assumptions are outlined by Bricker - Jenkins (1991). They include:

- The inherent purpose and goal of human existence is self-actualization: self-actualization is a collective endeavour involving the creation of material and ideological conditions that facilitate

it.

- We have created and institutionalized systems and ideologies of domination/subordination, exploitation, and oppression that are inimical to individual and collective self-actualization; patriarchy is only one of these, but has resulted in specific and profound injuries to women.
- Since people strive for self-actualization, it is possible to identify and mobilize inherent individual and collective capacities for healing, growth, and personal/political transformation.
- The world view informing all practice posits (a) that all things are connected; (b) that individual and collective pain and problems of living always have a cultural and/or political dimension; (c) that "reality" is a multidimensional process; (d) that diversity creates choices for all and is thus a source of strength, growth and health; and (e) that women have unique and relatively unknown histories, conditions, developmental patterns, and strengths that must be discovered and engaged by social work practitioners. (p.273)

The social work perspective and the feminist perspective each adhere to humanistic values and focus on individual and collective self-actualization. Both perspectives adhere to Kluckhohn's value orientations of viewing human nature as good. This model prefers activity that stresses being-in-becoming and existing with the environment. This is particularly evident in the feminist perspective that looks at the power imbalance between the client/worker relationship and advocates trying to break down this imbalance to whatever degree is possible, within the relationship.

Both the feminist perspective and the social work perspective stress the interconnections and interdependencies between the individual and the environment. Yelaja (1985) refers to Germain and Gitterman's 1980 ecological systems approach to social work which focuses on "the matching of peoples adaptive capacities and environmental properties, to produce transactions that maximize growth and

development and improve environments". (p.29). But the feminist perspective expands and strengthens this approach by the way it focuses on the relationship between the personal and the political. Bricker - Jenkins (1991) states, "Feminist practitioners lead with the assumption that individual and collective pain and problems of living always have a political and/or cultural dimensions" (p.279).

What the feminist perspective does for social work practice is that it forces practitioners to look at power: political power; social power; financial power; psychological power, as well as the power human beings hold over one another. Specifically this perspective looks at women's lack of power in society and the consequences this status has in their lives. The feminist perspective challenges the social work profession to look at sexist knowledge, oppressive therapeutic techniques, and dysfunctional social structures and institutions. It questions why social work would continue to stress adjustment to traditional beliefs and myths about women's place in society, if this focus is detrimental to a woman's well being. The feminist perspective opens the door for social work to research women's development, experiences and lives. This perspective points out to the social work profession, that to effect change at the micro and macro level in society, it is critical to consider gender as an important issue.

**Discussion**

The student's practicum group strove to empower the women to take charge of their recovery, to discover their strengths and to begin to form relationships with others in the group. While the discussion of the lack of power women experience in society may itself appear contradictory, validating women's social experiences promotes strength and helps women to plan strategies for future self-care. At the same time there is maximization of their personal growth and development while encouraging a commitment to social change. The practicum also gave the student the opportunity to hear and record the women's personal histories and their struggles for integrity within their social condition.

# CHAPTER 3

# LITERATURE REVIEW

## Long Term Consequences

Current literature stresses that childhood sexual abuse is very frightening, traumatic and leaves long-term psychological effects that persist into adulthood and require the victims to seek professional treatment (Briere, 1989; Courtois, 1988; Finkelhor, 1986; Gelinas, 1983; Herman, 1981; Jehu, Gazan & Klassen, 1984-85; Meiselman, 1978; Russell, 1986).

Sandra Butler (1978) stresses why it is important to deal with childhood sexual abuse and its effects.

> Whatever form the assault takes, the scarring of the child can be deep and lasting. Unlike physical abuse, the damage cannot always be seen but the scars are there nonetheless. The most devastating result of the imposition of adult sexuality upon a child unable to determine the appropriateness of his or her response is the irretrievable loss of the child's inviolability and trust in the adults in his or her life. (p.5)

## Mood Disturbances

### Self Esteem

Herman (1981) reported 60% of her forty father-daughter incest victims in psychotherapy had a predominantly negative self-image. "Many women felt that what set them apart from others was their own evilness. With depressing regularity, these women referred to themselves as bitches, witches, and whores. The incest secret formed the core of their identity" (p.97). There were thirty women survivors of incest that participated in Courtois's study (1979) and 87% of them stated their sense of self as having been moderately to severely affected. Jehu, Gazan and Klassen (1988) found 92% of their 50 female

subjects had clinically significant levels of low self-esteem. Thirty-nine (78%) of fifty female subjects answered partly, mostly, or absolutely true to the statement "I am worthless and bad," on their Belief Inventory. Bagley and Ramsey (1985) found 19% of abuse victims scored very poorly on the Coopersmith Self-Esteem category compared to 5% of the controls, whereas only 9% of the victims had very good levels of self-esteem compared with 20% of the controls. Women with poor self-esteem were nearly four times as likely to report child sexual abuse than other subjects.

**Guilt**

Survivors of sexual abuse often express enormous guilt for the abuse. The feelings of guilt, responsibility and complicity related to the incest negatively affect feelings about the self and intensify anxiety about relations with others. "Many survivors blame themselves for not having been able to say no, believing that not doing so was equivalent to want or pursuing the contact" (Courtois, 1988, p.220). Survivors may also feel guilty about their disclosure and giving up the role of protecting family secrets. Further confusion may result if the child experienced emotional or sexual pleasure from the incest. Bass and Thorton (1983) explain this experience:

> In some instances the abused child's body may respond to sexual stimulation even as her consciousness is horrified. Because she does not know that her body can respond without her consent, or even if it can respond that way at all, the abused child feels that she must have wanted the abuse, must have asked for it in some way. It is this betrayal of herself by her body that she sometimes finds the hardest to forgive. And again, she does not tell; she fears that anyone she tells would surely blame her as much as she blames herself. (pp.18-19)

Jehu, Gazan and Klassen (1988) found that 84%, 42 of 50 of their subjects endorsed the Belief Inventory Statement, "I must have permitted sex to happen because I wasn't forced into it." Herman (1981) on

blame states,

> Children do have sexual feelings and do seek out affection and attention from adults. Out of these undeniable realities, the male fantasy of the seductive daughter is created. But...it is the adult, not the child, who determines the sexual nature of the encounter, and who bears responsibility for it. (p.42)

**Depression**

In the literature, depression is the most common symptom reported by survivors of childhood sexual abuse. The DSM III-R describes depression "as a loss of interest or pleasure in all, or almost all activities" (p.218). Symptoms of depression include loss of appetite, sleep disturbances, psychosomatic agitation or retardation, loss of energy, decreased sex drive, guilt, thoughts about death, wishes to die, suicidal ideation and suicide attempts. Gelinas (1983) states the usual disguised presentation of an undisclosed incest victim is characterological depression with complications and with atypical and dissociative elements. Various theories have tried to describe the etiology of depression, most consider loss as a major element leading to the disorder. Incest survivors suffer various losses, loss of control, loss of possibilities, loss of self, loss of childhood, loss of security, and often loss of family.

Bagley and Ramsey (1985) completed a community mental health study in a random sample of 377 women in a large Canadian city. The subjects completed two standardized measures: the Centre for Environmental Studies Depression Scale and the Middlesex Hospital Questionnaire. Women with a history of sexual abuse scored more depressed on both measures, CES-D 17% versus 9% and with the Middlesex Hospital Questionnaire 15% versus 7% compared with the controls. Peters (1984) completed a community study in Los Angeles based on a random sample of women and found that the 119 women who reported sexual abuse involving physical contact had a higher incident of depression, a greater number of depressive episodes and were more likely to be hospitalized than non victims. Briere and

Runtz (1985) using 72 items from the Hopkins Symptom Checklist on 278 undergraduate women indicated the sexual abuse victims reported more depressive symptoms during the twelve months prior to the survey than did the non abused women. Sedney and Brooks' (1984) study of 301 college women found that women with childhood sexual experiences to be more likely to report symptoms of depression with 65% in the sexually abused group experiencing depressive symptoms verses 43% in the control group. A further 18% of the sexually abused group were hospitalized while only 4% of the control group were hospitalized. In clinical samples, Herman (1981) found major depressive symptoms in 60% of the incest victims, but 55% in the comparison group. Meiselman (1978) found depressive symptoms in 35% of the victims of childhood sexual abuse to 23% of the comparison group.

**Suicidal Ideation & Suicide Attempts**

A high incidence of suicidal ideation and suicide attempts has also been found by researchers. Herman (1981) found 38% of the incest victims at one point became so depressed they attempted suicide. Briere (1984) in a study of 153 walk-ins to a community clinic found that 51% of abuse victims had attempted suicide versus 34% of non abused clients. Sedney and Brooks (1984) found 39% of their college sample with a history of childhood sexual abuse reported having thoughts of harming themselves compared to 16% of the control group. Sixteen percent of these respondent had made at least one suicide attempt versus 6% of their peers (p.70). Briere and Runtz (1986) found that of 14 women who had made a suicide attempt before age 13. Thirteen (93%) had been sexually abused.

**Interpersonal Problems**

**Isolation and Stigmatization**

Herman (1981) states "Although helpless as children to prevent the incest, they nevertheless felt they had committed an unpardonable sin which left them permanently stigmatized. All without exception felt somehow branded or marked by their experiences" (pp.96-7).

Due to these feelings of being "bad", survivors often withdraw from social contact and feel isolated. Courtois (1979) in her community sample of incest victims reported 73% felt isolated versus 49% of controls. Briere and Runtz (1987) found 64% of their sexual abuse survivors felt isolated and alone. The isolation incest survivors feel is compounded by their difficulties in trusting others. Briere (1984) found 12% of survivors to fear women versus 4% of his controls. Herman's (1981) subjects had rage towards their mothers and seem to regard all women including themselves with contempt. Meiselman found 60% of incest victims dislike their mothers and 40% disliked their fathers. Many adult survivors fear men. Briere (1984) found 48% of victims fear men as opposed to 15% of the controls. Seventy-nine percent of Courtois (1979) community sample incest victims had severe to moderate problems in relating to men, 40% had never married. Sixty percent of Meiselman's (1978) incest victims complained of conflict and fear of their husbands or sex partners, 39% never married. Herman (1981) remarked although "these women had little hope of attaining a rewarding relationship with anyone, they desperately long for the nurturance and care which they had not received in childhood" (p.100).

Although distrusting men, many survivors idealized men which may lead them to be re-victimized in their relationships. Briere (1989) states some survivors overlook clues or behaviours such as aggressiveness or extreme sexism. Briere and Runtz (1987) found 49% of sexually abused women were battered as adults compared to 18% of the non sexually abused women. Jehu, Gazan and Klassen (1988) found 46 (90%) of women in their study had problems with their partners. Those who were married or living as married had 100% problems with their partners which they described as partners discord, being oppressed by their partner and being physically abused by their partner. Meiselman's (1978) study of psychotherapy clients reports 42% of her 26 incest victims were described by their therapist as women who sought out and passively tolerated relationships in which they were mistreated. They were often described by their therapists as "doormats", "punching bags" and "dish rags". Herman

(1981) states that 11 of her 40 incest survivors repeatedly endured beatings from their husbands or lovers. In many cases, "they seemed to feel that they deserved to be beaten" (p.101). Russell (1986) states between 38% to 48% of sexual abuse victims had violent husbands compared with 17% of non victims and between 40% and 62% of sexually abused women were sexually assaulted by their husbands compared to 21% of non victims. Fromuth (1986) surveying 482 female college students found women who were sexually abused before age 13 were especially likely to become victims of non-consensual sexual experiences. Russell (1986) reports 68% of incest victims were victims of rape or attempted rape by non-relatives compared to 38% who were never incestuously abused.

**Parenting**

Gelinas (1983) states incest victims often have problems parenting due to feelings of depletion, helplessness and poor self esteem. They have difficulty providing their children with an organizing structure and with a reasonable balance of discipline and affection. They are often ambivalent towards their children, withdraw and then are pursued by their children through mischievousness or misbehaviour calculated to induce mother to intervene and pay attention. As this progresses, mothers often feel that their children are malevolent and preying upon them - a feeling distinctly reminiscent of their father's behaviour towards them. (p.323) Goodwin, McCarthy and Divasto (1981) reported 24% of mothers in child abusing families were incest survivors compared to 3% in a non-abused control group. Closeness and affection were given a sexual meaning and therefore mothers maintained an emotional and physical distance from their children increasing the likelihood of physical abuse. Jehu, Gazan and Klassen (1988) found that 22 (70%) of 31 survivors acknowledged they had physically abused their children in the past and 6 (19%) were currently physically abusing their children while they received treatment for their incest experience. Herman (1981) stated many of her incest survivors were tormented that they would become bad mothers to their children, as they perceived their mothers were to them. They also feared they would

not be able to protect their daughters from sexual abuse.

**Social Problems**

**Alcohol and Drug Abuse**

Peters (1984) in a controlled community study reported 17% of sexually abused women had alcohol abuse problems versus 5% of women who had not been sexually abused as children. Also 27% of sexually abused women used at least one type of drug versus 12% of women who had not been sexually abused as children. Briere and Runtz (1987) reported 27% of incest victims had a history of alcoholism versus 11% of non incest victims. Herman (1981) found 35% of incest survivors abused alcohol and drugs versus 5% who had seductive fathers but had not been sexually abused.

**Prostitution**

The connection between child sexual abuse and prostitution has been investigated by a number of researchers. James and Meyerding (1977) interviewed 136 prostitutes and found 55% were sexually abused as children by someone 10 years or older prior to their first intercourse. In 1981, Silbert and Pines completed a study of 200 juvenile and adult street prostitutes in San Francisco. Sixty percent of the subjects were abused before age 16 by two people for an average of 20 months. Two-thirds 67% were sexually abused by father figures, 33% were abused by natural fathers, 30% by stepfathers or a foster father. Seventy percent of the subjects reported that the sexual exploitation affected their eventual entrance into prostitution. In 1987, Bagley and Young completed a similar study to that of Pine and Silbert in Alberta. They studied 45 women who had recently left prostitution. Nearly three-quarters 73.3% had experienced serious sexual abuse by the age of 16, prior to entering prostitution. This study was able to have a control group drawn from a community mental health study of 697 individuals randomly selected from the adult population in Calgary (Ramsey & Bagley 1985). The comparison group was 36 women from the community study under 40 years who had a history of childhood sexual abuse.

The comparison showed the prostitutes had experienced more severe forms of sexual abuse. The abuse began earlier in their lives, more often involved one or more biological relatives, it went on longer and it was likely to involve forms of sexual exploitation. A quarter of the incest victims had been involved in sadomasochistic activities and or posing for pornographic pictures or movies prior to entering prostitution. None of the controls had been involved in these activities.

**Sexual Dysfunction**

According to Maltz and Holman (1987), sexual dysfunction is evident in three areas: (1) sexual emergence; (2) sexual orientation and preferences and (3) sexual arousal, response, and satisfaction. Sexual emergence involves survivors either choosing one of two lifestyles becoming sexually withdrawn or sexually promiscuous. Both being the survivors' attempts to control their sexuality. Sexual orientation and preference questions how sexual abuse influences a survivor's sexual development. Some survivors believe the incest experience caused them to be homosexual. Others state it did not influence them at all. The authors:

> wonder if these women don't represent two different groups. One group being women who are lesbian and happen to be incest survivors. The other group heterosexual or bisexual women who experiment with same sex partners as part of the process of healing from the abuse or as a result of its trauma. (p.72)

In sexual arousal, response and satisfaction, Maltz and Holman (1987) state: "negative conditioning is very strong in survivors because the sexual abuse usually constituted their first experience with overt sexual stimulation. And their negative feelings were reinforced through the repetition of the sexual abuse" (p.76).

The authors also state that sexual dysfunction should be looked at after the survivor had addressed incest problems including self-esteem, responsibility for the incest and the negative sexual

conditioning.

Meiselman (1978) found 87% of her incest victims in therapy compared to 20% of the controls had serious problems in sexual adjustment. Twenty-five percent of her clinical sample were promiscuous and 74% of the 23 victims had orgasmic dysfunction. However, some victims could attain orgasm under specific conditions, masturbation, drinking, a new partner or a safe, undemanding and patient partner. Courtois (1979) reported 80% of former incest victims had an inability to relax or enjoy sexual activity and either avoided sex or had a compulsive desire for sex. Finkelhor (1979) studying college students found child sexual abuse survivors had lower sexual self-esteem than their classmates. Briere and Runtz (1987) found 45% of sexually abused women had difficulty in their sexual adjustment in contrast to 15% of the controls. Forty-two percent of these women had a decreased sex drive compared to 29% of the controls. Herman (1981) reported 35% of the incest victims had periods of promiscuous behaviour. Many moved from periods of promiscuity to periods of abstinence. Over 55% of victims complained of impairments in sexual enjoyment. Many reported pleasure in sex was minimal or absent. The memory of incest was often of the incestuous acts in the midst of their love making (p.105). Jehu, Klassen and Gazan (1984-85) found that half of their 22 clients had impairments in sexual functioning: they had impaired motivation, nine had phobic or aversion reactions to sex; twelve suffered from impaired arousal; and seven suffered from impaired orgasm and thirteen from sexual dissatisfaction.

Courtois (1988) lists six categories of sexual dysfunction. These include: (1) desire disorders; (2) arousal disorder; (3) orgasmic disorders; (4) coital pain; (5) frequency and satisfaction disorders; and (6) qualifying information. Desire disorder often involves low sexual desire and low sexual activity as well as aversion to sex characterized by negative emotions as helplessness, fear, shame and disgust. Arousal disorders involve lubrication difficulties involving partial or complete inability to maintain lubrication swelling response throughout the sex act and lack of feeling in the pelvic area. Orgasmic

disorders may be a response to the fear of being out of control or a defence against anxiety associated with sexual pleasure. Coital pain includes dyspareunia pain located in the genital area that occurs during the sex act, vaginismus and lower back pain. Frequency and satisfaction difficulties are survivor patterns of being celibate or hypersexual with survivors frequently being unable to feel any sexual satisfaction. Qualifying information involves a number of factors that may have an impact on sexual functioning. Often post-traumatic stress reactions can impair the ability to function sexually. Intrusive/re-experiencing symptoms such as flashbacks or memories can be triggered by sexual feelings, behaviours, sounds or smells. Denial/numbing symptoms such as depersonalization, derealization and dissociation may allow the survivor to be sexual but not present. (pp.109-110)

**Post-Traumatic Stress Disorder**

Post-Traumatic Stress Disorder (P.T.S.D.) refers to psychological reactions that often follow disaster or extreme psychological stress. It is often used to describe the experiences of war veterans, rape victims, victims of childhood sexual abuse and victims of natural disasters. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised (DSM III) lists the following criterion for the diagnoses of the post-traumatic stress disorder:

1. The existence of a "psychologically distressing event" that would evoke significant disturbance in anyone.
2. Later re-experiencing of the trauma in one's mind; for example through recurrent dreams of the stressor or as a flashback "intrusive sensory memories" to the original traumatic situation.
3. "Numbing of general responses" to, or avoidance of, the external world; for example, dissociation, withdrawal, restrictive affect or loss of interest in daily events.
4. A wide variety of other reactions or symptoms such as sleep disturbances upon exposure to situations that resemble the original traumatic event.

Many researchers have found child sexual abuse causes delayed or chronic PTSD in adult life (Gelinas, 1983; Black, White & Kline, 1985; and Briere & Runtz, 1987). Jehu, Gazan and Klassen (1988) found anxiety, phobias, dissociation and sleep disturbance was experienced by 44 (86%) of the 51 women in their study. Sedney and Brooks (1984) found 54% of incest victims had symptoms of anxiety compared to 41% of the controls, and 41% suffered from extreme tension compared with 29% of the controls. Further 51% had problems sleeping versus 29% of the controls. Bagley and Ramsey (1985) report 19% of childhood sexual abuse victims versus 9% of non-abused victims reported symptoms of somatic anxiety. Briere and Runtz (1987) reported 54% of sexual abuse victims had anxiety attacks compared to 28% of non-victims. Seventy-two percent of the victims had difficulty sleeping versus 55% of non-victims.

**Discussion**

It was anticipated by the student that all the women participating in the practicum would be suffering, in varying degrees from the long term consequences of sexual abuse. Addressing these issues formed the goals of the student's practicum group. By challenging the survivor's belief she is responsible for the sexual abuse, the process alleviates her guilt and depression. Children desperately try to make sense of the abuse, inevitably they blame themselves for something innate within them which has caused the sexual victimization. The power, control and sexual needs of the abuser are not recognized. This is compounded by any sexual pleasure or special privileges a child may have gained from the abuser. This self contempt is then carried into adulthood. Providing women with the opportunity to recognize their childhood vulnerability and childhood assumptions about self, allows them to reconstruct events and to gain a positive sense of self worth.

Distrust of men, women and frequency re-victimization in present relationships are all ongoing problems of adult survivors of sexual abuse. Re-educating women about what is normal in personal and

intimate relationships is essential. Sexual adjustment problems such as abstinence, promiscuity and prostitution are choices made based on feelings of guilt and shame. Learning to distinguish when trust is warranted in a relationship and when it is not, allows adult survivors to form relationships with others, but to remain safe. Boundary awareness and maintenance must be taught to survivors.

Providing women with detailed information regarding the symptoms of post traumatic stress, such as disassociative state and flashbacks, helps them feel less 'crazy' and afraid. Furthermore, providing women with coping techniques for flashbacks, whether these occur during sexual activities or throughout the day, allows women to regain a sense of control.

Treatment of sexual dysfunction was not addressed by the student's practicum. Group members who had problems with sexual dysfunction were advised to contact Klinic or the Psychology Department at the University of Manitoba for information about therapists and programs that had expertise to treat these particular issues.

All women who participated in the practicum group were recovering from alcohol and substance abuse as this was the criteria for acceptance into the agency's group treatment.

**Group Treatment for Women Who Were Sexually Abused As Children**

Group therapy for women who were sexually abused as children, helps to break the secrecy, isolation, and stigma of incest. It allows the women to identify with other group members and to recognize the commonalities of their experiences. Group problems of low self-esteem, guilt, addictive and self-destructive behaviour, dissociative responses and problems with intimacy and sexuality are viewed less as personal deficits and more as common reactions to incest. Group therapy provides its members with a safe, consistent environment to develop trust in others. There are a variety of groups described in the literature. Some groups are self-help in nature, others are led by trained therapists and focus on various clinical issues and therapeutic processes and techniques.

Faria and Belohlavek (1984) outline a treatment approach, goals, techniques and tools for working with adult survivors of sexual abuse. Their approach stresses that all incest must be desexualized. The therapist should believe the woman's account of the incest experience and respond with empathy. The therapist must know the details of the incest, its duration, and frequency, the client's age, the abuser's identity and the amount of force used. The therapeutic goals involve: (1) the therapist establishing a commitment with the client for involvement in the therapeutic process; (2) alleviating shame about her experience; (3) supporting her strengths; (4) providing a safe place where the client can constructively express her feelings and anger; (5) to help the client identify and gain control over self-destructive behaviour and (6) to increase the client's self-esteem through improving her body image and understanding of human sexual response. All specific tools and techniques should be modified to fit the needs of the survivor. Journal keeping and letter writing are two treatment tools. The journal helps the survivor keep track of her feelings towards the abuser or other family members. Letter writing also may give her the opportunity to express her feelings towards the abuser or other family members, although the letters are seldom sent. Books and reading materials on incest and sexuality may decrease the survivor's feelings of isolation. Many techniques can be used with a survivor: principles from cognitive therapy are useful in correcting distortions, techniques from psychodrama and gestalt are valuable in uncovering feelings and integrating incest experiences; photographs from the survivors' childhoods can help release memories; and/or hypnosis may also help in uncovering repressed material. In terms of a therapist, the authors favour a female therapist because she can provide more effective modelling.

Tsai and Wagner (1978) report on a series of ten groups run for women who were sexually molested as children. The goals of the groups were: the alleviation of sexual guilt and shame; and the clarification of the emotional and behavioural symptoms of the sexual abuse. Each group had four or five

members and the sessions were led by a male and female co-therapist. Treatment consisted of four structured sessions; session one, group members described the sexual abuse in detail; sessions two and three focused on how the sexual abuse affected the women regarding their interpersonal relationships, sexual functioning, and feelings about themselves, and session four dealt with individual stages of recovery and further feelings of guilt and depression, negative self-image, isolation, mistrust of men, difficulties in sexual functioning and underdeveloped social skills. Six months after termination of each group, participants were mailed evaluation questionnaires. Of the seventy-nine percent returned, it was found that the most helpful aspect of the groups was "being able to share feelings with women who have gone through similar experiences and could truly understand" (p. 425).

Gordy (1983) describes short-term structured groups for adult survivors of incest. Three groups met for eight weekly sessions for an hour and a half each. Each group member was to have an individual therapist prior to entering the group. Techniques used in groups involved the women making a list of symptoms children might experience when they were sexually abused. This list provided a vehicle for the members to discuss their past. Sessions three to seven involved the women discussing specific topics including guilt, depression, mistrust of men, feelings of isolation, sexual dysfunctioning, family of origin, their children, substance abuse, eating disorders and shame. Past attempts at disclosure which had not been believed, were also discussed. At termination, an evaluation questionnaire was administered to ensure accountability for funds. For group members, this group process helped them overcome social isolation, lessened guilt and shame and increased self-esteem. Group members stated, "The most helpful part was comparing experiences with one another and discovering how others learn to cope with their problems" (p.302). "The group helped me see I am a worthwhile person and have something to contribute to others" (p.306). Gordy emphasized the need for a co-therapist due to the intensity of the issues discussed in group (p.306).

Herman and Schatzow (1984) chronicle a series of time limited groups for women with a history of incest. The groups consisted of five to six members who attended ten weekly sessions. The criteria for group selection was that the client not be in crisis or feel too ambivalent to be involved in the group process. All women had to be involved in established individual therapy sessions. The group sessions focused on issues of guilt, secrecy, shame, and isolation. The first six sessions dealt with goal definitions identified by group members. Sessions six to nine focused on achievement of goals, such as rehearsing in group possible outcomes of disclosing to a family member or friends. Cohesiveness increased when the focus was maintained on commonality of experience. Six months after group therapy, an evaluation questionnaire was sent to the group members. Subjectively, members reported the most helpful experience from group was the contact with other incest victims. Additionally, 85% of victims reported increased self-esteem, 80% felt less isolated and 75% felt better able to protect themselves.

Carolyn Cole (1985) reported on a six week structured support group. Each session lasted two hours and was led by a female therapist. All group members attended a pre-group intake session with the group leader and were given a literature packet discussing incest. These articles were feminist in nature. Sessions one and two involved members sharing their incest stories. The clients also specified a goal they individually wished to work on and were given one another's phone numbers so they could keep in contact during the week. Sessions three and four involved the discussion of secrecy and isolation in their lives. Session five focused on the impact of incest in their present life. Session six focused on the integration of the information of the past six weeks and saying goodbye to each other. An evaluation was given to members and alternatives such as individual therapy and assertiveness training were discussed at termination. Results indicated decreased social isolation, as many women made at least one friend in the group and indicated an increased ability to disclose to friends. The authors recommended a co-therapist for the group and stressed the need for female therapists because, as it appears less

threatening for women to trust other women than it is to trust men. The feminist literature helped women feel less victimized by the sexual abuse.

Goodman and Nowak-Scibelli (1985) describe a time limited group of twelve weeks based on Mann's (1973) brief treatment model. Six to eight members were selected following individual screening sessions. Screening eliminated women who were psychotic, suicidal or in crisis. The ground rules for each session were: being in individual therapy; keeping confidentiality; bringing any discussion they had amongst themselves outside of group back to group the following week; and limiting their absences to two sessions. Three assumptions by the therapists underlie the group model: (1) in any situation involving sexual contact between an adult and child, the adult is responsible; (2) to hold the offender accountable without scapegoating; and (3) to acknowledge the loyalty of the victim to her family. The first phase of treatment dealt with anxiety and fear of disclosure by the group. In the middle phase, treatment focused on the details of incest. The final phase often dealt with feelings of abandonment and loss, by group members. The authors state the type of woman who benefits most from these groups is one who is psychologically minded and has been in individual therapy prior to group. Pre and post questionnaires were being developed for the group to evaluate the effectiveness of the program.

Deighton and McPeek (1985) report on a unique group treatment model for adult survivors that "is grounded in the family therapy, theory, and techniques of Murray Bowen and James Framo, which relates to family-of-origin issues in the treatment of young adults" (p.405). Group treatment emphasizes: (1) issues dealing with feelings of isolation that maintain the client's victim status; (2) issues facilitating the client's understanding of the generational problems in child sexual abuse; and (3) issues dealing with the client's position in and emotional cutoff from the family of origin as a means of mastering adult relationships. The group treatment goal was to coach clients to achieve a more functional relationship with family members, to be less emotionally reactive, and subsequently, to be more objective and have

more control over their own adult relationships with others. Membership in the group ranged from five to seven persons per group meeting. A male and female co-therapist were used to lead the group. The groups averaged approximately thirty sessions before termination. Success was measured by group members increasing their contacts with family of origin members and improvements in their marital relationships and their relationships with their children.

Cole and Barney (1987) present a group model for adult incest survivors that takes into account many survivors' experiences with symptoms of post-traumatic stress. They state survivors oscillate between denial and intrusive phases of post-traumatic stress, and that between the extremes of denial and intrusive phases, one can postulate a "therapeutic window" (pp.602-603). This therapeutic window is a zone where the survivors' symptoms are sufficiently manageable to permit a reworking of traumatic material. This allows the survivors to reintegrate material in a safe environment where tolerance limits are understood. All group members go through screening procedures. Members must not be in crisis or be involved in current or recent substance abuse and have a reasonable social support network. All group members must be in concurrent individual therapy. Ground rules emphasize no sexual contact between members, if a member wishes to leave group, she must come back to the group for one session to discuss her reasons for leaving with the other group members. Group members are free to contact each other outside the sessions. The group uses regular check in and wrap up exercises every session. Group members are given a presentation describing post-traumatic stress and the therapeutic window. Throughout the group, members look at the role of triggers (reminders of the incestuous event) that precipitate symptoms. Strategies used to help survivors deal with emotions include grounding, the gestalt empty chair, phototherapy and working with the inner child. This analogy is used to help survivors realize the emotions that they feel belong to a little child who was powerless to stop the abuse.

## Discussion

The review of group models for survivors of sexual abuse provided the student with information regarding group structure, clinical issues, treatment approaches, tools and evaluation procedures for use in her practicum group. The student chose to implement a closed, time focused group that would provide the women with clear boundaries as well as the opportunity to bond and explore their pasts knowing that the intensity of the group experience would not last forever. This program provided sessional topics that allowed the women to explore their issues at a measured pace while identifying common survival tactics and self-care strategies. The Women's Post Treatment Centre provided a closed, time focused group that the student implemented. A number of tools were used in the practicum including identifying group goals, reviewing family photographs and relaxation exercises. The practicum's treatment approach involved a humanistic growth/development model using a feminist perspective. The use of this type of model allows for the examination of distorted beliefs and for the dissemination of information pertaining to the long-term consequences of sexual abuse. At termination of the group, three evaluation questionnaires were given to the clients.

# CHAPTER 4

# METHODS AND PROCEDURES

## Objectives

The purpose of this practicum was the implementation and evaluation of a fourteen week group program which would provide adults an opportunity to heal from their childhood sexual abuse. This would be accomplished using a humanistic growth/development model within a feminist perspective. The primary focus of this practicum was to:

1. Increase the women's awareness of the social and political factors that contributed to their childhood sexual abuse and the resulting present problems;
2. Give permission and encouragement to group members for self-care;
3. Develop and increase the women's interpersonal skills;
4. Explore the family and personal relationships of group members;
5. Provide the opportunity for personal growth and development through an educational and skill building process; and

Often the labelling of being a victim takes over a woman's life. It is important for the woman's identity to move beyond this label. Dolan (1990) cites Trepper and Barrett (1989) who state:

> the abuse was not the only event in the adult survivor's life, and all her existent adulthood behaviours are not a function of the abuse. Each of the clients systems must be taken into account when developing a treatment plan lest she be forced to remain in the role of the victim, this time not of her father, but of the institution of therapy. (p.25)

Dolan (1990) states to "address the client's treatment needs, therapy needs to include and strongly emphasize an active utilization of the client's present life resources and images of future goals and possibilities" (p.25). Most importantly, the woman needs to be reminded of the healthy productive areas of her life, so her self-image is expanded beyond her image of being a victim of sexual abuse.

The goals of this practicum were: to decrease the clients' depression, challenge distorted beliefs and alleviate social isolation and alienation of group members. To accomplish this, it was essential that therapy take place in a safe environment where survivors could share their experiences with acceptance and support from group members.

To increase self-esteem, survivors had to be educated about the causes and consequences of childhood sexual abuse. They had to be helped to understand their behaviours were not pathological, but were necessary for survival.

Within the feminist perspective, the interpretation of some symptoms of psychological disturbance in women are viewed as survival tactics which can be "behaviour and attitudes developed in order to exercise power indirectly and express anger covertly" (Sturdivant, 1980, p.124). In therapy women must learn to let go of self-destructive and self-defeating behaviour (eg. self-mutilation, substance abuse) and develop new coping strategies. These can be increased by having survivors focus on their personal strengths and by receiving reassurances from group members regarding their personal value, uniqueness and ability for growth and change.

To decrease depression, the abused child may be experientially brought into treatment. The survivor is encouraged to reconnect with the child and share the child's feelings of guilt, anger and shame. The group supports the survivor, allowing the child's feelings to be validated by the adult, while allowing the adult to grieve what is lost. Being a survivor of incest involves loss: loss of security; loss of self; loss of childhood; and often loss of family. The survivors may feel cheated and deprived. This is often

expressed through anger and grief. Grief is a natural process leading to healing. The survivor needs to be given permission to grieve.

Anger may be experienced as an overwhelming emotion. Survivors need support for having this intense emotion. They need to be taught the difference between internalizing anger towards themselves and externalizing their anger towards the incest experience. Survivors need to understand this emotion, and to learn constructive methods of expressing it.

To decrease depression, survivors must be educated regarding the social, psychological and sexual development of the child. Guilt can be alleviated by providing survivors with information regarding human sexual responses, thereby providing a means for self-acceptance and knowledge to improve body image. Furthermore, by returning the responsibility for the incest to the abuser and by forgiving themselves and others in the group, survivors decrease feelings of guilt and depression and increase feelings of well-being.

To challenge distorted beliefs, survivors are encouraged to examine family rules and messages that serve to reinforce the incest and abnegate their experiences. Family rules may include: don't feel - do not show your feelings especially anger; deny what is really happening - disbelieve your own senses - lie to yourself be in control at all times; don't trust yourself or anyone else; keep the secret - it will not be believed, nobody will believe or help you; be ashamed of yourself - you are to blame for everything (Courtois, 1988, p.45). Survivors are further challenged to examine their beliefs because (Jehu, Klassen & Gazan, 1986)

> if beliefs are distorted or unrealistic, then feelings and actions are likely to be distressing and inappropriate. To correct distorted beliefs, survivors must: (a) become aware of their beliefs; (b) recognize any distortions they contain and (c) to substitute more accurate beliefs. (p.50)

Examples of distorted thinking include all or nothing thinking which involves survivors evaluating themselves in an extreme category such as: being totally ugly or absolutely beautiful (p.51) or mental filtering, which refers to a tendency to pick out a negative detail in any situation and to dwell on it exclusively (p.58). Thus the whole situation is perceived as negative and anything positive is filtered out or so personalized that it involves survivors assuming responsibility for events that are not their fault (p.59). To correct these distorted beliefs, survivors can be helped by providing information, logical analysis of events and beliefs, decatastrophizing events and distancing, which refers to survivors shifting from a subjective to an objective perception of their beliefs. Once family myths and distorted beliefs are understood, survivors may separate these beliefs and myths from facts, restructure their ideas about themselves and view themselves more positively.

To alleviate social isolation and alienation, survivors are encouraged to identify with other group members. Most survivors lack, or grow up with either no information or misinformation regarding relationships. These survivors need education regarding communication skills, decision making, conflict resolution, boundary setting as well as their own rights in social relationships. In addition, they need encouragement to examine their beliefs and behaviours in relationships. They need support to learn how to trust themselves and others.

## Discussion

The purpose of the practicum was to provide group treatment to women who were experiencing many of the long term consequences of sexual abuse. This was accomplished within a feminist perspective that emphasized examining the political and social factors that contributed to the abuse and continued to influence the lives of the women. The goals of the practicum stemmed from the long term consequences of sexual abuse. Three goals were chosen, (decreasing depression, alleviating social isolation and alienation and disputing distorted beliefs), because of the ability to measure changes in the

group members moods and belief systems over the time of the treatment program. This was attained by the use of the Beck Depression Inventory, the Revised UCLA Loneliness Scale (Short Form) and the Belief Inventory. The practicum's format included sessional topics, group exercises and handouts which allowed group members to examine their beliefs about themselves, their relationships, family rules, anger and the position of women in society. Throughout the practicum the expression of emotion was encouraged by the group facilitators.

**Rationale**

The rationale and advantages of group treatment are many, but perhaps most importantly, it allows for the breaking of secrecy, isolation and stigma resulting from the sexual abuse. In group therapy, survivors can start experiencing themselves as useful to other people. Group experience promotes the experience of being able to help oneself and others. The following advantages of group treatment are adapted from Courtois (1988). Group therapy allows survivors to identify with other group members and to recognize the commonalities of their experiences. Group therapy with other survivors can challenge an individual's poor self-image. A survivor may believe she and other survivors are damaged goods but then she meets and discover survivors looking and acting as normal people. As group cohesion and trust develop over time, survivors "often develop a sense of pride in themselves and other survivors for having gotten through the abuse and for their work at its resolution" (p.246).

Group therapy serves to raise members' consciousness about incest, assisting them in developing a more social, cultural and political perspective on incest. Group problems of "low self-esteem, guilt, addictive and self-destructive behaviour, dissociative responses and problems with intimacy and sexuality are viewed less as personal deficits and more as common reactive to incest" (Courtois, p.246).

Group therapy helps break the secrecy, isolation and stigma of incest. Attending an incest group is a public acknowledgement of abuse as well as an act of disclosure. Group attendance and disclosure often makes it easier for the survivor to discuss the incest with her partner, spouse, other family members

and or close friends. Preparation and rehearsal for disclosure, along with possible outcomes can be undertaken in the group. "Whether outside disclosures go well or not, the group provides support and processing for the survivor" (Courtois, p.247).

Group therapy provides its members with a safe environment to develop trust in others. It provides a practice environment for survivors to learn new ways of communicating and problem-solving not available in their family of origin. Some members need to learn how to ask for attention for themselves and to have their preferences taken seriously. Positive emotions may be as difficult to express as negative emotions. The task of the group is to elicit responses from one another so that the member who is sharing, can feel the full extent of the recognition.

Group therapy allows for the breaking through of denial and the expression of feelings. The disclosures of some members enables others to focus on aspects of their abuse which were previously unavailable to them due to their defence mechanisms. The group setting offers an environment for exploring and grieving the multiple losses from incest. Sessions can be devoted to feeling angry and sad with group members comforting one another.

Group therapy challenges the distorted childhood rules and messages. Incest families have boundaries which are too rigid or too permeable. As a result of the lack of clear boundaries, survivors have difficulties with individualization and separation. Survivors learn to approach the world as a continuous double-bind in which their responses are not effective. Survivors in group therapy are helped to learn how to identify and how to extricate themselves from double-bind situations and to avoid setting up similar situations in the future. The task of group therapy is then to help survivors identify these learned patterns of interaction and to offer opportunities to survivors for self-development as they separate from their family of origin.

Group therapy presents an opportunity for therapists to observe survivors' interactional patterns and defence mechanisms while survivors are engaged with other group members. Survivors' interaction

and communication patterns closely parallel those they have learned in their family of origin. Some patterns may include their own victimization or the victimization of others while others may highlight how survivors set themselves apart from their peers. Survivors may exhibit patterns ranging from over-control and caretaking (putting the needs of others first) to under-control and withdrawal (never asking or expecting anything from anyone). Group therapy allows members to practice new behaviour patterns within the group.

There has been much discussion in the literature regarding the length of time needed to run an effective group program. Courtois (1980) cites Mann and Sprei. Mann (1973) developed a brief treatment model where he states "twelve treatment sessions is probably the minimal time required for a series of dynamic events to develop, flourish and be available for discussion, examination and resolution" (p.250). Sprei (1986) states time limited groups offer the following advantages:

(1). They make it easier for members who are only willing to make a time-limited commitment to treatment.

(2). They promote goal-oriented work.

(3). They focus attention on common themes of sexual abuse and in doing so minimize the focus on interpersonal relations within the group.

(4). They limit the level of anxiety experienced by a survivor considering joining the group.

(5). They deliberately decrease the level of dependency survivors can develop.

(6). They provide a hopeful, optimistic outlook for survivors.

(7). They encourage bonding and minimize resistance to sharing by virtue of the time limit.

(8). They provide a clear structure during the intense and disorganizing aspects of treatment.

(9). They encourage the emergence of feelings and issues that can be further explained in individual and long-term group treatment.

(10). They fit the needs and organizational structure of most sexual assault centers, mental health

centers and other crisis service agencies. (p.250)

A further rationale for group treatment can be taken from the many comments of support voiced by incest survivors who have attended group programs. Gordy (1983) reports incest survivors stated "The counselling group showed me that I could change the way I am. It also helped me see I am a worthwhile person and have something to contribute to others" (p.306).

Herman and Schatzow (1984) found incest survivors stated

> It helped most to know I wasn't alone." "Since being in the group I have thought about the other members of the group at least every day in getting perspective on my life" (p.613). "I feel like I've come out of a fog where I felt alone, and now I'm an integral part of the human race. (p.614)

## Procedures

### Setting

The group treatment program was conducted at the Women's Post Treatment Centre. The Centre was founded in 1985 to provide services to women who have had treatment for addiction problems and who need to resolve issues stemming from the long term effects of childhood sexual abuse. The second objective of the Centre is to address the issue of societal denial of the seriousness and prevalence of childhood sexual abuse. The Women's Post Treatment Centre offers individual and group therapy to women who have had treatment for addiction (including family and/or co-dependency) and whose recovery is blocked by issues stemming from their childhood sexual abuse.

This agency was approached by the student for the setting of the group treatment program because of its feminist approach to therapy and the knowledge and expertise of the staff in treatment of adult women who were sexually abused during childhood. The facilities also had the appropriate space to hold group sessions and was easily accessible by foot, bus and car.

**Time**

The time that the group sessions were held was determined by the availability of the agency staff to provide supervision, co-leadership and support to the student. Fourteen group sessions were held once a week on a Thursday morning. The sessions were two and a half hours long with a ten minute break. A thirty minute de-briefing session was held for the student by an agency therapist after each group session. The student and agency therapists also consulted within the sessions during the group break to determine if a change in focus was needed during the session. A one hour pre-group planning and consulting session was held each Monday prior to the Thursday morning group to determine the focus, objectives and activities of each group session. The student took responsibility for planning each group session. Clients accepted for the group treatment program were screened as to their availability to attend Thursday morning sessions.

**Therapists**

During the group program, two therapists led each session. The therapists were the MSW student and one of two therapists chosen by the agency to assist the student in co-leading the group. Two agency therapists were chosen as one therapist was not available to co-lead the student's practicum group throughout the months of June, July and August 1992, due to the agency's scheduled annual holidays. The advantages to the group and the student of having two co-facilitators from the agency was that it allowed the group and the student to be exposed to two styles and philosophies of group leadership. The choice of female therapists was based on the feminist beliefs that female therapists prevent the re-enactment of traditional male/female gender roles and provide positive role models for women who are suffering from the long term consequences of childhood sexual abuse.

**Size**

The size of a group dealing with the issues of childhood sexual abuse needs to be carefully determined. Too few members may place undue pressure on women to disclose their feelings and/or their

fears in their experience of sexual abuse, before they are ready for this type of public disclosure. Too many group members may inhibit some women from participating in the group sessions. Furthermore, if some group members decide not to participate, women who have been open about their experiences may become ashamed and stop participating in the sessions. All these factors must be considered by the therapist when deciding on the size of the group. The therapist must be sensitive to the women's needs for safety and consistency in the group process, so they can listen and participate in sessions at a comfortable personal level.

Given these considerations, eight women were selected for the group program. Based on reports from the literature and the agency's staff's experience, it was expected that the group could anticipate dropouts for a variety of reasons. These dropouts may happen due to premature disclosures of feelings before enough trust and confidence in the groups process has occurred.

During the assessment procedure, nine women were interviewed and accepted for the group. Three women who attended group were referred to the group program by their individual therapists at the Women's Post Treatment Centre. Six women who were contacted were on the agency's waiting list for group treatment. One woman chose not to attend the group sessions. It appeared to the student therapist that this woman was only beginning to shop around for help in this area of her life. At this time she was still in the process of recovering from a long history of substance abuse, as well as having just begun educational upgrading. She did not appear to be ready to become involved in further therapy, or to have the time necessary to devote to the process.

**Individual Treatment**

Both the student and the agency preferred that all the women in the group have an individual therapist, as this offers additional support to the group members in processing the sessions. However, not all the women selected for group were involved in individual therapy sessions. During the group program, all women who requested individual therapy were immediately accepted for sessions by the staff

at the Women's Post Treatment Centre. All group members were also offered the opportunity to continue with individual therapy at the Women's Post Treatment Centre after the group program ended.

All the women who attended the program had previous experience in a group because each member had been involved in an alcohol or drug treatment program prior to contacting Women's Post Treatment Centre for therapy. The prior group experience allowed some women to become comfortable with the group process; however for others, who had been intimidated or hurt by previous group work, it often made them hold back until they realized they were safe in the group.

**Discussion**

The rational for group treatment is well supported by the literature (Cole, 1983; Courtois, 1988). The setting for the practicum provided the student with supervision and support. The agency's perspective on treatment verified the student's belief in feminist social work practice. The agency allowed for a time focused group co-led by female therapists. It provided the student with access to clients who were survivors of sexual abuse. As well as time and space to implement her practicum group. The size of the group was based on the literature (Courtois, 1988) and the agency's recommendations that six to eight women would allow for the reasonable development of safety and cohesion within a group program. Both the agency and the student encouraged concurrent individual therapy while the women attended the student's practicum group. Again this provided the women with additional help in processing their experiences while enhancing their strengths and coping abilities.

# CHAPTER 5

# ASSESSMENT PROCEDURES

## Client Selection

Due to the variability of the effects of the long term consequences of sexual abuse, most therapists employ a pregroup interview to assess the client's functioning prior to participation. Group participation is not advisable for all women. A group member must be able to deal with group process and content. The focus of the intake interview is to assess the woman's suitability to engage in a group therapy program. Cole and Barney (1987) and Courtois (1988) emphasize the factors to consider are the client's motivation, interpersonal skills, needs, current life circumstances and ability to care for herself.

Current literature (Cole & Barney, 1987, Goodman & Nowak - Scibelli, 1985; Herman & Schatzow, 1984) suggests various factors that contraindicate group participation. These factors are: denial that the incest took place; inability to discuss the incest without severe anxiety; dissociative or depressive reactions; lack of motivation for change; extreme substance abuse; active suicidal behaviour; acute crisis in present life and suffering from a multiple personality disorder.

Briere(1989) states he:

> has no quarrel with any of these exclusion criteria per se", but states many of the "screening parameters are similar to the major long-term effects of sexual abuse... and taken to their extreme, these criteria might successfully screen out most victims of severe abuse, leaving only those with less need for treatment"(p.144). He states from " his perspective, group screening criteria should be seen as advisory, as opposed to mandatory. (pp.144-145)

Many survivors need to complete individual therapy prior to joining group. Some incest victims may never be able to tolerate a group experience. Therefore, the following criteria were then established

for participation in the sexual abuse group:

1) The ability to relate to others.

2) The ability to make a commitment for thirteen weeks and to keep appointments.

3) The overt expression of interest in attending group therapy for incest treatment.

4) Intellectual acceptance of the abuse.

5) The ability to talk about the abuse at a minimal level.

6) The ability to negotiate or articulate goals and expectations of group treatment.

7) Not to be in personal crisis.

8) Not to be currently involved in severe substance abuse.

**Assessment Interview**

During the assessment period, one intake interview was held for each woman who was interested in participating in the group. This interview determined the woman's eligibility for group membership. The focus of the interview was the woman's personal stability, reasons for joining the group and commitment to a group treatment process. Prior to the interview the client was informed that brief demographic information would be taken and then each client was asked if her assessment interview could be audiotaped. Each women then gave her consent to the audiotaping of the intake interview. At this time, the client was also informed that the interviewer was a student completing her MSW program who would be videotaping all group sessions for educational purposes. This provided an opportunity for each woman to discuss her feelings regarding this process. The interview also allowed the women to ask questions regarding the structure of the group, the format of sessions, group size, expectations of group members and the personal and professional backgrounds of the therapists. Some clients were interested in whether the interviewer or the other group therapists had been sexually abused as children. They were informed that the interviewer had not been sexually abused as a child and that they could ask the other group therapists this question in the future.

The clients' inquiries about the therapist's background of sexual abuse, often originated from the clients' beliefs that only another woman who had been sexually abused could understand and help them deal with their personal issues. The clients were reassured that a therapist who had not experienced childhood sexual abuse could help them process their feelings and in no way would their experience be diminished by the lack of personal experience by the therapist. The fear of not being understood or accepted by others is overwhelming to victims of sexual abuse. A therapist must reach out to the clients to bridge the fear of rejection and help create with the women a safe environment where their experiences can be explored and acknowledged.

When the first half of the interview was completed, the clients took a ten minute break before returning to the assessment procedure, and at this point were asked to complete three pre-group measures. These measures were the Belief Inventory, (Jehu, Klassen & Gazan, 1985/1986), The Beck Depression Inventory, (Beck, 1978) and the Revised UCLA Loneliness Scale - Short Form, (Russell, Peplau & Catrona, 1980). They were also asked to complete a consent form for the audio/visual taping and a consent form to participate in the student's practicum project. The clients were reassured that all information given to the student and collected during the group treatment program would be kept confidential.

**Measures**

Three standard measures were used to evaluate levels of depression, loneliness and distorted beliefs. The measures were the Beck Depression Inventory, the Revised UCLA Loneliness Scale (Short Form) and the Belief Inventory. A client satisfaction questionnaire, a group evaluation measure and the Women's Post Treatment Feedback form were administered at termination of group therapy.

**Beck Depression Inventory (BDI)**

The Beck Depression Inventory (BDI) is a 21 item test which measures the presence and degree of depression in adolescents and adults. It was developed by Aaron T. Beck M.D. The original BDI was

published in 1961, the revised 21 item BDI was published in 1978. Each of the inventory items corresponds to a specific category of depressive symptoms and/or attitude. Each category describes a specific behavioural manifestation of depression and consists of a graded series of four evaluative statements. The statements are ranked, ordered and weighed to reflect the range and severity of the symptoms from neutral to maximum severity. Numerical values of zero, one, two, three are assigned to each statement to indicate degree of severity. The 21 items measure the following symptoms and attitudes: 1. Sadness 2. Pessimism/Discouragement 3. Sense of Failure 4. Dissatisfaction 5. Guilt 6. Expectation of Punishment 7. Self-Dislike 8. Self-Accusation 9. Suicidal Ideation 10. Crying 11. Irritability 12. Social Withdrawal 13. Indecisiveness 14. Body Image Distortion 15. Work Retardation 16. Insomnia 17. Fatigue ability 18. Anorexia 19. Weight Loss 20. Somatic Preoccupation 21. Loss of Libido.

Studies on the BDI reliability were conducted using test results from psychiatric outpatients. Test-retest reliability has been studied in the case of 38 patients who were given the BDI on two occasions (Beck, 1970). Changes in the BDI scores tended to parallel changes in clinical readings of the depth of depression, indicating a consistent relationship between BDI scores and the patient's clinical states. The reliability scores were above .90. Item analysis demonstrated a positive correlation between each item and the BDI total score with correlations significant at the .001 level. Internal consistency studies showed a correlation coefficient of .86 for test items. The Spearman-Brown correlation coefficient for reliability was .93. Content validity is high as the BDI evaluates a variety of symptoms of depression. Concurrent validity studies have been completed by Elumberg, Oliver and McClure (1978) demonstrated a correlation of .77 between the inventory and psychiatric ratings, using university students as subject. Beck (1970) reports a correlation of .75 between the BDI and the MMPI Scale.

The BDI is simple to administer and take. The reading level is at an eighth grade standard. Subjects are asked to read each group of statements and select the statement from each group which best

describes what they have been feeling over the past week, including the day of administration of the test. If several statements in the group seem to equally apply, subjects are asked to circle each statement they believe fits them. The score is obtained by taking the number of points for all items. The following guidelines are used: 0-9 Normal range; 10-15 Mild Depression; 16-19 Mild-Moderate Depression; 20-29 Moderate-Severe Depression; 30-36 Severe Depression. A score of 21 or above is the recommended cut off indicating a clinically significant level of depression (Beck & Beamesderfer, 1974).

**Belief Inventory**

The Belief Inventory was developed by Jehu, Klassen and Gazan and reported in their article "Cognitive Restructuring of Distorted Beliefs Associated with Childhood Sexual Abuse", (1985/1986, pp.49-69). The Belief Inventory is a measure of distorted beliefs associated with childhood sexual abuse. The seventeen items on the Belief Inventory address distorted beliefs that contribute to mood disturbances such as guilt, low self-esteem and sadness.

> The test-retest reliability of this instrument was obtained from the responses of twenty-five previously sexually abused women over an interval of one week during their initial assessment. The Pearson correlation was .93, PL.001, a very high level of reliability. The inventory has face validity and because of the alleged association between the distorted beliefs and mood disturbances one might expect it to have reasonable concurrent validity with the Beck Depression Inventory. This was supported by a Pearson correlation of .55, PL.001, between the scores of 25 previously sexually abused women on the two instruments. (Jehu, Klassen & Gazan, 1985/1986)

The response categories on the seventeen item, five point Likert scale are **0** - Absolutely Untrue: **1** - Mostly Untrue; **2** - Partly True, Partly Untrue; **3** - Mostly True and **4** - Absolutely True. The total score is derived by adding the scores for each item. Clients with a score of fifteen or more would be

considered to have clinically significant levels of distorted beliefs.

### The Revised U.C.L.A. Loneliness Scale (Short Form)

Since one of the outcomes of the group intervention was to decrease feelings of loneliness, a measure was needed to record this emotion. The four item short form of the Revised UCLA Loneliness Scale (Russell, Peplau & Catrona, 1980) was used for this purpose. It is a four item Likert type unidimensional, self-report measure of current degrees of loneliness. The scale contains an optimal subset of the longer RULS. The loneliness scale was developed systematically (Russell, Peplau & Ferguson, 1978) revised and validated (Russell, et al, 1980) and is one of the most extensively used measures of loneliness. The scale possesses excellent internal consistency (Cronbach alpha = .94). Several studies have demonstrated the concurrent validity of the scale including comparisons with such variables as loneliness, self-labelling, self-selection into a loneliness clinic, dating frequently, romantic involvement rating by others and relevant emotional states such as anxiety, and depression. Despite substantial correlations between related variables such as affiliation tendency, there is evidence supporting the discriminate validity of the scale (Russell, et al, 1980; Weeks, Michela, Peplau & Braff, 1980). Responses to the UCLA have been shown to be internally reliable over time and essentially unrelated to gender and social desirability (Borys & Perlman, 1985; Russell, et al, 1980). The short form has no clinical cut-off score provided, but norms are provided for various age groups (Russell, 1982). The total score on the scale is the sum of all four items. Items 1, 4, 5, 6, 9, 10, 15, 16, 19, 20 on the long form are reversed when scoring the scale results (ie 1 = 4, 2 = 3, 3 = 2, 4 = 1). Items 1 and 15 appear on the short form and are also reversed when scoring the results on the short form of the scale.

### Client Satisfaction Questionnaire (CSQ)

The Client Satisfaction Questionnaire was developed by Larson, Attikinson, Hargreaves and Nguyen (1979). The CSQ is an eight item measure which is easily administered and scored. The

measure has a high degree of internal consistency with a Coefficient alpha of .93. In other words, the eight items provide a homogeneous estimate of general satisfaction with services. The measure is used at the termination of group therapy to allow clients to evaluate the treatment program.

## Research Design

### One Group Pre-test Post-test Design

The research design used for the group program was the one group pre-test-post-test design (Cook & Campbell, 1979). This quasi-experimental design was used to evaluate data collected from the Beck Depression Inventory, the Revised UCLA Loneliness Scale (Short Form) and the Belief Inventory. The results were compiled, analyzed and discussed to examine differences between pre and post intervention. Although this is not an ideal research design, it did meet the requirements set down by the student to evaluate the group treatment of the adult survivors of sexual abuse. Threats to internal validity included history, maturation, testing, instrumentation and statistical regression. Threats to history and maturation were reduced by observation and taking information from group members regarding events in their personal lives. Testing effects were reduced by the limited numbers of times the questionnaires were administered and the amount of time between the pre and post testing (three months). As group members were not randomly assigned, results from the group intervention did not meet the criteria for generalization of other sexual abuse survivors.

# CHAPTER 6

## THE WOMEN

In this chapter the student will provide a summary of the demographic characteristics and the long term consequences of the sexual abuse for each group member.

The eight women who commenced group treatment ranged in age from 23 to 42. Six of these women were divorced, one was married and one was involved in a lesbian relationship. Seven women had children. Three women had completed a grade 12 education, one had graduated from university, one had post-secondary professional training, one was attending university and two were planning to enrol in an academic upgrading program. All of the women were caucasian and had been brought up in Christian denominations. One women was employed in a professional occupation, one in a managerial position, one employed part-time, one unemployed due to illness and three women were unemployed and supported by provincial social assistance.

In general, all the women came from families of origin where verbal, physical and sexual abuse was the norm. The family characteristics involved: social isolation; alcohol abuse; male supremacy; role reversals; and multiple victimizations. Three women were abused by their fathers, one woman by her father as well as a neighbour. One woman was abused by her cousin and father. One woman was abused by her grandfather and older brother, and another women by her step-father. In addition to being abused by male caretakers at a boarding school, one woman was victimized by another women.

The long term consequences of the sexual abuse were strikingly similar for each of the women. In this section, the student will present a brief summary of the effects of the sexual abuse for each group member. To protect confidentiality neither names nor pseudonyms have been used:

**Client 1**

Client became sexually promiscuous during her adolescence. She married a man who was physically, verbally and emotionally abusive. She is extremely fearful about being around men; but only has a few female friends as she believes women can be more hurtful than men. Client 1 has low self-esteem, often feels enraged and suffers from generalized anxiety and frequent periods of depression. She is often frightened of leaving her child with a babysitter and feels isolated and trapped in her social situation. She joined the group hoping to learn how to clarify and maintain her boundaries when she is with other people.

**Client 2**

Client 2 likes to be extremely busy to keep her mind off her personal needs and often spends 16 to 17 hours a day working. At times she has been unable to slow down and has wondered if she maybe having a manic episode. Client 2 is a recovering alcoholic, suffers from infertility and has had frequent periods of depression. She has been unable to maintain a long term relationship and has become promiscuous, angry and cynical. She is cut off from her feelings and her ability to trust others. She is frequently victimized by men.

**Client 3**

Client 3 does not trust people, especially helping professionals. She is hypervigilant, wary and tests peoples limits. She is an extremely angry woman, but is unable to express her rage. She has a history of depressive episodes, suicide attempts and hospitalizations. She has poor parenting skills and a history of drug and alcohol abuse. She is needy. She has low self esteem and is often re-victimized in relationships. She craves attention and wants to be recognized by others, but lacks the social skills to get her needs met.

**Client 4**

Client 4 describes herself as a recovering alcoholic. She has had periods of depression and sleep disturbances. She describes herself as an enabler, a care-taker and a fixer in relationships. She over-values men and disparages women. She intellectualizes all situations and is unable to express her feelings. She has had frequent episodes of dissociation. She has few childhood memories. She is an avid reader, but has been unable to read any material on sexual abuse without becoming frightened, agitated and emotionally shutting down.

**Client 5**

Client 5 has experienced many difficulties. She has a history of drug and alcohol abuse. She has poor parenting skills and admits to period of self-hate and loathing. She became a prostitute at age 11. In her adult relationships she has repeated a cycle of physical abuse. She is aware of her behaviour as an abuser, but is unable to give up her sense of power, control and manipulation with her partner. She states she does not respect other women and she is often fearful that they will misunderstand her and hurt her.

**Client 6**

Client 6 describes herself as a recovering alcoholic. During the five months prior to group, she had been withdrawing from others. She had been experiencing flashbacks and periods of dissociation which she described as feeling confused, forgetful, and numb. She has experienced recent sexual difficulties with her partner and periods of depression and sleep disturbances. She has become tired of the pain and wishes it would stop. She would like to get on with her life, but the flashbacks and the shock of these memories has enraged her.

**Client 7**

Client 7 has a history of drug and alcohol abuse. She has a history of depressive episodes and suicide attempts. She is often re-victimized in her present relationships and has experienced intense feelings of rage. The continuing fear of confronting the issues of her betrayal and abandonment by her family has kept her looking for avenues to escape her pain. Addressing the issues of guilt, shame and rebuilding trusting relationships are paramount in her recover from her sexual abuse.

**Client 8**

Client 8 suppressed the abuse for many years. She began to experience flashbacks three years ago. She is a people pleaser and has been unable to set realistic boundaries for herself. She has been victimized in her personal relationships. She is frightened of her anger and rage. She has intellectualized her abuse and is unable to get in touch with her pain and sadness. She is frightened about being out of control and losing her identity if she shares her feeling with others.

# CHAPTER 7

# TREATMENT PROCEDURES

## Introduction

As previously discussed, the objectives of the group intervention program were to challenge distorted beliefs, decrease depression and alleviate the social isolation of group members. The objectives of the group were to decrease and/or alleviate these problems, in a measurable way. These changes can be evaluated by standard measures (Beck et al, 1961; Jehu, Gazan & Klassen, 1988; Russell et al, 1980). Furthermore, it was felt that the alleviation of one problem would interact with the alleviation of another problem. By using cognitive therapy to restructure the women's negative beliefs about their culpability in the sexual assaults, it was hoped their feelings of depression would also decrease. The anticipated results would be that the women would become more frank and receptive to one another's sensitivities. This would then reduce their feelings of social isolation.

The strategy determined by the student for achieving the stated goals was the implementation of the Women's Post Treatment Centre group treatment program using a humanistic growth/developmental model within a feminist perspective and a variety of therapeutic tools.

## Humanistic Growth/Development Model

This model advocates that women must examine social roles and then choose whether these roles reflect their personal needs and lifestyles. Sturdivant (1980) proposed a growth/development model for feminist therapy stating personal and social change, not adjustment to social norms is the goal of feminist therapy. Sturdivant's model reflects the concept of feminist humanism which is the positive belief in the capacity of women to self-actualize based on their own self-knowledge and human potential.

Women who were sexually abused as children often have negative beliefs about themselves, men, other women and society, and it is these negative beliefs that contribute to feelings of guilt, depression, low self-worth and social isolation. The humanistic growth/development model emphasizes growth and development beyond the long term consequences of sexual abuse. It emphasizes that human beings strive to create meaning from their experiences. By focusing on social and political factors that contribute to women's personal problems, this model provides information to women disputing their beliefs of personal blame for the sexual assaults. The growth development model provides a vehicle for a re-socialization process in group therapy by:

1. Release. This is a release of those feelings--anger, fear, guilt, and affection, that tend to block effective social task performance if not openly expressed and unburdened, preferably in the presence of others who are in comparable situations and can thus appreciate and respond to these expressions.
2. Support. This is a receiving of acceptance and affection through translated into achievement, which encourages the tapping of further strengths, with a resultant gain in self-esteem.
3. Reality orientation. Through seeing others in similar situations, seeing how they handle themselves, and seeing how others see oneself, each member can gain a clearer orientation to his own behaviour among peers.
4. Self-reappraisal. This involves attaining from all of the above a clearer perspective on oneself and others, new options for handling situations, increased ability to make judgements, and a more responsible taking hold of one's own life in relation to the reasons for being in the group. (Tropp, 1976, p.213)

It is anticipated that the re-socialization process begun in group will continue to be used by group members to evaluate their lives' experiences after the group's termination. Furthermore, the

cognitive restructuring of basic ideas about oneself, other women and society should continue to reinforce the women's feelings of power, competence and autonomy.

## Group Structure

Adhering to feminist beliefs the group sessions were structured and time limited. Therapists who have worked with female victims of childhood sexual abuse advocate time limited groups. Herman and Schatzow (1984) give three reasons for time limited therapy:

1) The time limit works to facilitate bonding and diminish the women's resistance to sharing emotionally important material.

2) The time limit offers structure within which regressive aspects of treatment could be contained.

3) The time limit permits a concentrated focus on the theme of sexual abuse with a minimum of distractions. (p.5)

Structured group sessions help provide a safe atmosphere for group members to explore their issues and concerns. Many therapists who have conducted group therapy sessions for women who have been sexually abused, advocate the importance of structure for this client population. These therapists contend that structure and boundaries are essential for this client group because chaos and uncertainty has been the lifestyle most sexually abused women have known (Cole, 1985; Courtois & Leehan 1982; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984). The format was designed to have group sessions lasting two hours with a ten minute break between check in and the commencement of the sessions weekly topic. Midway through the program, the sessions were extended by thirty minutes to provide the group members with extra time for discussion and closure. This decision, to extend the sessions, was made by the women in the group.

Group sessions were closed so no new members could be added once the program had begun. Women who have a history of childhood sexual abuse need consistency and security to develop mutual trust and to facilitate self-disclosure in a group.

Throughout the group and during the pre-group interviews, the therapists emphasized the importance of telling one's story or sharing one's feelings concerning the abuse. But there was no mandatory pressure for each woman to disclose the details of her own victimization. The amount, nature and rate of disclosure was a decision made independently by each group member. Throughout the group the therapists emphasized to the women the need for personal safety and that no group member should disclose any information to the group if she was feeling overwhelmed. Disclosures need to be made within a therapeutic window of personal comfort and safety. This is very important because premature disclosures or forced disclosures can be damaging to a woman who is not ready for this type of public exposure. Ultimately this can result in an experience of further victimization, but this time within the practicum group, members readily disclosed their experiences of sexual abuse and at times, needed to be held in check and "grounded" to ensure their psychological safety. The women appeared relieved to finally get their feelings about their experiences unfettered. It appeared that the safety of the group and the opportunity it provided for sharing and for being understood opened a floodgate of memories and feelings for the group members.

The group began each week with check in. This was an opportunity for open discussion where the participants could explore their reactions to previous sessions, their feelings and insights regarding their sexual abuse as well as exploring their present concerns. After break, the focus of the group was on a specific clinical issue such as shame or anger. The purpose of this part of the group was to give the women the opportunity to explore these issues within a structured format, as well as providing an educational and skill building component of the group.

Following the termination of sessions, the group met again on a self-help basis. This self-help group evolved after a group decision to meet for coffee following each session. This group included all group members who wished or had the time to meet. This outside group contact helped to develop further group cohesion. It reinforced feelings of solidarity and respect among the women. It allowed group members to have a greater amount of time to debrief after group.

**Group Exercises**

A variety of group exercises were used during the program. During several sessions, a brainstorm exercise was used. This involved posing a question to the group and having the members work together for an answer. This type of exercise was done during the first few sessions when the group developed its ground rules and goals.

Letter writing is another therapeutic tool for sexual abuse survivors, letter writing exercises utilized by the women, involved writing to an older and wiser part of themselves to help them feel empowered to heal from their sexual abuse. Another exercise involved writing to someone who had hurt them in the past and confronting the pain and loss of the experience. Often when the letter exercise is utilized, women choose to write to their offender or to a non-protective member of their family. These letters are not meant to be sent. Their value lies in the actual writing of the letter and its ability to give voice to the many painful memories and feelings. If a group member decided to send a letter, the consequences of this type of confrontation would have to be thoroughly explored with the woman and the group, by the therapist.

During the treatment program, group members were asked to bring in photographs of themselves as children and of their families of origin. Viewing old photographs can help women recognize how young, innocent and dependent they were when the abuse took place. It also may help to jar repressed memories and provide a chance to review family patterns of interaction.

During two group sessions, visualization exercises were used. In session three, visualization was used as a relaxation exercise to help calm the group members' anxieties after a number of stressful disclosures. The second visualization exercise used helped group members gain contact with their inner child. Diane Mariechild (1988) states visualizations move group members to a relaxed, trance-like state, "A trance is simply a very relaxed state of mind in which you are able to come in closer touch with your intuitive powers , images, symbols, and feelings" (p.1). It is important, when using this type of visualization with a group of sexually abused women, that before and during the visualization, they are given the opportunity to change, stop or leave the visualization if they feel uncomfortable.

During the thirteenth session, the group was involved in creating a collage. The group collage allowed the women to reflect, and express their growth and healing. The collage was a source of pride for the women. It was the realization of their courage and strength and a testament to their accomplishments during the group treatment program.

The ending stage of a group can be difficult for women who have been sexually abused as children because it might be like the first time they have had a sense of belonging. Goodman and Nowak-Scibelli (1985) state, "The realization that the group is going to end brings with it a resurfacing of long held feelings of abandonment and loss"(p.540). It is not only important for group members to grieve the loss of the group experience, but also important for them to focus on their strengths and the personal changes they have experienced since joining the group.

The closing exercise, called the Candle Ceremony, allowed group members to say goodbye to each other and comment on each others strengths and abilities. The Candle Ceremony involved the group forming a circle and each woman lighting a candle. The candle was lit, symbolizing the beginning of the group. Group members give and receive from one another, a positive statement to take with them from the group experience. The group takes whatever time it needs to complete this exercise. To symbolize

the dissolution of the group, the women blew the candles out. This helped the women end the group with care and respect.

The group program also had an educational component. The group watched the video, Its Not Like Scraping Your Knee (Krause & Hirsh, 1983) which presented several women who were sexually abused as children disclosing their assaults and discussing the long term effects of their abuse. This documentary was a deeply moving account of childhood trauma and adult pain. It was shown to help the group members get in touch with their own issues and perhaps to reawaken old memories that needed expression. It also emphasized to the group the commonality of women's experiences. It highlighted the strengths of the women who publicly expressed their pain and their rage about the continued victimization of female children in society. The video emphasized that social action, to prevent further abuse is a rewarding and empowering experience.

Throughout the group sessions the women were given access to a variety of articles and books on childhood sexual abuse. This access to educational material helped to decrease the women's feelings of isolation and provided them with hope for a productive and healthy life beyond their past.

Throughout the group program, the women were encouraged to become involved in self-nurturing activities. The women chose to pursue hobbies, recreational activities, to relax and spend special times with their families and friends.

Group members were also asked to keep journals. Journal writing can be beneficial to women who have difficulty expressing themselves in a group, because writing allows them to record their memories and feelings. They may decide at a later time, to share their journals with the group, or to keep them as a personal record of their struggle to heal from their abuse.

**Termination Interviews**

Following the last session, each group member was seen for a two hour termination interview. This gave each woman an opportunity to discuss with a therapist, her thoughts, and feelings of the group experience. The interview also provided an opportunity to complete the following measures: the Beck Depression Inventory; the Belief Inventory; the Revised UCLA Loneliness Scale (Short Form); the Client Satisfaction Questionnaire; the Women's Post Treatment Centre Feedback Form and a group Evaluation Measure. One women missed her termination interview and completed the group measures at the agency and had her individual therapist send them to the student. The termination interviews also provided an opportunity for closure for the client and therapist.

# CHAPTER 8

## REPORT ON SESSIONS

A series of fourteen therapy sessions were conducted on a weekly basis between May 21, 1992 and August 20, 1992. The sessions followed the stages of group development as outlined by Tropp (1976). This chapter will present a description of each group session and a brief outline of the activities and important issues that emerged each week. The formats of the group sessions have been placed in the Appendixes (A, B, C, D, E, F, G, H, I, J, K, L, M, N). The women who participated in the group sessions have been previously described in Chapter 6 of this report.

**Session 1**

The session began with the women sharing their fears and expectations of the group program. Many women hoped the other group members would provide them with support outside of the group sessions. All had attended recovery programs in drug and alcohol addictions and had been given sponsors to contact during the week after their meetings had ended. They felt similar contact during this group program would be beneficial.

This led to a discussion on personal boundaries and the women's ability to look after themselves while maintaining contact outside of Group. Initially all members agreed they could handle this responsibility. This focus on boundaries was maintained by the facilitators helping the group explore this issue.

One group member was able to say "no" against outside group contact. She felt she would be unable to care for herself, if she was overwhelmed by the other women's issues. Her ability to be open and state her feelings allowed the other women to acknowledge their own fears about being responsible for each other outside of Group. Group members were able to admit that being able to say "no" to outside

contact was a relief.

The remainder of the session was spent determining group rules (Appendix O).

**Session 2**

The Group opened with Check In. The women continued to voice fears and general anxiety about attending Group. The focus discussion was on the group members' feelings about being in a women's group, as well as their individual beliefs about a woman's place in society.

The group's feelings about being in a women's group, emphasized the safety and the opportunities it provided to share their experiences. Their beliefs about women were consistent with accepted social values which emphasize that women are powerless and dependent on men to validate their basic worth.

> I didn't know how I would react to a group setting. But it seems to be okay as long as it's just women. I have another counsellor, but he's a male. It's been difficult to talk to him about it. It feels comfortable to be with other women.
>
> It's nice having a woman to relate to. I had, I don't think the word is a low opinion, but I really haven't wanted to relate much to women. I guess I haven't seen them with having any kind of power at all, so I leapt in where I thought the power would be.

After these statements, the facilitators validated the participants' beliefs that women live in a misogynist society and we all are vulnerable to its effects.

Group members were then asked to discuss, for the benefit of new members, their expectations of the group program. These included not blocking their own feelings about sexual abuse, exploring their interpersonal problems, and working through their anger and rage.

The last half of the session involved answering the Miracle Question (Appendix P). This involved a spirited discussion which helped the women formulate personal and group goals.

At wrap up many group members were experiencing physical symptoms. Two women commented they felt tearful during the session. Two participants admitted to feeling nauseated as well as having headaches.

The group was advised by the therapists that their feelings indicated their bodies' ability to being to release its memories which had been held and blocked for many years. Group members were reassured this was the beginning of the healing process and it was important for each of them to care for their whole self, both their physical and emotional being during the group experience. The tears, nausea, headaches and physical discomfort are all symptoms of Post Traumatic Stress Disorder most often involving the undercontrolling defences of the intrusive phase of the disorder (Cole & Barney, 1987).

**Session 3**

Three themes emerged during Check In; these included feelings of anger; fears of losing control, and the need for further support after each session had ended. One woman disclosed that during the previous week she had experienced such intense anxiety that she felt she should go to a hospital to get medication to help calm her down. Another women stated: "When I leave here, I feel lost, out of control...I was very agitated inside and very critical of myself and outside things, really getting pissed off with things in general. I locked my keys in my car..."

A third group member commented that, "What I felt like after group, (last session) sometimes is a need to debrief with somebody in the group...to go out for coffee...and just calm down." This member's need for further "grounding" (Blake-White & Kline, 1985) due to the stress inherent in the early stages of group work initiated the idea of going for coffee, after each session by the women in the group.

The topic for the third session was "What is sexual abuse?" Group members were asked to explain what child sexual abuse meant to them. This gave many of the women the choice and/or the

opportunity of disclosing their experience of sexual abuse. Many feelings, fears and perceptions were voiced by the group members. Often, the tone of voice changed and the fear, hurt, confusion, and longing of a small child were heard for the first time.

One woman disclosed the pain of her lost innocence when she was violated by a neighbour at age eight and later her fear and panic when he threatened to kill her. "I was hurt, I was confused...Why couldn't he have left me alone! Sad, all I remember is sad and really ashamed...I'm feeling scared now, like the little girl."

Another woman disclosed how she felt when a woman sexually abused her when she was six years old. "She touched me and got me to touch her...I used to see her after and I used to really, really hate her and wish she would die...Until very recently I thought I was a real bad person...I can't remember being a child. That's what sexual abuse is to me. Being violated, being touched and...living with those feelings."

The women were also able to express how the sexual abuse had confused their feelings and ideas about trust and intimacy. One woman stated, "Family is a lie. Love is a lie. Trust is a lie...I think loving someone is very confusing..."

These disclosures were an extremely intense emotional experience for all group members. It also affected the student facilitator who felt quite numb after the session. The student later discussed her reaction with her practicum supervisor.

After the discussion on sexual abuse, the group had its break and when they returned the facilitators negotiated a fifteen minute extension on the group session. Due to the emotional nature of the disclosures of the group members the therapists suggested a grounding technique (Briere, 1989) to help the members return to the present. The group was given a relaxation exercise (Appendix Q). Prior to wrap up the group had a discussion on how they could care for themselves during difficult times .

(Appendix R).

**Session 4**

The focus of the Check In Four was to continue to process feelings from the last week's group. These included feeling anxious, irritable, disconnected from others, hung over (without using drugs or alcohol) and exposed. One group member stated:

I've been having this one flashback all week long. Always at night, when I'm in bed.

I start crying, but it's still there and it usually takes me, three or four hours to get back to sleep.

After Check In, it was suggested to group members that it might be helpful for them to have coffee together after Group, and the decision was made to meet after at a nearby restaurant. The topic for the session, survival skills, was introduced to the group. The women quickly identified many of their survivals skills:

**Survival Skills**

| | |
|---|---|
| •sports | •eating/not eating |
| •being outside | •being with animals, cats, dogs |
| •education | •school |
| •jobs | •dressing in suits |
| •drinking | •stare, isolate |
| •rebelling | •getting angry |
| •rage-acholic | •relationship/sex addict |
| •co-dependent | •fixing other people's problems |
| •drugs | •nicotine |
| •shopping | •sleeping |
| •space out, dissociation | •crisis - anything can be a crisis |
| •depression | •meditations, meetings |
| •reading, talking, denial | •lying, fantasy world |
| •looking for a way to feel better | •becoming absorbed with your children, your son |

| | |
|---|---|
| •forgetting, blocking everything out | •workaholic |
| •strive for perfection | •lie about a mistake |
| •justification | •tolerate abuse |
| •involving self in too much | •therapy |
| •using guilt to manipulate | •put others down |
| •criticize | •lash out at others |
| •become abusive | •being alone |

Weighing the benefits, costs and needs met by their survival skills proved more difficult for the Group. Group members were reminded by the facilitators how their survival skills had protected them and allowed them to survive the abuse. Group members stated:

> Spacing out was good because it allowed me to keep my feelings to myself. It's bad because I never lived a real life. I never learned ways to be close to people who would be good for me.
>
> The abusive behaviour... I'd be abusive to people so that I could feel in power. I can't justify or rationalize any of that, and say it was good because it wasn't. But that's how I coped - looked after myself. I hurt people.
>
> My addiction was sex. I didn't have to deal with reality...I didn't have to be alone. The costs... I ended up hating myself.

Prior to wrap up, the group was introduced to the Post Traumatic Stress Model (Appendix S). This model allowed the group members to identify their experiences of intrusive and dissociative symptoms and to accept their symptoms as normal reactions to a traumatic experience.

**Session 5**

The development of trust and the willingness to take risks within the group was evident this

week. One woman was able to disclose that she was a lesbian and a misinterpreted incident she had with a counsellor which had left her feeling betrayed, the previous week. She also acknowledged the guilt and shame she felt because of her physically abusive behaviours within her relationships. Group members were able to provide this woman with feedback about her disclosures. By supporting her, the group became more cohesive and the members more sensitive to each others needs.

Another participant emphasized how difficult it was for her to maintain her boundaries with others. She explained she had stopped attending a couple of support groups in order to help her friends. She became resentful, when she realized that she was not looking after herself. Two women discovered how their behaviours in their present relationships often mimicked their behaviour with their abusers. Both women noted that they resorted to helplessness and infantile behaviour to gain approval from others. Their insights regarding the need for boundaries and autonomy in interpersonal relationships provided group members with important information on how they themselves might be re-victimizing themselves in the present.

Another woman informed the group that she had tried to confront her abuser the previous week, but had not been able to follow through on her plan due to nausea and fear. This led to a group discussion on the need to clarify one's motives and goals before confronting the abuser (Herman, 1981).

Prior to the group's break, a discussion was held concerning the need for group members to give each other feedback. The conclusion was that each group member would try to remember to ask for feedback after speaking. The group also decided to extend the sessions until 12:00 o'clock and decided to see the video, **It's Not Like Scraping Your Knee** during session six. The remainder of the session involved a lively discussion on why sexual abuse happens and the roles of men and women in society.

**Session 6**

Check In Six revealed various feelings, awareness and discoveries by the group. One participant

focused on her relationships and her need for more support in her life. She identified that she often hides her needs from others and then doesn't get them met.

Another woman revealed, after having seen a counsellor, how she began to tentatively explore her sexual preference. She was reassured by the facilitators that it is healthy to go back to a place in your life and raise the questions you might have asked, had it not been for the sexual abuse.

One group member was angry. She perceived that she was being forced to attend Group and found this frustrating and demeaning. The Group supported her feelings of frustration. The facilitators suggested a meeting after group to explore this situation.

After the break the group viewed the video, **It's Not Like Scraping Your Knee**. The group was overwhelmed by the content of the tape. The women dissociated and many appeared to be in a regressive state. The group was encouraged to stand up, stamp their feet and walk around as a grounding technique. Group members stated:

> I have a really bad headache. I'm just numbed out.
>
> The tape makes me so sad. Your just so alone...how the girls, the women had no one to talk to. You feel so alone...Nobody is there to ask the right questions. That's the worst thing about sexual abuse.
>
> I didn't tell everybody everything that happened to me. I was afraid to."

Many women also commented on how frightened they were for their own children and their attempts to keep them safe from sexual abuse (Faria & Belohlavek, 1984). Prior to the wrap up the group was given a homework assignment.

**Session 7**

The topic for Session Seven was the Inner Child. During Check In the group was asked if anyone understood what the term inner child meant. The following replies were given:

It's my little girl who has all my feelings. All my memories.

Mines negative. I don't really remember any good things about my childhood.

Prior to the visualization of their own inner child the women were informed that each of their experiences would be unique and that over time their perceptions of their child would change as they healed from their sexual abuse.

Following the visualization the group was left with mixed insights:

It's hard to describe she just jumped into my arms. It's incredible, very beautiful. I feel so much.

I didn't want to go back. I was very angry and scared...I couldn't bring myself to say to her...the worst is yet to come...When I was supposed to go around the corner and meet my friends, I was all alone.

After the visualization the co-therapist helped each group member process her experience. It was interesting to note, what each woman revealed depended on the previous work she had done to connect with her inner child. In general, women who felt close to their child could express such feelings. Women who were afraid of the child or had no memories of her, became lost or frustrated within the visualization. Women who were angry with their child, felt their anger, their loneliness and their disconnection from themselves and others.

Prior to break the group passed around childhood photos. One member realized that her parents had taken only two photographs of her as a child. Another member showed a family picture with her father pinching her "bum". Another woman had no pictures of herself the year the abuse had occurred.

One member disclosed at age five, she had been sexually assaulted by a doctor. This led to a group discussion about the need to contact authorities about the assault.

Following the break the group was asked to share their homework assignment. Many group

members did not complete their assignment. One woman shared the letter she had written to her father with the group. Her disclosure was powerful and helped the other women connect with their own pain and sadness (Visualization Exercise, Appendix T).

**Session 8**

During Check in Eight, the women reflected on the last week's writing exercise and their relationships with their families and friends. One woman continued to explore her confusion about her sexuality and intimate relationships. Another woman concluded it was too soon for her to confront a doctor who had abused her as a child. Another member disclosed she had written a letter to her father, but was now plagued with feelings of guilt. The group suggested that she symbolically burn the letter as an acknowledgement of her freedom from her father.

At the conclusion of Check In, the facilitators reminded the group that each step they took towards personal awareness, needs to be celebrated. This is extremely important as victims of sexual abuse often experience all or nothing thinking and are unable to honour their own progress in healing from their abuse.

The topic of Session Eight was Anger. Many group members disclosed histories of family violence and fear surrounding the expression of anger. The group also discussed the difficulty women have accepting their own feelings of anger as well as the social taboo against women's expression of anger.

The group completed the anger exercise commenting on their caregivers' expressions of anger towards them and their own adult expressions of anger

> My mother yelled at me. Slapped me. Withdrew from me. My Dad - clenched his teeth. Called me names - stupid. Beat me. As an adult, I slam doors, clench my teeth, withdraw, cry and sleep. I deny I'm angry. I don't like to be angry. I feel it is wrong

to get angry.

My parents were both really critical. My Dad was sort of a rage alcoholic..after the rage and the bitting. He would sulk...I don't love you anymore was a very clear message. Now as an adult..I'll intellectualize it. I'll rationalize it. I'll minimize it...I control my anger...I'm fearful of letting it out.

The women described anger as violence and abandonment. They were informed by the facilitators that anger is about being who they are - saying "no" and setting limits or letting people know "this is me." It is not only a healthy emotion, but also an appropriate expression of self which can be learned.

**Session 9**

Check In Nine involved group members sharing their individual discoveries. One member remembered her grandfathers love and support during her childhood and proudly brought his photograph to group. Another woman explained she had been struggling with a lot of stress and anxiety. "I can feel it in my body now. It's swimming up and down my spine. It sits in my neck." She was encouraged by the group to become involved in a physical activity to help release her tension.

Prior to break the group members decided they would meet the faculty advisor the following week during the last fifteen minutes of Group. The topic of this week's session was Shame. Group members emphasized negative self-talk as contributing to their feelings of shame. They were able to attribute these thoughts to the childhood memories of the voices of their abusers. They noticed when they accepted these thoughts as true they often became involved in self defeating behaviour or left themselves open to further abuse from others. Disputing these beliefs contributed to healthier and more positive image about self. Importantly, the women were able to connect their feelings of shame to many societal messages about women's sexuality and women's bodies. Group members realized that it often takes a

daily effort for women to accept their physical self when they are constantly bombarded by society's image of the beautiful woman.

The group stated:

> I think shame is learned I don't think we start out being ashamed. I think shame is a reaction to outside negative input. You start feeling self-doubt. I think shame is negative self-talk. I had a lot of physical shame. It was about sexuality. It was shame about myself as a female person.

At the end of the discussion group members were informed by the facilitator that shame can be used as a tool of oppression. Shame is a means of keeping women in their place.

The women were also informed that shame is an injury that results when trust is broken. The most healing thing to do to fight feelings of shame is to become involved in relationships with people who accurately reflect our own goodness.

**Session 10**

The focus of Check In Ten was on trust, change and loss. One member informed the group she decided to resign from her job after an unexpected confrontation with a co-worker. Initially she thought, "It's all my fault and I'm a bad person." Now she was able to acknowledge that the stress and unrealistic deadlines of the job had become too much for her. One woman left Group during Check In. She was joined by one facilitator.

Prior to break an overview on grief and the grief exercise was given to the group. Shortly after the exercise began, the group was asked to reopen Check In to give one woman the opportunity to share the events of her past week. She stated:

> I have until ... to get my shit together or they are going to go for permanent custody of my child. The social worker outright called me a liar and a manipulator. I'm afraid to

trust anyone else including this group. I have four months. How am I going to clarify my sexual abuse issues and my other issues in four months.

The group was able to support this members feelings of hurt, betrayal, anger and loneliness. They replied, "Sexual abuse takes time to heal from. It's not a course." This opportunity to express her fears in a safe place allowed this woman to resolve her crisis. She concluded, "I'll go day by day...

**Session 11**

The issues discussed during Check In Eleven included anger, revenge fantasies and dealing with a perpetrator. All group members had revenge fantasies and were reassured that this was a normal reaction to their sexual abuse. One woman stated, "I wouldn't like to be in a room alone with him. But I'd like to be in a room, face to face and let all my anger out and get on with my life." Another woman disclosed that she had tried to talk to her father about her sexual abuse, but received no validation from him and as a result was furious. She stated, "I'm really angry at him and I'd like to go out and kill him...I really felt like punching him in the nose...If I had a gun, I would have shot the gun..."

After break the group focused on their relationships. One woman who was involved with a chemically addicted person stated, "I have to make a decision to leave the relationship or continue." She realized he was using again felt he was pushing her back to her addictions. Group members urged her to trust her intuition and leave the relationship. They surmised that it was their childhood fear of abandonment that often kept them in abusive relationships.

Another member stated she remained in an abusive relationship for an extra year because the AA philosophy recommended not to make any personal changes during the first year in recovery.

All group members disclosed that they had experienced difficulties in choosing partners, maintaining relationships and coping with the loss of a relationship.

The group ended with members giving each other a hug.

**Session 12**

The Group opened with discussion on the grief exercise. One group member had written a book of fifty pages. Another group member stated, "I don't want to do it, I've had too many losses. My whole life had been one loss after another". The wording of the grief exercise was unfortunate as group members interrupted the exercise as having to focus on all their losses which was overwhelming. The student's expectation was that they would focus on only one or two experiences. However, this expectation was not communicated to the group. This led to a discussion where group members decided they would focus on only one loss and would share this with one another the following week. The group then decided to have Check In and complete a collage after the break.

Check In focused on the issues of personal choices, safety and relationships. One woman revealed that at age eighteen she vowed, never to cry. She concluded, "How absolute it is not to cry. How unhealthy it is for me not to express how I feel." Two women revealed how they had been recently re-victimized. One related a story on how she had been conned out of $1,500.00 by a man with a hard luck story. Another woman revealed that she had given a man her phone number, but as soon as he called she began to feel something was not right. She later learned he had been charged with harassing another woman. The group responded by emphasizing how important it is to listen to your intuition and to act on it. They pointed out that feelings are proof of certain realities and that you can trust your body for this type of information.

After the break the women completed a group collage.

**Session 13**

The group began with a discussion concerning what activities would take place during the last session. The group decided they would meet at the agency and spend quiet time reflecting on their experience. Check In Thirteen focused on good-byes, new opportunities and family relationships. One

woman announced to the group that her mother was visiting the city. She stated, "I'm looking forward to getting to know her, because I don't really know her. I might have spent a year of my life with her. It's the first time I've experienced her without being on some kind of chemical."

Another women stated, "I'm happy I had the courage to join the group. I found when things happened in my life I could hear you guys sitting and sharing." This member's comments illustrate what Briere (1989) refers to as the portable therapist.

One group member shared with the group how difficult it had been for her to attend a family celebration. She stated, "I didn't want to be there with these people, I couldn't look at any of them..." Swink and Leveille (1986) eloquently point out the losses of victims of sexual abuse endured when they attempt to separate from their families to regain their sense of self-worth. Later in the session this woman disclosed the rage she felt when her family attempted to gain custody of her own child. She stated, "I flipped. I tried to kill them. The police came and removed me. I was so serious..."

Briere (1989) discusses the vulnerability that sexual abuse victims have to rage, when exposed to stimuli that restimulate feelings of exploitation and injustice.

The group responded to this woman's disclosures with compassion, understanding, acceptance and support. The co-therapist reassured her that her reactions were not unique, but were shared by many victims of sexual abuse. At break, this woman left group and threw up. After break the group discussed the grief exercise.

**Session 14**

Check In Fourteen provided each group member with the opportunity to reflect and review experiences. One woman stated: "I learned how to cry. I needed to cry."

Another member stated: "I'm going to miss the honesty...in this group I could say whatever spilled out of my mouth... It's possible to be open to people. You just have to find the right ones."

At this point the women were advised by the co-facilitator that the group had provided them with an intense experience of intimacy which is difficult to duplicate in the community. They were reminded to respect their boundaries and carefully evaluate the demands and needs of the people in their lives.

After break the women quietly said good-bye to each other.

# CHAPTER 9

# RESULTS

In this chapter the student will present and discuss the results of the Group Treatment Program. Three standard measures, The Beck Depression Inventory (BDI), the Revised UCLA Loneliness Scale (Short Form) (RULS) and The Belief Inventory (BI) were used to evaluate levels of depression, loneliness and negative beliefs of the group members. To protect confidentiality, client numbers (1-8) do not correspond to client numbers (1-8) in chapter six.

## Beck Depression Inventory (BDI) (Beck, 1978)

The results from the BDI pre-test and post-test measures were compared to determine changes in the scores of each group member. A score of 21 or over indicates a clinically significant level of depression (Beck & Beamesderfer, 1974). The group therapy program was directed at reducing the level of depression in group members. A decrease in BDI score was expected between the administration of the pre-test measures and the administration of the post-test measures. The individual results from the Beck Depression Inventory, for each group member, are presented in Table 1.

**Table 1**

**Individual Results of the Beck Depression Inventory**

| CLIENT | SCORE AT ASSESSMENT | SCORE AT TERMINATION |
|---|---|---|
| 1 | 26 | 36 |
| 2 | 26 | 11 |
| 3 | 17 | 5 |
| 4 | 18 | 8 |
| 5 | 27 | 11 |
| 6 | 7 | 4 |
| 7 | 20 | 8 |

| CLIENT | SCORE AT ASSESSMENT | SCORE AT TERMINATION |
|---|---|---|
| 8 | 32 | 36 |

Analyzing the data collected from the Beck Depression Inventory, it was found that: At assessment four (50%) of the individuals in the group had scores indicating clinical depression and four (50%) of the group members scored below the clinical cut-off point of 21. At termination of the group therapy, six (75%) group members had scored below 21 in the BDI indicating depression was not a problem at this time. Two group members (25%) scored above the cut-off indicating severe levels of depression.

**Table 2**

**Group Results for the Beck Depression Inventory (N=8)**

| | Assessment | | Termination | |
|---|---|---|---|---|
| Score | N | % | N | % |
| 21 or above | 4 | 50% | 2 | 25% |
| 20 or below | 4 | 50% | 6 | 75% |

**Decreasing Depression**

At assessment four women (50%) of the group had scores indicating clinical depression. The two women who scored as moderately depressed at assessment, both dropped to insignificant levels of depression at termination indicating the group therapy program decreased their levels of depression. One woman, who scored at a severe level of depression at termination also scored at a severe level of depression at assessment; this individual had a history of hospitalizations for depressive episodes. The group program had no effect on decreasing her level of depression, which is not surprising, considering her history of a recurring depressive disorder. At termination it was suggested she contact her psychiatrist to be assessed regarding her need for an anti-depressant medication. Offering a client the choice to use

medication to help treat a depressive illness can be an effective tool in enhancing the woman's sense of self-control. The other individual who scored at a severe level of depression at termination scored at a moderate level of depression at assessment. Her vulnerability to depression was likely to have been enhanced, as she had chosen not to be intensely involved with the group until the end. It is likely that these depressive feelings were due to a lack of closure for her. The end result was a hurried attempt to deal with her issues at termination of the Group, rather than gradually through the entire fourteen weeks.

In general, the intervention of the Group Program was effective in decreasing dysphoric mood disturbances associated with the long term consequences of sexual abuse, but was not effective in treating clinical depression.

**Revised UCLA Loneliness Scale (Short Form) (RULS)**

The results from the RULS pre-test and post-test measures were compared to determine changes in the scores of each group member. It was assumed that contact with other women who had been sexually abused in childhood, would help alleviate feelings of loneliness in group members. Based on a group norm of 9.5, scores above this level would indicate unacceptable levels of loneliness. Scores were expected to decrease between the administration of the pre-test measures and the administration of the post-test measures. The individual results of the group on the Revised UCLA Loneliness Scale (Short Form) are presented in Table 3

**Table 3**

**Individual Results of the Revised UCLA Loneliness Scale (Short Form)**

| CLIENT | ASSESSMENT | TERMINATION |
|---|---|---|
| 1 | 11 | 9 |
| 2 | 10 | 10 |
| 3 | 9 | 11 |

| CLIENT | ASSESSMENT | TERMINATION |
|---|---|---|
| 4 | 9 | 11 |
| 5 | 11 | 10 |
| 6 | 9 | 11 |
| 7 | 9 | 6 |
| 8 | 8 | 11 |

The group results for the Revised UCLA Loneliness Scale (Short Form) were analyzed for eight women. At assessment five women (62.5%) scored below the norm indicating they felt less lonely than the average adult woman. Three women (37.5%) scored above the norm of 9.5. At termination of the group intervention, two women (25%) scored below the norm indicating they felt less lonely than the average adult woman. Six women (75%) scored above the norm indicating an increase in loneliness after the group intervention.

**Table 4**

**Group Results for Revised UCLA Loneliness Scale**

(Short Form) (N=8)

| | Assessment | | Termination | |
|---|---|---|---|---|
| Score | N | % | N | % |
| 9.5 or above | 3 | 37.5% | 6 | 75% |
| 9.5 or below | 5 | 62.5% | 2 | 25% |

**Alleviating Loneliness**

An analysis of the scores from the Revised UCLA Loneliness Scale (Short Form) leads one to conclude that the Group Program did not help to alleviate feelings of loneliness and alienation for its

members; but the scores do not entirely reflect the group experience. All the group members felt by sharing their experiences and feelings, they had learned to respect and value other women. They also experienced a feeling of closeness and connection to each other. Friendships among the women did develop during the Group Program. The women who attended the Group all had different levels of social supports in the community. Many of the women were divorced, had few friends or ongoing family contact. Group members who had experienced family support and stable relationships were less likely to feel alienated or alone. Throughout the Group, the women discussed their problems in developing and maintaining relationships. Often they did not trust their intuition or perceptions that a relationship was abusive. Each group member surmised it was her inner child's fear of abandonment that often kept her involved in these relationships. Learning to trust their own feelings and to act assertively when problem solving, remained a skill the women needed to further develop and better utilize in their lives. During Group the women did become more aware of their personal boundaries and were able to address their needs for healthier and more stable social relationships. The women's increased knowledge of their rights in a social relationship and their increased awareness of the frequency of their own revictimization with others may have increased the Group's reported levels of loneliness at the program' end. The length of the treatment program may have also contributed to the participant's feelings of isolation as they did not have enough time to once again feel trust in others outside of the Group.

Perhaps the short form of the Revised UCLA Loneliness Scale (RULS) was not a precise enough instrument to measure the women's feelings of loneliness. The longer 21 item instrument may have provided more depth and information regarding the women's experience of loneliness. Perhaps a different measure specifically focused on the level of social support valued or needed by women who were sexually abused as children, needs to be developed to explore this dimension of their life experience. This type of measure could be a useful tool in future studies.

**Belief Inventory (Jehu, Klassen & Gazan, 1984/5)**

The belief inventory is a measure of distorted beliefs associated with childhood sexual abuse. These beliefs contribute to feelings of guilt, depression, shame and mistrust. A score of 15 or more indicates a clinically significant level of negative beliefs. The measure was administered on three occasions, including at assessment, at the midpoint of group sessions and at the termination of the group sessions. As one of the objectives of the Group Therapy Program was to decrease the level of distorted beliefs, the scores were expected to go down at each administration of the belief inventory. The individual results of the Group on the Belief Inventory are presented in Table 5.

**Table 5**

**Individual Results of the Belief Inventory**

| CLIENT | ASSESSMENT | MID-POINT | TERMINATION |
|---|---|---|---|
| 1 | 23 | 10 | 3 |
| 2 | 50 | 0 | 8 |
| 3 | 13 | 7 | 28 |
| 4 | 53 | 30 | 23 |
| 5 | 24 | 21 | 5 |
| 6 | 16 | 9 | 8 |
| 7 | 51 | 34 | 17 |
| 8 | 24 | *missed | 20 |

The group results for the Belief Inventory were analyzed for seven individuals, as one group member did not complete the midpoint measure. At assessment, six (86%) women had clinically significant levels of negative beliefs and one (14%) woman scored below the cut-off point of 15. At midpoint, three (43%) group members had clinically significant levels of negative beliefs about sexual victimization and four (57%) group members scored below the cut-off point. At termination 3 (43%)

women had clinically significant levels of negative beliefs and four women (57%) scored below the cut-off point of 15.

**Table 6**

**Group Results for Belief Inventory (N=7)**

| | Assessment | | Midpoint | | Termination | |
|---|---|---|---|---|---|---|
| Score | N | % | N | % | N | % |
| 15 or above | 6 | 86% | 3 | 43% | 3 | 43% |
| 14 or below | 1 | 14% | 4 | 57% | 4 | 57% |

**Challenging Negative Beliefs**

The Group Treatment Program was effective in decreasing the women's distorted beliefs about themselves and others. The Program allowed the women to understand they shared similar problems regarding guilt and low self-worth and that these problems stemmed from the sexual abuse rather than personal deficits. The group experience allowed the women to confront the reality that they were not to blame for the sexual abuse but were to place the blame back on the abuser. The educational component of the Group Treatment Program provided the members with information regarding society's denial of the abuse and the opinions available to complete the healing process.

Although the percentage of scores at midpoint and termination remained the same, all the individual scores from the Belief Inventory continued to decrease throughout the assessment, midpoint and termination points of the group. The decreasing scores indicated that the growth/developmental model (Sturdivant, 1980) used to restructure the group member's beliefs about self, others and society was effective. The Group Treatment Program did provide the women with more insightful and socially

perceptive beliefs about their experiences.

**Group Evaluation**

At termination of the group therapy sessions, each woman was asked to complete three group evaluation measures. The first measure was the Women's Post Treatment Centre Feedback Form. The group members were asked to identify what had changed for them since the beginning of the group. Their responses are placed in Appendix U. The second measure was a Group Evaluation Measure that was designed by the student (Appendix V). The women's responses are placed in Appendix W. The third measure was the Client Satisfaction Questionnaire. The group members individual responses are placed in Appendix X. The group responses to the Client Satisfaction Questionnaire are presented in Table 7:

**Table 7**

**Client Satisfaction Questionnaire (CSQ)**

Overall, the responses to the CSQ were positive indicating the eight group members perceived the group therapy as a valuable and useful experience for them.

**Group Results for Client Satisfaction Questionnaire (CSQ)**

| Score | N | % |
|---|---|---|
| 19 or above | 5 | 62.5 |
| 18 or below | 3 | 37.5 |

**Discussion**

The majority of women who attended the group reported that their feelings of depression, shame, isolation and stigma had been greatly reduced by attending the treatment program. They had learned to

value, respect and trust other women. The group had given them the opportunity to gain some measure of control over their feelings and various aspects of their personal lives. The program helped the women to "normalize" their experiences and value themselves. They became more confident and capable of acting on their own behalf. They came to understand the reasons for their past actions and were now aware of new possibilities and solutions to their person difficulties which stemmed from their sexual abuse. Their self-concepts changed from believing they were powerless to heal from the abuse, to recognizing their personal strengths and abilities. Many of the group members stated that he handouts on clinical issues given at the end of each session were valuable educational tools; tools they could keep, read over and use for support in difficult times. The women also acknowledged the safety the group had provided for them to explore their issues and how they valued the knowledge, support and respect they received from the group facilitators. All members wished the group had run longer. The videotaping of the group was identified as a concern by the women who felt they would have been more comfortable without this distraction. However, the videotaping did not prevent the women from being open and frank and did not impede the group process. All members had consented to the videotaping procedure. Overcoming the consequences of sexual abuse is a life-long process. The benefit of the short term program was to provide the women with the opportunity to begin to deal with their issues from a position of strength, courage and self-respect.

# CHAPTER 10

# IMPLICATIONS, RECOMMENDATIONS AND CONCLUSIONS

In this first part of this chapter, I will discuss the effectiveness of the group's structure and the use of therapists. In the second half, I will discuss my personal learning make recommendations for future studies and conclude.

## Group Structure

The group structure was a valuable intervention tool in facilitating a safe environment for group members to explore the long term consequences of their sexual abuse. The group was closed and time limited to fourteen weeks. The format moved from general to more specific issues as trust developed and the group members began to disclose personal experiences and beliefs. Incorporated within the structure of each group session was the examination of the social, economic and political factors that influence women's lives and their beliefs about self. Weekly topics were provided to group members so sessions would offer no surprises and a consistency and flow could be maintained throughout the treatment program. The process was stable and emotionally safe. Feedback was requested from the women and their needs and suggestions were given priority. Helen Levine (1983) states that feminist counselling involves a healing process, an educational process and a political process. These criteria were met by the group treatment program and proved to be essential components in providing validation and treatment to women who were sexually abused during their childhood.

Check In was the heart of the group treatment program. It provided the women with the opportunity to discuss their present concerns and to connect these to their past experience of sexual abuse. Check In allowed the women to explore their feelings, to reflect on the commonality of their experiences and to support one another. This aspect of group allowed for the integration of new beliefs, concerning

clinical issues, processing of their feelings from week to week.

The second half of group focused on specific clinical issues. It offered an educational process through the completion of group exercises, discussions of community resources, a video presentation, handouts and suggested readings.

The skill building component of the group treatment program was achieved through the Check In. This involved group members increasing their skill in identifying, naming and verbalizing their feelings. Also most of the group exercises assisted the women in developing the skill of cognitively restructuring their experiences and emotions stemming from the abuse. What was significant for the women was that they kept the group exercises which gave them the opportunity at home to reuse them again and again. Many group members commented that the use of visualization and relaxation exercises were helpful and comforting in reducing their levels of anxiety and they would have benefited from more group time being spent on teaching the use of these techniques.

Throughout the sessions the women were asked to question and examine the beliefs they had about women. They were asked to consider: 1) How did these beliefs develop? 2) Who benefited from these beliefs? 3) Are they true? 4) Do they accurately reflect a woman's worth? 5) How did these beliefs influence their lives? 6) How were they going to live with these belief? : 7) Did they want to change them? 8) Could they? 9) Would they? 10) What kind of political/social action was comfortable for them? And 11) How did these beliefs make them feel? Two participants responded by saying:

> I don't think the word is a low opinion, but I really haven't wanted to relate much to women, I guess I haven't seen them with having any power at all. Shame is learned.
>
> I was shamed about my sexuality, my body and myself, as a female person. I had to work hard just to accept myself.

The examination of their beliefs about women helped the group members become more

politically astute and to connect their personal experiences to social forces.

### Therapists

The use of three female therapists as to facilitators in the group treatment program supports the literature that this form of intervention is effective in facilitating groups for women who were sexually abused as children. Forming a relationship with female therapists was particularly significant for women who had been hurt and devalued by women in their lives. It helped to promote a level of trust and respect with the other group members and it became the vehicle for the healing process. Lerner (1988) states, "to be accepted by another woman in the context of close relationship characterized by trust and mutual respect may be more validating of one's worth and self-esteem than working with a cross-sex therapist" (p.22).

Working with female therapists allowed the women to be more open and frank regarding their sexual abuse without the threat of being exploited and to feel greater acceptance of their hurt and pain. Within the group women were able to explore their clinical issues and then look at their subsequent behaviour.

For the therapists the important component of the co-therapy model is the support it provides for each therapist involved in the group process. For the student the co-therapy model provided the opportunity to explore the values, skills and knowledge needed for group therapy work by the process of modelling and discussion with the co-therapists.

### Individual Therapists

When designing the group treatment program providing a safe environment for each woman to explore her issues was of prime importance. Therefore, each group member was encouraged to become

involved in individual therapy sessions, because ongoing contact with an individual therapist, can help a group member re-integrate the intense emotions, that are aroused during the group experience.

When group began five women were involved in individual therapy. All women were asked to sign consent forms so their individual therapists could be contacted. This was necessary as there is the possibility that the two therapy processes can be at odds with each other (Herman & Schatzow, 1984) which can place the client at risk.

During group one woman was receiving individual therapy from one of the group's co-therapists. Having the same therapist in both processes can provide a woman with the sense of security and continuity. It does allow her to see her therapist in a different setting which broadens her perception of her therapist's skills and humanity. It provides the therapist with the opportunity to see how her client interacts with others. It also allows the therapist to receive feedback on her client from other group members and colleagues.

During the course of the group, the three group members who were not being seen by an individual therapist requested this form of intervention. They were immediately seen by the staff at the Women's Post Treatment Centre. When planning future groups, I believe it is important that ll participants be involved in individual therapy prior to the commencement of group and during the group program. During this practicum, all the women felt they needed and benefited from concurrent individual therapy sessions.

## Unanswered Questions

Although many of the clinical issues involved in the treatment of women sexually abused in childhood have been addressed, many questions about these clients still remain. One member of the student's practicum group was sexually abused by a woman. Russell (1986) states only about 5 percent

of all sexual abuse of girls is perpetrated by older females and the abuse is less traumatic than abuse from a male perpetrator. This student believes all forms of sexual abuse creates psychological trauma for the victims which can not be dismissed or diminished by the gender of the abuser. As the group member's feelings of violation was not less than other group members further research investigating the effects of same - sex sexual abuse needs to be taken in the future.

A second population of women with special issues relating to the after effects of childhood sexual abuse is women with a lesbian orientation and lifestyle. One group participant felt she would benefit from joining a short-term group treatment program with other lesbian sexual abuse survivors. Research into the needs of this population warrants further analysis and study.

Many women with a history of sexual abuse are diagnosed as having a Borderline Personality Disorder. According to DSM-111-R, Borderline Personality Disorder involves:

> a pervasive pattern of instability of mood, interpersonal relationships, and self-image, beginning by early adulthood and present in a variety of concepts, as indicated by at least five of the following:

1) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of over idealization and devaluation.
2) Impulsiveness in at least two areas that are potentially self-damaging, e.g., spending, sex, substance abuse, shoplifting, reckless driving, binge eating (Do not include suicidal or self-mutilating behaviour covered in [5]).
3) Affective instability: marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days.
4) Inappropriate, intense anger or lack of control of anger e.g., frequent displays of temper, constant anger, recurrent physical fights.

5) Recurrent suicidal threats, gestures, a behaviour of self-mutilating behaviour.

6) Marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values.

7) Chronic feelings of emptiness or boredom.

8) Frantic efforts to avoid real or imagined abandonment. (Do not include suicidal or self-mutilating behaviour covered in [5]). (p.347)

One group member met the criteria for this disorder. A number of authors (Briere, 1984 and Herman, 1992) have speculated that the presentation of a Borderline Personality Disorder is similar to the symptoms of the Post Traumatic Stress Disorder which has not been widely recognized in the psychiatric community. I concur with these authors' speculations that many women with histories of sexual abuse are misdiagnosed as suffering from a Borderline Personality Disorder. This misdiagnosis has caused these women to be mistreated within psychiatric settings. The label has many negative connotations. The most significant are that these women lie about the severity of their distress to maintain a "sick role" and to manipulate mental health professionals. This has resulted in the history of sexual abuse being minimized or dismissed and the women being revictimized by the mental health system. How this specific client population can be served in the future needs to be investigated. Women with these presenting complaints are often excluded from group participation or labelled disruptive in a group setting and subsequently do not receive the therapy they need and deserve. Group work would be effective, but the format would need to address issues of impulse control, reality testing, affect regulation, interpersonal relationships and the perpetual crisis state that often precludes effective intervention with these clients. A group designed to focus on problem solving, cognitive restructuring of black and white thinking as well as the long term consequences of sexual abuse within a time limited format could be

beneficial to this population.

**Personal Learning**

As a beginning therapist in the area of sexual abuse, I became aware of the importance of maintaining secure boundaries within the therapeutic relationship for myself and my clients. Childhood sexual abuse involves emotional and physical boundary violations, which results in severe damage to the clients ability to trust herself or others. Secure boundaries create a safe environment where the work involved in recovering from the sexual abuse can proceed without fear of further revictimization. By maintaining clearly defined boundaries, the therapist provides her clients with the opportunity to identify appropriate personal and social boundaries and to begin to evaluate their effectiveness in social situations. Boundary maintenance is not a rigid stance taken by the therapist and client, but rather an evolving process that involves reflection, negotiation and flexibility by both parties. Providing appropriate and secure boundaries within a therapeutic relationship is a major responsibility for all therapists.

The practicum group also reinforced my belief about the need and benefit of having a professional support system to review ones clinical work. As well as the need to balance your professional and personal life, and to nurture yourself and respect your own needs.

I was inspired by my clients' courage, determination and hope. Focusing on the women's experiences gave me a greater understanding of the social and cultural forces that cause sexual abuse and maintains women's lack of power in society. Most significantly, the women taught me the importance of focusing on individual and group strength. This strength provided the women with the dignity and resolve to move from the stance of victim to the stance of survivor.

## Conclusion

The use of the humanistic growth/development model within a feminist perspective to provide group treatment for women, who were sexually abused during childhood proved to be a highly effective mechanism in decreasing mood disturbances, challenging negative beliefs about self and others and decreasing social isolation and alienation of group members.

By participating in group therapy the women's feelings of shame and guilt for the sexual abuse was decreased. The group members began to understand the innocence and dependency they had in childhood was violated by their abuser and this violation was not their faulty. By exploring the long term consequences of their sexual abuse, the women began to understand their feelings and choices as valid reactions to traumatic experiences.

By disclosing their sexual abuse in group, the women broke down their feelings of isolation and alienation from others. The pain and the power of their sexual abuse history was decreased. During the treatment program, friendships developed. Although this would appear to be a common development, it is significant due to the lack of personal connections many of the group members had in their lives.

The group's intervention strategy which emphasized a cognitive therapy approach helped the women to acquire new beliefs about themselves, their families and society. By reframing survival tactics and experiences in group, the women began to believe in themselves and their potential. They began to nurture themselves. Some women kept journals, others began to engage in physical activities. Time alone was not interpreted as deprivation, but as a healthy choice for personal renewal. As group members began to learn about personal rights and began to express their needs to others, they asserted themselves in a variety of situations. One woman resigned from an abusive employment situation. Another woman who wanted to spend more time with her family, negotiated with her employer to decrease the number of hours she had to work.

The awareness group members gained about themselves, their interactions with others and their rights to express their needs all contributed to feelings of competence, empowerment and respect. A women's group that emphasized the reality of women's lives, helped the group members to realize that many of their experiences and issues affect all women and they were not alone.

This practicum was successful. The group provided the women with increased social support, decreased various mood disturbances and challenged their negative beliefs about self and others. The practicum provided the student with a valuable educational experience and increased professional skill and wisdom.

## Author Notes

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# APPENDIXES

## Appendix A

### Format, Session 1

Goals

1. To introduce group members to each other.
2. To socialize group members into the group process and role.
3. To develop group rules.

Activities

1. Introduction: [Name Tags for Group Members] What is it like for you to be in the group this morning?
2. Go Around: [Focus on Feelings] What are you expected from the group?
3. Brainstorm: What do you think should be in groups ground rules?
4. Continue to develop and refine the group's ground rules.
5. Introduce the concept of keeping a journal to help group members clarify issues for themselves.
6. Wrap up.

Handouts

1. Group Agenda.
2. Women's Post Treatment Centre's article on keeping a journal.

Two group members missed the first session. All facilitators attended the first session to introduce themselves to the women and to explain their roles and coverage during the program.

## Appendix B

### Format, Session 2

Goals

1. The introduction of two new members to group.
2. To continue to facilitate group members contact, participation and sharing.
3. To enable group members to explore their needs for healing and articulate group goals.

Activities

1. Check In.
2. Last Week Review: What are you expecting from group? Share and discuss this with the two new members.
3. The Miracle Question. If a miracle happened in the middle of the night and you had overcome the effects of childhood sexual abuse to the extent that you no longer needed therapy and felt quite satisfied with your daily life, what would be different? Dolan T.M. (1990, p.28)
4. Share and discuss.
5. Wrap up.

Handouts

1. Group Rules.

   All group members attended group.

## Appendix C

### Format, Session 3

Goals

1. To enable group members to discuss and share what child sexual abuse personally means to them.
2. To introduce the concept of self-care.

Activities

1. Check In.
2. Session Topic: What does child sexual abuse mean to you?
3. Relaxation Exercise.
4. Nurturing.
5. Wrap Up.

Handouts

1. The Miracle Question Group Answers/Goals.
2. Bepko C. and Krestan J., Nurturing, (1990, pp. 81-91).

All members attended group.

## Appendix D

### Format, Session 4

Goals

1. To enable group members to identify adaptive behaviours as survival skills.
2. To help group members alleviate self-blame through reframing survival skills as defence mechanisms.
3. To enable group members to make choices about these defence mechanisms through increasing their awareness about the benefits and costs and the underlying needs the behaviour meets.
4. To introduce the Post Traumatic Stress Model to the group members.

Activities

1. Check In.
2. Brainstorm with the group, "Ways you have survived."
3. Have each woman identify a survival skill she has used and look at its benefits, costs and the underlying needs it meets for her.
4. Discuss and share these costs, benefits and needs in group.
5. Introduce and discuss the Post Traumatic Stress Model.

Handouts

1. Extremes of State Experienced by Post Traumatic Stress Survivors Adapted by the Women's Post Treatment Centre from, Cole C.H. and Barney E.E. (1987).
2. Flashbacks, Blume E.S., (1990, pp. 103-105).
3. Nurturing: Answers from the group exercise session 3.

Two group members did not attend session four. One contacted the agency stating she would attend the next session.

## Appendix E

### Format, Session 5

Goals

1. To help group members examine their need for feedback and closure.
2. To consult with the group members as to whether they felt that they needed to extend the session for another fifteen to thirty minutes to allow for more discussion time.
3. To raise awareness of child sexual abuse as a social problem related to our assumptions about men and women in our society.

Activities

1. Check In.
2. Discussion on group time, feedback and closure.
3. Discussion:
   1. Why Sexual Abuse Happens
   2. Stereotypes
4. Wrap-Up.

Handouts

1. Kelly L., (1988, p.85). Common Myths and Stereotypes About Sexual Violence.
2. The Boston Women's Health Collective (1981, p.102). Summary of Myths that Supports Violence Against Women.
3. Penfold S., (1983, pp.103-106).
4. Sanford L.T. & Donovan M.E., (1984, pp.105-129).

One group member missed Session Five.

## Appendix F

### Format, Session 6

Goals

1. To give group members the opportunity to share their experiences of abuse and provide them with support while lessening their feelings of guilt and shame.
2. To have them identify what they need to do now to heal from their sexual abuse.

Activities

1. Video
2. Discussion
3. Homework Assignment: Write a letter to someone who has hurt you in the past/or present focusing on: 1) What happened; 2) How you felt.
5. Wrap Up.

One group member missed this session.

## Appendix G

### Format, Session 7

Goals

1. To help the group members get in touch with their inner child.
2. To have the group members explore significant experiences through the child's eyes and then gain a different perspective through the adult's eyes.
3. To continue to have the group members share their experiences with one another.

Activities

1. Check In.
2. Visualization.
3. Processing the visualization.
4. Childhood Photographs.
5. Discussion.
6. Homework assignment from last session.
7. Wrap Up.

Handouts

1. Evidence of Childhood, The Child Within, Observing Children, The Child Within Writing Exercise; Adapted from Davis L. (1990).

Two members missed group. One was ill. The other did not contact the agency to explain her absence.

## Appendix H

### Format, Session 8

Goals

1. To enable group members to identify what they learned about anger as a child and connect it to their difficulties with anger as an adult.
2. To enable group members to identify how they express anger today.
3. To help them explore healthy ways of expressing anger.

Activities

1. Check In.
2. Anger Exercise.
3. Discussion.
4. Wrap Up.

Handouts

1. Anger, adapted from Weber D. (1991).

One participant missed this session. One woman did not participate.

## Appendix I

### Format, Session 9

Goals

1. To help group members identify and understand shame.
2. To help group members identify and understand the origins of their negative self-messages and start to develop ways to resolve this form of internal self-abuse.
3. To help grasp members grow and heal through positive affirmations of self.

Activities

1. Check In.
2. Brainstorm on Shame
3. Group Exercise on Shame
4. Wrap Up.

Handouts

1. a) Bradshaw J. (1988). Chapter Ten

   b) Women's Post Treatment Centre, Shame and Recovery

   Two group members missed this session.

## Appendix J

### Format, Session 10

Goals

1. To enable group members to identify their losses and feelings of grief.
2. To enable group members to connect to their feeling of loss and their power to heal from their grief.

Activities

1. Check In.
2. Grief Overview.
3. Grief Exercise.
4. Check In Reopened.
5. Wrap Up.
6. Professor Visits Group

Grief Exercise: Adapted from Dolan Y.M., (1990, p 36).

I want you to imagine that you have grown to be a healthy, wise old woman and you are looking back at this period of your life. I want you to write this older, wiser self about the losses you have suffered.

I now want you to take the role of your older wiser self and respond to your letter. Offering comfort and helpful instructions on how to deal with your losses.

Handouts

1. Women's Post Treatment Centre, Grief

## Appendix K

### Format, Session 11

Goals

1. To continue to address the issue of the termination of the group.
2. To provide group members with the opportunity to explore their relationships and identify the patterns in their relationships.
3. To provide group members with the opportunity to explore ways to change their current relationship patterns through discussion.

Activities

1. Check In.
2. Relationships
3. Wrap Up.

Handouts: Adapted from the Women's Post Treatment Centre

1. Human Rights For Women In Intimate Relationships
2. Eighteen Traditional Assumptions and Rights

All group members attended the session.

## Appendix L

### Format, Session 12

Goals

1. To give group members the opportunity to discuss the grief exercise.
2. To give group members the opportunity to explore their feelings towards the group experience and to celebrate their growth through a creative visual exercise.

Activities

1. Discussion on the grief exercise.
2. Check In.
3. Collage.
4. Wrap Up.

Handouts

1. Four Phases of the Grieving Process in Adult Life.
2. Sanford L.T. & Donovan M.E., (1984, pp. 3-20).

All group members attended group.

## Appendix M

### Format, Session 13

Goals

1. To give the group members an opportunity to begin to process their feelings regarding the termination of the group.
2. To give the group members the opportunity for closure of the grief exercise.

Activities

1. Discussion of the agenda for the last session.
2. Check In.
3. Loss Exercise.
4. Wrap Up.

Handouts

1. Loulan J. (1987, pp.71-82).
2. Sanford L.T. & Donovan M.E. (1984, pp.105-129).

All group members attended group.

## Appendix N

### Format, Session 14

Goals

1. To give the group members the opportunity to say good-bye and bring the group to an end.

Activities

1. Check In.
2. Food and Refreshments.
3. Candle Ceremony

   One woman missed last group.

## Appendix O

1. When providing feedback be honest and show respect towards each other and treat each other kindly.
2. Crosstalk: Provide feedback after the speaker finishes. Provide feedback only with the speakers permission to comment.
3. Outside group contact. Always remember your own needs, issues and limits. You can say no to outside contact.
4. Confidentiality. What is said here stays here.
5. Respect each others boundaries and feelings.
6. Please do not judge one another.
7. If you have an issue with another person please bring it up in group.
8. Attendance: Don't miss group. Make a commitment to attend.
9. Phone if you can't make it. We want to know you are okay.
10. Start group on time and end group on time.
11. No smoking in group.

## Appendix P

### Miracle Question

-Be more connected to my feelings, my body and my spiritual self.

-Acceptance of the reality of past abuse.

-Feeling 'free' of past abuse.

-Being clear about my relationship needs.

-Be able to feel and exercise choice about the way other people treat me.

-Be comfortable with who I am (my humanness)

-Feel self worth, self esteem

-Only relate to people who respect me.

-Have a strong sense of who I am and what I want.

-To feel more a sense of 'balance' in my life.

-to learn to be more discriminating in terms of what I want and don't want from others.

-Be less vulnerable, more in control, autonomous, have less 'emotional hooks' and be able to respond from true self.

-Be less dependent on others opinions of me.

-Feel less discouraged, and feel more sense of purpose and direction.

-To feel less shame. To feel more wholesome.

-Stop "fixing" others and take care of me.

-To stop "overloading" -be able to set limits.

-Stop running from self.

-Feel stronger - less like a "victim" and feel a sense of strength in and through my survivorhood.

-To love myself.

-To feel proud of myself.

-Be able to have deeper committed intimate relationships.

-Learn how to hear and relate to my inner self and inner voices.

-To be able to take a stand.

-To be able to trust.

-To be able to protect myself.

-to be able to care for myself.

-Continue to be supportive of others.

-Be able to practice healthy detachment.

-To be able to say no without feeling guilty.

-Feel less fear and more calmness and confidence.

-Be able to feel self love.

-To be comfortable with my sexuality.

## Appendix Q

### Visualizing Safety and Comfort

Purpose to relax the mind and body by picturing safety and comfort. Picture yourself in a place where you feel warm, safe and comfortable...It may be a place from your childhood, a place in nature you go to, or a place that exists only in your imagination...Experience how safe and comfortable you feel. See where you are - inside or outside, the colours and shapes around you, the warmth you may feel from the sun or other energy source.

Pause half a minute

As you rest in that state of comfort and security, allow your mind to drift...Pictures of beauty, strength and wisdom float slowly across your mind's eye. They are clear and bright. As they drift by, however you picture them, absorb the energy and good feelings they give you...Remember you are perfectly comfortable, safe and relaxed.

Pause one or two minutes

"When you are ready, return to the group, feeling refreshed and energized."

## Appendix R

### Nurturing Thing To Do In Tough Times

-sitting in an armchair and being still

-talking to a sponsor

-writing in a journal

-meditation

-affirmations

-connecting with a higher power

-cutting down on meetings

-talking out loud about what is bothering me

-what can I do right now. Make a list.

-bubble bath

-T.V.

-lying down

-lighting a candle in the bath

-talking to self

-making a place for me, getting poster

-hanging poster crooked

-flowers

-remembering to eat

-sating NO!

-celebrating your triumphs

-going for a walk

-locking the bathroom

-learning to say NO!

-learning who to say NO to

-allowing self to be a kid

-saying nice things to self - saying Good Morning to self, saying I Love You to self.

-looking in the mirror.

**Appendix S**

Adapted By Womens Post Treatment Centre
from The Therapeutic Window by Carolyn
H. Cole and Elaine E. Barney

EXTREMES OF STATE EXPERIENCE

POST TRAUMATIC STRESS SURVIVORS

DENIAL PHASE
(over controlling defences)
experience too stressful

Symptoms include:
- amnesia (not able to remember)
- forgetfulness
- minimizing ("Oh, it wasn't so bad! Why am I making such a big deal?")
- dissociation (spacey feeling, foggy, feeling nothing, shutting down feelings)
- fatigue (feeling tired)
- headaches
- selective inattention (drifting in and out)
- Chemical dependency or abuse
- other addictive processes (over-eating, compulsive washing)
- low tolerance for others emotional pain
- high tolerance for physical pain-dissociation from body.
- denial of reality of abuse-inability to perceive danger for own child

INTRUSIVE PHASE
(under-controlling defences)
affect/emotional pain

Symptoms include:
- physical pains, aches (often related to nature of abuse)
-hypervigilance (being over-cautious or over-aware)
- unbidden, repetitive thoughts imagery (UNWANTED)
- hallucination-like phenomenon (seeing, hearing, touching smelling, tasting, unreal images) (Flashbacks)
- disturbances in perception
- confusion (feeling mixed up)
- waves of intense emotions (extreme anxiety, fear, etc. overwhelming feelings)
- tremors (shaking)
- sweating
- nightmares (frightening dreams
- feelings of blame, guilt
- body memories
- difficulty functioning, concentrating-staying focused
- preoccupation with danger to our own child/children

## Appendix T

Visualization: Embracing Your Lost Inner Child

Sit in an upright position. Relax and focus on your breathing...Spend a few minutes becoming mindful of breathing...Be aware of the air as you breath it in and as you breath it out...Notice the difference in the air as it comes in and as it goes out. Focus on that difference...(one minute). Now imagine that you're walking down a long flight of stairs. Walk down slowly as I count down from ten. Ten...(ten seconds) Nine...(ten seconds) Eight...(ten seconds), etc. When you reach the bottom of the stairs, turn left and walk down a long corridor with doors on your right and doors on your left. Each door has a coloured symbol on it...(one minute). As you look toward the end of the corridor there is a force field of light...Walk through it and go back through time to a street where you lived before you were seven-years-old. Walk down that street to the house you lived in. Look at the house. Notice the roof, the color of the house and the windows and doors...See a small child come out the front door...How is the child dressed? What color are the child's shoes? Walk over to the child...Tell her that you are from her future...Tell her that you know better than anyone what she has been through...Her suffering, her abandonment...her shame...Tell her that of all the people she will every know, you are the only one she will never lose. Now ask her is she is willing to go home with you?...If not, tell her you will visit her tomorrow. If she is willing to go with you, take her by the hand and start walking away...As you walk away see your mom and dad come out on the porch. Wave goodbye to them. Look over your shoulder as you continue walking away and see them getting smaller and smaller until they are completely gone...Turn the corner and see your Higher Power and your most cherished friends waiting for you. Embrace all your friends and allow your Higher Power to come into your heart...Now walk away and promise your child you will meet her for five minutes each day. Pick an exact time. Commit to that time. Hold your child in your hand and let her shrink to the size of your hand. Place her in your heart...Now

walk to some beautiful outdoor place...Stand in the middle of that place and within yourself, with your Higher Power and with all things...Now look up in the sky; see the purple white clouds form the number five...See the five become a four...and be aware of your feel and legs...See the four become a three...Feel the life in your stomach and in your arms. See the three become a two; feel the life in your hands, your face, your whole body. Know that you are about to be fully awake -- able to do all things with your fully awake mind -- see the two become a one and be fully awake, remembering the experience.

## Appendix U

### Responses to the Women's Post Treatment Centre Feedback Form

Changes: The group has allowed me to see how important my needs are. I feel believed for the first time in my life. As a result I believe more in myself and my feelings. I have incredibly strong feelings. I feel a certain level of freedom. I no longer feel I am in jail. I have this strong feeling of power inside of me. I have learned to stay present. I have learned it's okay to be sad and cry. And what a feeling of relief. I have also learned that if I share my feelings in this group, these feelings were not minimized. I have also learned that society is not going to change. I must change first.

Changes: I learned that it is possible to get along with other women.

Changes: It helped to normalize my experiences by hearing others share about feelings and behaviours as a result of the sexual abuse. It also helped to allow me to feel anger about the experience and the people involved. Being able to accept myself more as a lesbian woman. Being able to accept other women and their experience and not feel threatened by them. I trusted women a lot more and respected them more at the end than I did at the beginning.

Changes: I could see others with the same feelings. I now know its OK to share my needs. I understand why I've acted the way I have and I don't have to anymore. There are solutions. I liked connecting to women. I feel like I'm just beginning to live. I'm excited and scared but most of all its okay!

Changes: I found you have to be vulnerable to heal. I found you need other people to help you heal.

Changes: I'm very satisfied with the program offered at WPTC. It has helped me gain additional awareness of my child's sexual abuse issues. It has also offered me a safe place to discuss my secret shame. I have struggled with my sexual abuse issues and since this program I seem to have some control over my feelings relating back to the abuse. My feelings are starting to make sense and are understandable. The counsellors were excellent in their participation in the group. Very knowledgeable with their words and actions in keeping the group balanced. The group experience taught me a lot about what it is like to be a woman. And my need to stop being a victim and to value myself as a worthwhile abusive - free woman.

## Appendix V

### Group Evaluation Measure

(1) What did you like best about the group?

(2) What did you like least about the group?

(3) Are there any topics you feel should have been discussed more?

(4) Were the handout materials helpful/useful? In what way?

(5) In what ways would you have liked the group to be different?

## Appendix W

### Responses to the Group Evaluation Measure

(1) The women. I grew to respect their individualities. Being with a group of women gave me a chance to get somewhat close. To really respect and care about them and therefore myself. Also that these women felt the same way I did and I didn't feel so alone. I enjoyed being with these women because they were open and honest in their recovery to listen to me and understand.

(2) I can't really think of something I liked least about the group.

(3) Yes, there wasn't a topic on sexuality. An open discussion of what that means to everyone.

(4) Yes, the handouts are very helpful. They helped sum up the group each session. And I will have them always for strength in helping understand my feelings.

(5) Maybe to have more group discussion.

(1) Finally being validated about what happened to me.

(2) The fact I had a hard time fitting in because of my therapy hat getting in the way.

(3) No.

(4) Yes. They gave me more insight into my feelings.

(5) Keep the group small. No videotaping. It makes you uncomfortable.

(1) Establishing trust with other women. Learning to respect other women. Feeling connected and hearing other stuff.

(2) Sometimes "advice giving" or "control" or "changing" of people's content by one co-facilitator.

(3) Anger, family relationship (parents/siblings and sexuality.

(4) Pendulum drawing of phases recovery.

(5) Three hours minimum (8 persons) or six persons maximum in 2 - 2 1/2 hrs. Homework on current topic and more visualizations.

(1) The opening and honesty to participate and the freedom to pass and be respected. I appreciated the empathetic understanding that was communicated. The group had respect. The instructors had respect for each member. The facilitators had great empathy skills and empowerment skills. I appreciated the facilitators honesty when giving feedback.

(2) It ended too soon.

(3) Relationship building; more on self.

(4) All material were very helpful, e.g. getting in touch with the child within.

(5) Another 2 - 3 more weeks on the group to cover all the material would have been an asset to me.

(1) The honest sharing of feelings being able to cry and have that experience validated by other women. Seeing the caring going on someone was having a bad week and everyone pitching in to help the person see things in a different way. The acceptance of my lesbianism and not being treated differently... feeling safe.

(2) I would have liked it to be longer maybe weeks... we were just starting to let our walls down and I think another six weeks would have... or even going four hours instead of two and a half would have made a difference.

(3) Lesbianism or the lesbian experience after childhood sexual abuse. I feel the group wasn't comfortable in discussing that, probably because they weren't lesbians. ... also about how we became the abuser... I would have liked to have others talk about that... Also sex wasn't

discussed a lot it would have been informative to hear how other feel about sex in survivors how its affected an adult sex life.

(4) The one we got about the unreality to reality one was very helpful to see myself being in denial and feeling safe enough to be more real it helped me to explain my feelings and behaviours. Also the handout about what is a healthy relationship and my rights and my partners rights in a healthy relationship.

(5) It would have been great if we were all lesbians and could connect on that level... There was some trust issues between some people of the group... it stopped these people from participating fully and cheated themselves and possibly the others from their experience.

(1) Learning to respect women.

(2) It took longer than I thought for the women to start giving feedback.

(3) Can't think of any.

(4) The handouts helped me realize and understand more about what I was feeling.

(5) I would have liked it to be longer.

(1) I liked check-in and the literature we took home.

(2) The video camera and being so early in the morning.

(3) No

(4) Yes very helpful helped me to realize I was not alone or crazy.

(1) The sharing learning to trust. Everyone seemed different at first then I found the common thread and it was very moving for me.

(2) It could have been longer.

(3) I loved 'Check In' but some days it took so long we didn't cover everything.

(4) I didn't use them perhaps as much as I should have, but they are there for me to go through again at my own speed.

(5) I liked the make-up of the group, the way it was run - everything - the process was a bit too fast for me.

## Appendix X

**Responses on Client Satisfaction Questionnaire**

(N = 8)

| | | N | % |
|---|---|---|---|
| 1. | How would you rate the quality of service received? | | |
| | Excellent | 6 | 75.0 |
| | Good | 2 | 25.0 |
| | Fair | 0 | 0.0 |
| | Poor | 0 | 0.0 |
| 2. | Did you get the kind of service you wanted? | | |
| | Yes definitely | 7 | 87.5 |
| | Yes generally | 1 | 12.5 |
| | No not really | 0 | 0.0 |
| | No definitely not | 0 | 0.0 |
| 3. | To what extent has our program met your needs? | | |
| | Almost all my needs have been met | 7 | 87.5 |
| | Most of my needs have been met | 1 | 12.5 |
| | Only a few of my needs have been met | 0 | 0.0 |
| | None of my needs have been met | 0 | 0.0 |

| | | | |
|---|---|---|---|
| 4. | If a friend needed similar help would you recommend our program to him/her? | | |
| | Yes definitely | 8 | 100.0 |
| | Yes I think so | 0 | 0.0 |
| | No I don't think so | 0 | 0.0 |
| | No definitely not | 0 | 0.0 |
| 5. | How satisfied are you with the amount of help you received? | | |
| | Very satisfied | 7 | 87.5 |
| | Mostly satisfied | 1 | 12.5 |
| | Indifferent or mildly dissatisfied | 0 | 0.0 |
| | Quite dissatisfied | 0 | 0.0 |
| 6. | Have the services you have received help you deal more effectively with your problems? | | |
| | Yes they have helped a great deal | 5 | 62.5 |
| | Yes they have helped somewhat | 3 | 37.5 |
| | No they really didn't help | 0 | 0.0 |
| | No they seemed to make things worse | 0 | 0.0 |

| | | | |
|---|---|---|---|
| 7. | In an overall, general sense how satisfied are you with the service you received? | | |
| | Very satisfied | 7 | 87.5 |
| | Mostly satisfied | 1 | 12.5 |
| | Indifferent or mildly dissatisfied | 0 | 0.0 |
| | Quite dissatisfied | 0 | 0.0 |
| 8. | If you were to seek help again would you come back to our program? | | |
| | Yes definitely | 7 | 87.5 |
| | Yes I think so | 1 | 12.5 |
| | No I don't think so | 0 | 0.0 |
| | No definitely not | 0 | 0.0 |

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