EMPOWERING OLDER FEMALE VICTIMS OF SPOUSAL ABUSE: A GROUP WORK PROCESS

By

Janice L. Christie

A Practicum Submitted to the
Faculty of Graduate Studies in
Partial Fulfillment of
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MASTER OF SOCIAL WORK

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ABSTRACT

Increasing concern about elder abuse has evolved from knowledge of other types of domestic violence. Elder abuse shares several similar characteristics as victims are weakened, powerless, and dependent relative to abusers. In many cases, elder abuse is "spouse abuse grown old." A social group work intervention strategy was used to empower older female victims of male spousal abuse. The group, conducted for ten weeks, involved a co-leader and seven elderly women, most of whom resided within the greater Winnipeg community. Based on an increase in group score on the Lubben Social Network Scale and by the accomplishment of personal goals, the practicum finds that members were able to benefit from their treatment experience. By interacting with other women who shared similar life experiences, most members were able to make some positive decisions and changes about their abusive relationship. The practicum concluded that the group enhanced self-confidence, self-worth and fostered greater independence. Implications for practitioners working with elderly abused victims are outlined and recommendations for further study are offered.

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INTRODUCTION

The aged in our Canadian population are growing at a faster rate than any other age group. In addition, the increasing numbers of frail elderly within the elderly population, the decreasing availability of family and paid caregivers, and spiralling health care costs, are factors which may contribute to the elder abuse which exists and which may increase.

The aged are vulnerable to abuse because they are more likely than people in other age groups (except for the very young) to be dependent on others to carry out their activities of daily living. Gnaedinger (1989) states that those who are victims of family violence are individuals who are in a weakened, powerless, and dependent position relative to abusers. In short, elderly persons who are chronically ill, female, low income, physically/mentally disabled or are members of an ethnic minority seem to have a higher probability to be victimized.

Working as a community case coordinator with the provincial continuing care/home care program, I became aware of the increasing incidents of elder abuse in the community. Elder abuse is believed to occur with approximately the same frequency as child abuse, at about four percent of the general elderly population (Fulmer, 1988). A national Canadian survey on the incidence of elder abuse was conducted in 1989 and contacted 2,000 elders residing in private residences (Podnieks, 1989). The survey revealed that approximately 98,000 or 4 percent of Canadian elders residing in private dwellings have been abused. Victims of physical abuse, approximately 12,000 seniors, are

more likely to be married and in the majority of cases the abuser is the spouse. A problem of this magnitude calls for attention and intervention.

Innovative intervention strategies that allow older adults to control their own lives, to make their own decisions and at the same time decrease the incidence of abuse are needed. With this goal in mind, a group intervention strategy was developed for elderly female victims of spousal abuse. The very existence of this group, the first of its kind in Winnipeg, communicated to its members a value of the older abused woman and instilled a sense of hope.

In our North American society, these elderly women were confronted not only by an abusive male partner, but also with the denigrating practices of "ageism" and sexism. The general public holds many negative stereotypes about the aged. The elderly are viewed as senile, lonely, unhealthy, rigid, poor, and dependent (Atchley, 1985; Kart, 1981; Levin & Levin, 1980). Cohen (1984) points out that although the elderly in our society are generally rejected, we are particularly disdainful of older women. The older woman is perceived as unattractive, unneeded and parasitical. "Ageism" and sexism contribute to victimization by dehumanizing the elderly, thereby granting permission for some to mistreat them or ignore their needs without feeling guilty (Conklin, 1987). Elder mistreatment must be viewed from a domestic violence perspective, the same as the battering of women (spouse abuse grown old) and the mistreatment of children.

Objectives of the Practicum

A. Objectives of the Practicum Intervention

1. To empower elderly female victims of spousal abuse.

2. To further expand the literature on elder spousal abuse.

B. Objectives of Professional Learning

1. To develop and facilitate a treatment group for elderly female victims of spousal abuse.

2. To increase my knowledge, assessment and counselling skills with regard to elder abuse.

Throughout the group process, empowerment of group members was facilitated by:

1. acknowledging the women's courage in reaching out for help, and by focusing on their strength and survival skills rather than on their helplessness and failure to leave the relationship.

2. reframing their individual defeats and fears into victories and validating, while learning what they have done to survive.

3. offering the tools for choice and with which to better control their lives. For example, financial, housing and legal information were combined with identified options for safety and protection plans.

The educational components of the group content was aimed at assisting the member to reject the violence and the abuser's justification for it. An important aspect of this empowerment process

included recognition of the women as the experts about their own situations.

Specific objectives were:

1. to increase self-esteem by eliminating self-blaming tendencies and by confronting the myths of abuse.

2. to increase social support and decrease isolation through group attendance and participation.

Hypotheses based on intervention objectives were:

a) that altering the victim's perception of the abusive relationship and offering options for choice would decrease feelings of helplessness.

b) that reclaiming personal strengths and abilities would increase feelings of self-esteem.

c) that providing an opportunity to connect with other women of similar experiences would increase a personal support network.

Organization of the Practicum Report

This report begins with a literature review about elder abuse, describes the female victim of spousal abuse, and group counselling specific to the older adult population. The literature provides a basis for an understanding of the problem and for a treatment approach. A description of the group intervention approach is provided, case studies are then presented and a description of the group experience follows. A discussion and evaluation is included after each presentation section.

Lastly, suggestions for practice and recommendations for further study are offered for anyone or any agency interested in a group intervention strategy for elderly female victims of spousal abuse.

CHAPTER I

ELDER ABUSE: A THEORETICAL FRAMEWORK

This review begins with a description of elder abuse and points out that there is no commonly agreed-upon definition. This makes the comparison of studies very difficult. As well, confusion about the definition of terms affects the estimates of incidence and fuels disagreements over the frequency and intensity. In an attempt to shed some light on this confusion, I examined types of elder abuse and the theories that account for this mistreatment.

Definition of Elder Abuse

There is little consensus about what constitutes elder abuse and neglect. Researchers have focused almost exclusively upon abuse perpetrated by family caregivers and any abuse and neglect of the elderly by spouses or of the elderly in institutional settings have been mainly ignored (Stathopoulos, 1983). As well, maltreatment practised by non-caregivers who are not family members are usually considered to be criminal acts and are, therefore, regarded as victimization rather than abuse. According to Family Law, for legal intervention to occur in Manitoba, an elder should be involved in a situation of spouse abuse or must be deemed mentally incompetent by the provincial psychiatrist. Otherwise, there is no legal mandate to identify and intervene in situations of elder abuse/neglect.

In defining elder abuse, most researchers tend to differentiate between physical and psychological or verbal/emotional abuse (Crouse, Cobb, Harris, Kopecky & Poertner, 1981; Douglas, Hickey & Noel, 1980; Giordano & Giordano, 1984; Lau & Kosberg, 1979; O'Malley, Segars, Perez, Mitchell & Knuepfel, 1979; Phillips & Rempusheski, 1985; Podnieks, Pillemer, Nicholson, Shillington & Frizzell, 1989; Wolf, Strugnell & Godkin, 1982). Many writers include neglect (Gioglio & Blakemore, 1983; Hageboeck & Brandt, 1981; Hall & Andrew, 1984; McLaughlin, Nickell & Gill, 1980; O'Brien et al., 1984; O'Malley et al., 1979), while other authors distinguish between neglect that is active or passive (Crouse et al., 1981; Douglas et al., 1980; Wolf et al., 1982). As a result, dissimilar occurrences have been categorized under the definition of elder abuse.

Moreover, the literature indicates that researchers have applied different terms to similar concepts. For example, the same type of abuse, called exploitation by Hall and Andrew (1984), Law and Kosberg (1979), O'Brien et al. (1984), and O'Malley et al. (1979), may be referred to as financial abuse (Gioglio & Blakemore, 1983; Giordano & Giordano, 1984; Hageboeck & Brandt, 1981) or material abuse (Hall & Andrew, 1984; Phillips & Rempusheski, 1985; Wolf et al., 1982).

Because of the variability in the definitions employed in research, comparing the results of different studies as difficult, attempting to measure the rates and amount of abuse is complicated, and allocating funds to resolve this problem are affected (Connidis, 1989). Furthermore, Connidis (1989) points out that the tendency to rely on official statistics such as police and agency reports excludes all

behavior that does not come to public attention and/or is not appropriately labelled as abuse by social workers, police, medical practitioners, the courts, etc. Thus this confusion increases the likelihood that official data under-represents the incidents of elder abuse.

For the purposes of this practicum, elder abuse refers to what the perpetrator (spouse) has done or failed to do in the domestic setting that results in harm to an elderly person. It may involve physical, psychological, material//financial abuse and neglect. Although self-abuse and self-neglect (Hall & Andrew, 1984; O'Brien, Hudson & Johnson, 1984) is referred to in the literature, this abuse does not involve a perpetrator and clearly does not fit the definition.

A Taxonomy of Elder Abuse

Elder abuse may be divided into three types: physical, psychological, and material abuse, while neglect is divided into two main categories: active and passive neglect (Wolf, Strugnell, & Godkin, 1982). The dimensions of neglect may be further subdivided into intentional and unintentional neglect as neglect by definition tends to be passive.

Physical Abuse

Physical abuse signifies acts that involve the intentional infliction of physical discomfort, pain or injury and leads to bodily harm (Anetzberger, 1987; Breckman & Adelman, 1988; Douglas & Hickey, 1983; Lau & Kosberg, 1979; O'Malley, Everitt, O'Malley & Campion, 1983;

Phillips & Rempusheski, 1985; Quinn & Tomita, 1986; Steinmetz, 1988; Valentine & Cash, 1986; and Wolf, 1986). As well, it may include maltreatment by withholding medications or sexual assault.

Psychological Abuse

Psychological abuse, according to Douglas et al. (1980), and Crouse et al. (1981), is frequently referred to as verbal or emotional abuse. The intentional infliction of mental anguish, fear of violence or isolation, verbal assaults, humiliation or intimidation, threats of nursing home placement or acts treating the elder as a child are common behaviors included in psychological abuse (Giordano & Giordano, 1984; Lau & Kosberg, 1979; O'Malley et al., 1983; Phillips & Rempusheski, 1985; Valentine and Cash, 1986; Wolf, 1986). The phenomenon of psychological mistreatment is the most difficult to identify or measure and is usually a matter of degree rather than kind. For example, how does one measure mental anguish? When is emotional pain so extreme that it causes unnecessary suffering? Not only is this category difficult to define and operationalize, its signs are less visible when compared to physical mistreatment and individual thresholds of tolerance are highly subjective.

Due to the fact that all manner of family problems have been included under this label of psychological abuse, it has received considerable criticism (Callahan, 1982; Crystal, 1986; and Pedrick-Cornell and Gelles, 1982). Consequently, Podnieks, Pillemer, Nicholson, Shillington & Frizzell (1989) focus on repeated insults or threats and devise yet another category labelled chronic verbal aggression.

Material Abuse

Material exploitation is indicated when intentional, illegal or improper use of the elder's property or financial resources occurs. Simply put, financial abuse means that some of the individual's assets are misappropriated. It may include theft, conversion of property, or use of funds without the elder's authority or consent (Douglas & Hickey, 1983; Phillips and Rempusheski, 1985; Shell, 1982; Stevenson, 1985; Valentine and Cash, 1986; Wolf, 1986). Podnieks et al. (1989) broadens the scope to include attempts to influence the older adult to give up money or control over finances; however, exploitation must occur in order for it to be classified as abuse.

Neglect

Passive neglect is characterized by abandonment or deliberate denial of basic life essentials, a lack of social contact or emotional support. Block (1983), Crouse et al. (1981), Valentine & Cash (1986) and Wolf et al. (1982) find that intentional abuse refers to situations in which a caregiver impinges on the elder's well-being by limiting or denying the fufillment of basic needs. By contrast, unintentional neglect points out an act of omission, of not doing something, of withholding goods or services, perhaps due to ignorance or stress on the part of the caregiver. Passive neglect includes situations in which the needs of the older adult are unknown, not fully recognized or not handled appropriately by the caregiver.

There can be no doubt from this review that under the umbrella of abuse there are a variety of behaviors which include: physical abuse, financial abuse, self-abuse, neglect, psychosocial abuse, mental or psychological abuse (Bristowe & Collins, 1989; Pillemer & Suitor, 1988; Podnieks, 1989; Quinn & Tomita, 1986; Schlesinger & Schlesinger, 1988; Shell, 1982). However, not only has the problem of elder abuse and neglect been difficult to define, detect and comprehend, but many questions come to mind in trying to understand why abuse of the older adult occurs. What causes elder abuse? Existing studies do offer a place to begin and can help to consider theories of causation.

Theories of Elder Abuse

In the field of family violence, theories of elder abuse are frequently based on the situational model, the social exchange model and the symbolic interaction model (McDonald, Hornick, Robertson & Wallace, 1991). Johnson (1991) expands the number of theories and adds psychoanalysis, role theory, ethnomethodology, conflict theory, social learning theory and functionalism. Moreover, she connects specific variables that have been associated with abuse to each theory. The risk factor variables include: transgenerational family violence; web of dependencies; personality traits of the abuser; filial crisis; internal and external stressors; social isolation; social attitudes towards the elderly; and institutional factors. The three theoretical explanations, however, incorporate a variety of factors and any one may be included in any of the theoretical explanations.

The Situational Theory

The situational model examines external circumstances that impact upon the individual with particular attention to those that are likely to alter one's circumstances. Isolation plays a primary role in this perspective as the premise is that if one is isolated, that individual may be vulnerable to abuse. Indeed, a relationship has been found to exist between isolation and abuse in regard to all forms of family abuse (Pillemer & Wolf, 1982). For the older adult who experiences multiple additional losses such as the loss of health, employment, peers, and age-mates, the result is a significant decrease in patterns of social interaction with others. Pillemer and Suitor (1988) find that small dense support networks are generally characteristic of abusive families. From a caregiver perspective, social isolation may account for a possible lack of resources to cope with accumulating stress. As well, isolation results in undetected abuse and victims who are powerless with few options to change the situation. Schlesinger & Schlesinger (1988) find that isolation, as well as environmental problems such as poor housing and a lack of social supports, may be viewed as a contributing factor to all forms of abuse.

Stress is associated with certain situational factors. Factors such as physical and emotional dependency; economic strain; environmental problems and caregiver factors, increase the likelihood of abusive acts toward a vulnerable elder who is perceived to be associated with the stress. External stress refers to macro level conditions such as economic conditions and unemployment which are external pressures in addition to interpersonal stressors and dynamics. The situational model

has its roots in the theoretical literature on child abuse. Many researchers find a positive correlation between physical/emotional dependency of an elder and the incidence of abuse/neglect (Block & Sinnott, 1979; Pillemer & Wolf, 1986; Rathbone-McCuan, 1980; Schlesinger & Schlesinger, 1988).

Financial abuse is the most common abuse (Block & Sinnott, 1979; Pillemer & Wolf, 1986; Podnieks, 1989; Schlesinger & Schlesinger, 1988; Shell, 1982; Steinmetz, 1978). As the elderly person's resources decline, economic strain is created, savings are used up and pension levels drop below inflation. Often financial security has been exchanged for caregiving services with the idea that the money will provide the elder with some control and power. Violence and intimidation may be used to force the older adult to give up pensions, change wills or insurance policies or purchase unnecessary items or house repairs.

In short, the situational theory suggests that mistreatment is an irrational response to environmental conditions and situational life crises. From this perspective, early development is less emphasized than current situations and social conditions (Shell, 1982). A major difficulty with this theory is that it fails to explain the behaviors of individuals who encounter the same difficulties yet respond to the crises in a nonviolent manner. As well, this theory can only delineate factors that caused the abuse after the violence has occurred, and therefore, it lacks a preventive focus.

The Social Exchange Theory

The social exchange theory defines relationships as the product of a cost/benefit exchange (Gelles, 1983). On the one hand, if one gets nothing from the relationship, there is no reason to sustain it. While on the other hand, if there is some benefit and the cost/contribution to the relationship is less than the benefit, then the relationship is maintained.

Dependency of either the abuser or the victim is the most frequently mentioned risk factor associated with the social exchange. However, in most relationships, there is an imbalance of power as each person has different access to resources and different capabilities for providing instrumental services. But the older adult, who experiences increasing age and dependency over time, has less access to power, fewer resources, and is less able to perform instrumental tasks. Thus, the imbalance increases and the elder becomes less powerful, more dependent and more vulnerable than the caregiver. Referred to as "generational inversion" (Steinmetz, 1983), this imbalance creates a breeding ground for abuse (Pillemer & Wolf, 1986). Schecter and Gary (1988) confirm that abuse/battering is created by an inequality of power within a relationship, which leads to an abuse of power. In the recent past, the literature on caregiving focused primarily upon "caregiver stress" and the burden of caring for the dependent elderly as the precursors to elder abuse. However, the dynamics of the interactive process and the stress experienced by the elder generally appears to have been overlooked.

Pillemer (1986) disproved the "caregiver stress" theory. He found that abused and non-abused elderly have many similarities in terms of serious illness, functional ability and activities in daily living. In fact, the abused elderly in his study were no more dependent upon their relatives than were the non-abused. Rather than the victim being frail and dependent, research exposed the dependency of adult children upon their parents (Pillemer & Finkelhor, 1988).

Three elements of identified caregiver dependency are physical and functional, emotional, and financial (Fulmer et al., 1990). Greenberg, McKibben and Raymond (1990) also find a strong correlation between chemically and financially dependent caregivers and the incidence of elderly parent abuse. This suggests that, in addition to dependency factors, individual characteristics of the abusers may contribute to the risk of abuse. Finkelhor (1983) contends that dependent adult children feel powerless because of their own sense of failure, and therefore use violence to regain a perceived sense of control or power over their victims and their own lives.

The Symbolic Interactionist Theory

Symbolic interactionism is a process that involves at least two individuals interacting together over time. The process involves identifiable recurring phases that are negotiated and renegotiated repeatedly. McCall and Simmons (1966) state the phases of symbolic interactionism include a cognitive phase, an expressive phase, and an evaluation process in which each person alters their behaviors and expectations. This theory examines how the individual perceives the situation and assigns meaning to it. It is tied to social learning and

modelling, with abuse perceived as a recurring cyclic pattern within the family history of violent relationships (Shell, 1982).

Steinmetz (1983) clarifies stress from the perspective of symbolic interactionism, and states that if one perceives a situation is stressful, then it is approached that way; if it is not perceived as stressful then it is less likely to cause undue concern. She articulates that each person maintains a unique, individually constructed threshold of tolerance. Therefore, what may be stressful for one person may not have the same effect on another.

Interactions between an older adult and a caregiver may be best characterized as protracted negotiations, in which each individual starts with a personal construction of the situation, strives to develop a shared understanding, and in the process attempts to preserve individual status and reputation (Pillemer & Wolf, 1986). The negotiations of role and expectations are nowhere more emotionally distressing than within the family. The relationships between the elderly parent and children are charged with uncertainty and open to more than one interpretation and many renegotiations.

The most frequently mentioned risk factor/variables associated with the symbolic interactionist theory are transgenerational violence and filial crisis. An example of filial crisis would be where the child is unable to see the parent in any other role even when the parental ageing process renders her/him more dependent and childlike (Block & Sinnott, 1979; Law & Kosberg, 1979). This model fails to consider structural variables such as economic strain, social isolation, and environmental problems which may influence the abusive situation. As

well, empirical testing is difficult as it relates to cognitive processes and individual symbolic meanings.

Discussion

From this review of the literature it appears that there is no single explanation for the abuse and neglect of older adults. Rather, elder abuse and neglect are probably the result of a multiplicity of factors.

For example, Johnson (1991) suggests that the state of being overwhelmed is the primary risk factor for mistreatment, while Connidis (1989) states that the key risk is in living with someone else since a spouse or a child is as likely to abuse. The lack of knowledge about the care of older adults, the lack of resources to care for the elder, inappropriate expectations about what the older adult can do, plus an intolerance of the older adult's behavior are identified as additional indicators for abuse. Further research to correlate predisposing factors to each other is necessary to provide a more accurate picture of the causes of abuse.

There are many studies emerging that contradict earlier findings connected to elder abuse. Pillemer and Finkelhor (1988) find that the risk of abuse for elderly men is actually double that of elderly women in contrast to Kosberg's (1988) first characteristic of the high-risk female elder. However, it is unclear whether or not women are more likely to be reported as victims simply because there are more very old women than very old men or because the proportion of very old women who

are abused is higher than the proportion of very old men who are abused (Connidis, 1989). Godkin, Wolf and Pillemer (1989) find that the abused elder is not necessarily older or economically disadvantaged, and several researchers find that the older abused elder is not more impaired than the non-abused elder (Bristowe, 1987; Phillips, 1983; Pillemer, 1986; Pillemer & Finkelhor, 1989). As well, dependency is more characteristic of the caregiver than the victim (Anetzberger, 1989; Bristowe, 1987; Godkin et al. 1989; Pillemer & Finkelhor, 1989), and intergenerational violence is not always the norm (Godkin et al., 1989; Pillemer, 1986).

In the end, it appears that most of the risk factors/variables are limited to the current stereotype that older persons are abused by their adult children. However, growing evidence suggests that a substantial proportion of elder abuse is actually spousal abuse (Giordano, 1982; Hageboeck & Brandt, 1981; Pillemer & Finkelhor, 1988; Podnieks et al. 1989; Wolf et al. 1984). Connidis (1989) contends that most of the elder abuse committed is essentially spouse abuse in older age. A major difficulty in the literature is pointed out by Mastrocola-Morris (1989) who finds that the literature on family violence exists separately on wife abuse and elder abuse and, to date, there has been no attempt to link the two.

In Manitoba, the Pedlar (1991) report on domestic violence found that Manitoba Family Dispute Services estimates that one out of six women has been abused by their partner. Prior to the 1970's, however, wife abuse was so embedded in society that it was viewed as normal (Freedman, 1985; Jaffe, 1988), therefore, statistics on actual incidents

of spousal violence are limited. Davis (1987) recalls that wife abuse was considered to be a private, personal matter and violence of an extreme physical nature was regarded as a problem affecting only a small number of women.

As our culture upholds the institution of marriage with the family idealized as a private institution, it is not surprising that the women initially assume responsibility for the violence. In fact, Schecter (1982) points out that intervention practices in the past encouraged and reinforced this belief by blaming the women and holding them responsible for their situation. Social supports such as shelters were nonexistent and the justice system did not regard wife abuse as a serious crime. As a result, many battered women experienced the loss of dignity, control, and safety. Based on the reality of their situation, MacLeod (1987) states that many abused women felt and were trapped behind closed doors. Yet wife battering continues and is a fact of life for many women, even today. Abuse of this nature knows no geographical, economic, or cultural boundaries--any woman can find herself in the position of being battered.

Podnieks (1989) finds that elderly victims of physical abuse, approximately 12,000 Canadians, are more likely to be married, and in the majority of cases the abuser is the spouse. In fact, Mastrocola-Morris (1989) demonstrates a relationship between wife assault and elder abuse that indicates that many of the victims of elder abuse are women who have suffered years of abuse at the hands of their partners. A recent Canadian study shed light on the fact that two of the greatest predictors of violence are traditional ideology and battering

experience, both of which are more intensive in middle-age and older women (Kincaid, 1984). Sinclair (1985) finds that not only are these women more vulnerable due to their increased time at risk, but also because the severity and frequency of violence tends to increase with time.

A theory frequently used to explain family violence/wife abuse is that of power/control. Mastrocola-Morris (1989) contends that it is men's socially ascribed status over women and the imbalanced power structure of a sexist social order that leads to the victimization of women, of which wife assault/abuse is only one aspect. The less power a woman has educationally, economically, and in decision making in the family, the more likely she is to be abused, "the use of violence by husbands was strongly associated with their dominance over their wives..." (Bowker, 1983, p. 8).

At this time, there appears to be a growing struggle between competing theoretical frameworks of family violence, caregiver stress and dependency, when in fact all perspectives are most likely viable. This practicum focuses on elder spousal partner abuse which falls within the family violence framework and uses the power/control theory as an explanatory base.

The Older Female Victim of Spousal Abuse

As one travels through life, the marital relationship normally assumes increasing importance to the aging individual. After children are launched, the relationship once again dominates family life and is

often the most important relationship left to both partners (Wolinsky, 1990). But, the older woman who is a victim of spousal abuse, this may not be a valued relationship. Retirement and financial insecurities coupled with the increasing loss of health, friends and relatives pose adjustment difficulties. However, the most difficult adjustment may be the threat or actual loss of a spouse. This loss entails a problem of reorganizing one's entire life alone after many years as a couple and of having fewer relationships available to help replace the loss (McGoldrick & Carter, 1982).

Erikson (1959) defines the developmental task of aging as the evaluation and acceptance of one's life, one's history, and the uniqueness and inevitability of one's life cycle. It is believed that a successful mastery of this life crisis leads to integrity, while a negative resolution leads to despair, a sense of meaninglessness, and a feeling that one's life has been wasted or should have somehow been different (Hartman & Laird, 1983). The accomplishment of this task for the elderly victim of abuse may be particularly problematic. The process seems to imply that to accept ones life of abuse one must accept the blame for the violence and thus one's powerlessness. Certainly this would lead one to despair and reinforce a lack of self-worth.

The goal in a life review is to reassess and to reintegrate, to come to terms with one's own life cycle, to resolve conflicts that may reemerge, and to complete any unfinished life business. Naturally to achieve these goals, one returns to the past which usually yields good results in the development of positive self-image and continued interest and involvement in the life process. But to what degree does a return

to the past yield the same good results for the older female victim of spousal abuse? This is unknown. Also unknown is what actions or decisions might be made if this population is treated at this time. Central to all of the tasks at this stage of the life cycle is the search for meaning.

Victims of abuse, in particular women, experience shame and embarrassment; they are fearful for their safety and of institutionalization. The longer the abuse continues and the older the woman becomes, the more powerless and helpless she feels to manage her life. More traditional socialization, with a strong emphasis on loyalty to the institution of marriage and the family, also keeps the women in abusive relationships. Gesino, Smith and Kekich (1982) state that, "women of [the older] generation were raised in a male dominant-female subordinant culture. This role structure influenced the women to be submissive to their husband's domination and abuse. It also contributed to the women's perception that the abuse was something their husband's could not control [which] was a significant factor in their unwillingness to leave the relationship" (p. 64).

Poor self image, social isolation, a value of family privacy, the belief the husband will change, loyalty, denial, a lack of resources, fear of retaliation, embarrassment and shame, all contribute to the profile of the victim and also limit women's options to leave the abusive situation (Cohen, 1984; Gesino, Smith & Kekich, 1982; Quinn & Tomita, 1986; Shell, 1982). As stated, victims of abuse are isolated socially, which is both a part of the abuse tactics and a result of being abused. Pillemer and Wolfe (1982) indicate a relationship between

social isolation and elder abuse. In fact, social isolation is a common theme in the literature as a contributing factor to all types of family abuse/neglect.

Browne (1986) notes a variety of long-term outcomes of wife abuse such as confusion and feelings of powerlessness and helplessness, increased dependency on others, depression, disturbed eating and sleeping patterns, and a sense of isolation. Many clinical and case study data find that some elders experience severe emotional distress as a result of maltreatment (Quinn & Tomita, 1987; Wolf, Godkin, & Pillemer, 1984). Pillemer and Prescott (1989) conclude that the abused elderly are significantly more likely to be depressed than non-victims.

Depression is particularly problematic as it may prevent victims from seeking alternatives to their current situations. Such feelings of helplessness and loneliness may decrease actions to either resolve the abuse or break off relations with the abuser.

Hartman (1987), a feminist practitioner working in the area of family violence, identifies characteristics that create difficulties for women who are in abusive relationships. They are isolation, dependency, low self-esteem, a lack of information, and skill deficits. She emphasizes that these traits do not cause the abuse and may indeed be a result of the violence. Hartman (1987) points out that for most female victims of domestic abuse, low self-esteem predates their involvement in their current relationship. She reports that a majority of abused women have experienced incest, sexual assault, child abuse, and/or had parents in abusive relationships. As many women were raised in emotionally neglectful homes, she suggests they were deprived of nurturing and

learned to equate love and abuse. She contends that they may believe they deserve to be abused and may not be aware that any other kind of relationship is possible.

Strauss (1980) states that three factors account for the widespread existence of family violence. They are a high level of conflict within families, the training in violence and the link between love and violence established by physical punishment and the implicit cultural norm which gives family members the right to hit if someone is doing wrong and won't listen to reason. Often victims and perpetrators were raised in homes where violent actions are legitimized as a first resort not the last (Star, 1980).

Counselling Services for the Elderly

Counselling services for elders is basically like counselling with any other adult. Any difference may be related to a decline in health and vigour, a health-related loss of control over one's life, the loss of friends and family, or a different milieu or past experience during earlier life, and the different resources available to meet the changing needs of an older adult. However, old age is negatively characterized by interrelated conditions of decreased social interactions, lowered income, limited housing options, declining health and widowhood. The internalization of generally held stereotypes by the elderly themselves (Botwinick, 1984) may contribute to feelings of powerlessness, uselessness and ultimately low self-esteem.

Despite the psychological needs of the older adult, mental health services are underutilized by individuals over sixty-five (Blank, 1974; Fleming, Buchanan, Santos & Richards, 1984; Group for the Advancement of Psychiatry, 1970; Kahn, 1975; Redick & Taube, 1980). Lakin (1988) observes that calls for more extensive therapeutic efforts with the elderly have pessimistically blamed current ageism biases, e.g., that the aged are rigid and can't change themselves, for the decision not to provide adequate psychological services.

There can be no doubt that popularly held beliefs can stigmatize large numbers of people and "provide justification for those who would like to discriminate against older persons" (Atchley, 1980; p. 254). For example, industrial changes have created a high degree of competition for technical jobs, which puts a premium on youth and leads to early obsolescence of job skills (Specht & Craig, 1982). Thus the value and status of older people declines with age in a society that values productivity, youthfulness, and independence. In fact, practitioner's images of aging may be distorted by negative stereotypes, and Wills (1978) finds that professional helpers are more likely to underestimate the capabilities of clients than are lay people.

The geriatrician Kassel (1983) contends that the real issue in the growing concern over the expenditure of the health care dollar is not the inability of the older adult to change but rather the concept of reserving health care for the young where there may be a profit from the investment in sickness. He declares that this is just one more of the anti-aged bias: the denigrating of the worth of older individuals in our society.

The older battered woman is at a greater disadvantage than the victim who is under 30 (Pagelow, 1981). She may believe that it is too late to start a new life and consider previous years as wasted or she may fear the unknown. It may also be possible that change cannot even be thought of, or a plan of action devised. Mastrocola-Morris (1989) states that the cycle of violence can be readily applied to the older abused woman who has been a perpetual victim of family violence since childhood. Often victims and perpetrators were raised in homes where violent actions are legitimized as a first resort not the last (Star, 1980).

The power/control theory maintains that the social order places value on the male gender and devalues the female gender. Therefore group work needs to counteract the dysfunctional consequences that result from life-long reinforcement of sex specific and subordinate roles. Pittman (1987) declares that during the counselling process, the victim of abuse must be empowered for her competence, courage, and strength, and not reinforced for her helplessness.

CHAPTER II

GROUP INTERVENTION AND ELDER ABUSE

There are many different types of group therapy such as psychotherapy, counselling, behavior modification and activity therapy. Tross and Blum (1988) classify the different types of groups into two major categories: insight therapy which includes psychoanalytic, self psychology and life review groups; and supportive therapy which includes verbal/social rehabilitative groups and activity therapy aimed at reducing the stresses of aging, maintaining coping skills, bolstering self-esteem and correcting distortions in one's world view. A third group approach related to supportive therapy has developed, cognitive-behavioral (Beck & Rush, 1978; Beck, Rush & Shaw, 1979), and a fourth, attribution theory (Jones & Davis, 1965), has evolved from social psychology. This practicum may be perceived as falling within the classification of supportive therapy.

Group Work as an Intervention Strategy

Group work with the elderly in the community at first glance appears to be a fairly new phenomenon, with the first reference to such groups appearing in the mid-twentieth century (Weiner & White, 1988). However, group therapy with the aged is not a new intervention strategy. Historically, it developed in three distinct settings: settlement houses, homes for the aged, and state mental hospitals during the first three decades of the twentieth century (Toseland, 1990). Some early

pioneers were Jerome Kaplan (1953), Maurice Linden (1953), Jacob Moreno (1910), and James Wood (1953), to name but a few.

Robertson (1989) advocates the support of an age-specific group program for three main reasons. The first reason is that most older adults have been raised in families where privacy and loyalty were common values. Specifically, the unspoken rule was to take care of any problems within the family and not share them with the outside world. This is particularly relevant to elderly abused victims who believe that whatever happens within the realm of family living should be regarded as a private matter. They may be ashamed, embarrassed, and unwilling to risk being rejected by loved ones, or blame themselves for the abuse rather than risk being sent to an institution upon disclosure. Quinn and Tomita (1986) contend this is in part why victims do not report the abuse and neglect they are suffering. An age-specific group may be of benefit to the older victim by connecting with life experiences common to the older women and in doing so end the silence about the abuse.

For a female victim, the traditional female role keeps her passively accepting what life brings her. Socialized to believe that her worth as a person depends upon maintaining her relationships and her ability to catch and keep a man, she holds herself responsible for the success or failure of the union. Moreover, because the two-parent family is considered the ideal, many people feel the family should stay together at all costs. Thus the tendency to hide abuse behind the closed doors of the family is reinforced and the tendency to blame the victim exists (Sinclair, 1985). Mastrocola-Morris (1989) believes that the interactive dynamics of a more traditional socialization with

respect to loyalty to the marriage, and the effects of variables such as poor self-image, social isolation, in combination with the belief that the partner will change, the sense of shame, a fear of retaliation and stigmatization by friends and family, are stronger for older versus younger abused women.

The second reason Robertson (1989) espouses an age-specific group is that the older adult is not a member of the therapy culture and does not know how to share at a personal level. In fact, older abuse victims fear public exposure and the embarrassment they are sure it will bring. More fundamental is the humiliation that victims would experience by admitting that their relatives are capable of such behavior (Cohen, 1984, p. 123).

The third reason Robertson (1989) advances an age-specific program is that for this aged population, depression and grief are major issues and most individuals have suffered severe losses. Indeed, victims of abuse and neglect worry that disclosing the abuse means yet another loss, that is the possible incarceration of the abuser who may be the only caretaker or even the only relationship the older adult has left.

A Social Group Work Model

A social group work model was developed in the early 1960's by Garland, Jones, and Kolodney (1976). The central theme is closeness, and it consists of five stages through which the group and its members pass. They are as follows:

1. A pre-affiliation stage in which members show their ambivalence toward involvement, a need for distance and protection from the promised closeness.

2. A power and control phase in which members demonstrate their needs for both autonomy and the protection of each other.

3. Stage three involves the emotional challenge of intimacy where the strong familial feelings and the striving for satisfaction of dependency needs dominate the group process.

4. A stage of differentiation follows in which the separateness, individuality, and interdependence of members is established, functional roles and shared leadership emerge and a sense of cohesiveness develops.

5. The fifth stage involves the termination process, anxiety over loss, and the breaking of group bonds.

Group Process

Although each group has its own structure and identity, the power of the group lies in the content and process oriented contributions of each member and the leader to the shared purpose of the group. Four stages of a group process has been identified by Tuckman (1965) and Toseland (1990). Tuckman (1965) has labelled the stages as forming, storming, norming and performing, while Toseland (1990) refers to planning, beginning, middle and ending. Toseland (1990) emphasizes that healthy older adults who come together with a clear purpose in mind may coalesce quickly but the frail elderly may take longer to develop group cohesiveness.

Kahn (1979) offers a word of caution in choosing terms and in pushing the elderly to explore the sources of troubled or conflicted

inner feelings and ambivalent relationships. He suggests a concrete and slower pace of therapy interaction. Knight (1986) agrees with the need for therapists to be less abstract and more tied to familiar experience and stresses the importance of allowing sufficient time for information to be processed. Lothstein (1988) states that the leadership style for active elders should be correspondingly active, that is problem-focused, and Weiner (1988) notes that important functions of the leader include enhancing coping skills, anxiety reduction, and emphasizing a positive viewpoint.

A typical initial reaction to group therapy at any age is ambivalence, however, a special problem that surfaces for the elder is the fear of status devaluation. The vulnerability attached to self-disclosure in a group setting can overshadow any promises of support and encouragement. This fear may be intensified by the possibility of lowering one's self-esteem.

Lakin (1988) finds that the older adult group member discloses more intimate details than the younger member about mutually expected problems such as loneliness, rejection and fear of abandonment. In elderly groups, Lakin (1988) observed a continuous flow from self-disclosure to reassurance or advice followed by comforting responses. He concludes that the elderly appear to reveal feelings with the confidence that others in the group probably feel the same way. This confidence facilitates emotional communication.

The muted emotional tone has implications for strategies that confront intrapsychic and interpersonal tensions. The finding suggests that practice should oppose tendencies in this age group to lessen the

intensity of their emotional reactions. According to Lakin (1988), the aged may be more self-protective than the younger in that they avoid strong overt reactions to other members. Group interventions should then stress an accepting, encouraging, supportive mode and avoid attempts to arouse emotional responses.

Co-leadership

This practicum is a group counselling program in which two social work professionals jointly shared the responsibility for interviewing group members and for facilitating the group activities. Liebermann and Blievise (1985) find that professionally led groups have a greater impact in improving the mental health of the elderly than peer-led groups. For the older abused woman who is fearful of her own power and who has little experience acting in a non-authoritarian structure, the presence of two leaders for structure and guidance may enhance a sense of safety.

Many writers (Heap, 1985; Henry, 1981; McMahon & Links,, 1984; and Starak, 1982) find that co-leaders model ways for coping with relationship problems. For example, leaders may act as models of mutual respect and support to socio-emotionally disadvantaged group members by inductive not deductive interaction (Starak, 1982). Objectivity is created by providing helpful insights into transactions, slowing down the group pace, and examining in detail growth limiting behavior (Henry, 1981; Starak, 1982).

Starak (1982) suggests that another positive aspect of co-leadership includes an increased limit setting capacity. This is particularly useful when facilitating a group with emotionally disturbed

members such as abused women. Tomita & Quinn (1986) emphasize that violence in the home is an emotionally charged issue and helplessness produces emotional disturbances.

The co-leaders also act as a catalytic ingredient to generate process and energy exchanges in the group, thereby facilitating a positive, therapeutic, growth-inducing environment. Within this risk taking atmosphere, members can experience feelings of safety in testing their boundaries, exploring their alternatives, and identifying their strengths as they are sheltered from consequences that could befall them in another setting (Starak, 1982).

The group contains all the complexities that accompany networks like the family, work, friendships and other relationships. As such, a support group for older assaulted women should be co-led, as this results in support and a decrease of anxiety and stress on an individual leader. Additionally, many writers find that crisis may be more effectively managed if there are two sources of consistent strong support (Heap, 1985; Henry, 1981; NiCarthy, et al., 1984; Sinclair, 1985; Starak, 1982). Walker (1979) confirms that a group for abused women can be an extremely therapeutic experience, "Such a group combines the best of the consciousness-raising groups with the expertise of (preferably) two therapists familiar with group process" (p. 240).

Working together, co-leaders experience a continual process of mutual growth and refinement of their therapeutic skills. Patterns of relating in a co-leadership setting focus on flexibility, sharing of responsibility and power, growth and learning, and a value-added component (Starak, 1982). The opportunity to debrief after each session

(see Appendix II, D) allows leaders to review the group process, facilitate planning, and help to keep the group's movements on track (Sinclair, 1985). Moreover, co-leaders may share their perceptions of the group and their roles in it.

Disadvantages of the co-leadership approach include the unpredictability of partner response during the group process. As well, it is time consuming and costly as two not one leader is involved in the planning stage, determining the content and guiding the group process. Furthermore, different counselling styles may become a point of contention between leaders.

Advantages and Disadvantages of a Group Approach

Group work has many advantages. One advantage is that a member must learn to deal with the idiosyncrasies of other individuals and acquire skills in offering feedback and advice in a constructive and tactful way (Rose, 1991). This is particularly relevant to group work with older abused females. As females are socialized to a role that does not carry appreciable value in society, a tendency to devalue women may be set in motion.

NiCarthy, Merriam and Coffman (1984) report that conflict may arise between women who have left an abusive relationship and those who remain with the abusive partner. Women of these two subgroups may regard each other suspiciously and will learn to overcome the fear that the other will not understand or respect the decisions they have made to remain with or leave the abuser. For the older woman, personal success and economic security have depended upon the acquisition of a husband.

Thus other women have become rivals in the marital game and this competitive position continues throughout the life cycle.

Another advantage of a group strategy involves the process of helping others. Through the group involvement, members are likely to practice strategies for helping themselves and extend what they have learned about helping to others outside of the group (Rose, 1991). If members give and receive phone numbers they will leave the group knowing that there are quite a few people they can talk to during the week who will understand what they are experiencing and who will be able to listen empathetically (NiCarthy et al., 1984).

Support is extended to the older adult by being an accepted member of a cohesive group. The group provides socialization, self-help, and is a setting where attitudes of caring and concern are readily expressed (Fisher, 1988; Hainer, 1988; Hancock, 1987; Krill, 1986; Lakin, 1988; Matorin & Zoubok, 1988; Stern, 1988; Weiner, 1988).

As well, the group provides an opportunity in which psychosocial difficulties relating to interpersonal interaction have the potential to be resolved. Consequently, members are likely to improve their extra-group relationships and decrease isolation as they learn that the world is composed of other abused women facing the same struggles, fears and anger.

A problem-solving approach creates an atmosphere in which physical and emotional benefits may result from effective adaptation to stressors that threaten independence and autonomy. Members can take pride in having information to offer each other that is derived from life experiences and from their ongoing efforts to cope with stressful life

events (Liebermann & Blievise, 1985; Toseland, 1990; Tross & Blum, 1988; Rose, 1991).

Negative expectations of clients towards group therapy appear to be the greatest disadvantage (Rose, 1991). A survey of 206 subjects reflected three categories of expectations for group therapy: (1) it is unpredictable, (2) it is not as effective as individual therapy, and (3) it can be detrimental to participants (Slocum, 1982). Individuals who are extremely shy or who possess extremely negative perceptions toward the group may not be able to use this type of counselling/therapy.

Discussion

A number of gaps exist in the literature regarding group work with the older adult, which includes the relative sparsity of evaluations of the effectiveness of group interventions. Specifically, in examining the literature on small groups, there appears to be very little integration of research finding between the disciplines of sociology, psychology and the professional group work practitioners. Rather than the sharing of research, independence from each other seems to be the common practice.

Rose (1991) finds that group research has not kept pace with practice and process and outcome are not sufficiently examined. Although many studies are completed, most have methodological flaws and many have extremely small samples, and in some research, subjects are not randomly assigned or matched for the various conditions. As well, the explanatory power in many research cases is often too low to

demonstrate the significance of small differences and individual rather than the group is incorrectly used as the unit of analysis.

However, groups help older adults to overcome isolation and to expand their informal support networks. Additionally, a sense of hope is provided to counterbalance situational depression arising from multiple life losses and other traumatic experiences. In a group setting, members demonstrate their wisdom and are presented with a chance to play a useful and meaningful role in helping others with similar problems and concerns.

The women's literature (Belenky, Clinchy, Goldberger, & Tarule, 1986; Brody, 1987; Miller, 1976; Sturdivant, 1980) contend that all-women groups break the isolation of women from each other, provide new role models for self-definition, and attempt to transcend the traditional emotional dependence on male approval. As well, all-women groups facilitate more self-disclosure. They focus on intra-personal issues such as the establishment of independence, expression of one's potency, resolution of expectations, the elimination of self-hatred and the repression of one's abilities. Thus, for the elderly female victim of abuse the group is a place that offers safety for members while fulfilling many psychosocial needs.

CHAPTER III

METHODOLOGY

In this section the value perspective, the intervention, the design, instruments and the program content will be presented.

Value Perspective

This practicum took the position that change is an option at any age and developmental crisis offers an opportunity to readdress and overcome earlier unresolved tasks. To this end, group members were empowered to face new challenges for coping and to make some crucial choices and decisions about some long-standing issues. In essence, the intervention process attempted to restore a sense of power, control and dignity to the older abused woman's life.

The group encouraged its members to nurture themselves and to act self-protectively against further abuse. However, the choice to leave or not to leave the abuse relationship was not the issue. Rather the important decision was to decide not to be abused anymore. This practice recognized that older adult women have taken responsibility for protecting themselves and their children throughout their lives. It articulated that change is an option at any age and that older adult women can improve their lives given the needed support, information, and the necessary resources.

The value system is based on the underlying belief that women have the strength, power, and potential to help each other change their lives individually and collectively. The equality of women is endorsed as it is believed that violence is a result of a power disparity and is perpetuated systemically through the institutions within our society. This feminist approach shifts the blame from the woman onto the larger social system that affects all women in our society. In practice, this supports counselling that is non-judgemental and client-centred, and recognizes that individual circumstances and situations will result in varying needs and personal goals.

The Intervention

This practicum was a group intervention strategy. It was composed of a voluntary sample of seven female victims of male spousal abuse within the community population of Winnipeg.

The group was designed as a problem-solving, educational and support group based on the cognitive-behavioral theory. It took place over a 10-week period of time from April 7, 1992 to June 16, 1992 with sessions held one afternoon each week for two and one-half hours. It was co-led by an MSW agency counsellor.

The group was advertised as an opportunity to reach out and learn some self-care techniques. It was offered free of charge to individuals who were:

1. female;
2. over 60 years of age;

3. presently in or recently been in an abusive male spousal/partner relationship;

4. free of any history of dissociative states, psychosis, or chemical dependency; and

5. responsible for their own transportation.

The group was sponsored by the Elder Abuse Resource Centre, a three-year pilot project of Age and Opportunity Centre of Winnipeg, which has served the elderly community of Winnipeg since 1957. The Resource Centre responds to the needs of men and women, aged 60 and over, who are victims of, or at risk of, abuse. Services provided by the Elder Abuse Resource Centre include counselling, crisis intervention, education, professional and public awareness programs and volunteer peer support.

Recruitment Process and Group Membership

Members were referred to the group by the staff at the Elder Abuse Resource Centre and by several social service agencies in the Winnipeg area upon receipt of a newsletter advising of the program (see Appendix I, A). Recruitment occurred in conjunction with such social service agencies as the Fort Garry Women's Resource Centre, the Evolve program for abused women, Manitoba Corrections and Probations, the Women's Health Clinic, and Family Services of Winnipeg, etc. As this was the first time a group for older female victims of spousal abuse had ever been offered in Winnipeg, and with a newly formed agency, there were

difficulties in acquiring group members. As a result, the starting date was postponed monthly for a three-month period of time until April, 1992.

During this time, initial advertising occurred on the local television stations and in the newspapers. A second recruitment action included mention in education and public awareness workshops conducted by the Center for agencies. A third recruitment thrust resulted in advertising at university social work and gerontology courses, senior centres, hospitals, personal care homes, and with the provincial continuing care case coordinators.

Although it was expected that several elders would be interviewed, only seven individuals expressed an interest in joining the group. They were interviewed and accepted for the program. Three other women who were advised of the group stated that they would have liked to attend but they had other demands placed on their time and would join a group at a later date, while another woman preferred to keep the abuse a "family affair." As a result, six of the seven clients were agency referrals.

Quite possibly the name of the agency, The Elder Abuse Resource Centre, served as a deterrent for some potential group members. Simply, in order to access the group experience, the client would have to accept that she was being abused. Since this population has been socialized to believe that they are responsible for the success of marital relationships, a sense of embarrassment, shame, denial, and failure may have been connected with this acceptance. This assumption is supported by the literature on elder abuse.

Another barrier to access may have been the same one encountered by this student during the literature review. Specifically the confusion surrounding what exactly qualifies as "abuse." If the clients, who risked scorn and abuse by contacting the agency, did not think of themselves as victims, was it reasonable to expect older women in violent relationships to realize that they were being "abused"?

Not only could there be some possible confusion about the definition of abuse with the older adult victim of abuse, but also with professionals who work with this segment of the population on a regular basis. Upon follow-up with professionals, I was advised that referrals were not made because the worker "did not know anyone who was being abused." However, when this concept was reframed to knowing any older women in "lousy relationships" several individuals immediately came to mind.

Recruitment of Group Members

For individuals who contacted the agency about the group, the intake procedure began with a telephone prescreening that ensured that the individual met the criteria. Once eligibility was established, an intake interview was scheduled, each lasting an average of one-and-one-half to two-and-one-half hours.

As individuals who were initially interviewed in January and February became restless and impatient with the increasing delay, the start date for the group was established in order to retain the interested members. Thus the first group began with seven older female

adult victims of spousal abuse in April, 1992 after individual interviews were conducted. The group was closed with no new members interviewed after the start.

Design

As stated, this practicum is based on the work of one MSW student and one MSW abuse agency counsellor and seven clients. It utilized a case study approach with interviews conducted prior to the group experience. The practicum also included the pre and post-treatment standardized measures.

Anecdotal information was gathered during the initial interviews for the group. To decrease errors, notes were recorded during the one and one-half to two and one-half hour discussions by one member of the co-facilitation team while the other leader asked questions.

Kazdin (1982) refers to a case study as a pre-experimental design that does not allow internally valid conclusions to be reached. As the study of elder abuse is in its infancy, more data and information is needed to determine exactly how best to assist this population and, therefore, conclusions are difficult to form. In a case study design, a group is studied in such a fashion that unambiguous inferences cannot be drawn about the factors that contribute to performance (Campbell & Stanley, 1963; Paul, 1969).

The pre-test/post-test measures were client self-reports which identified the extent of problems with regard to social support networks, self-esteem and dysfunctional attitudes. The three measures

were selected to help develop a broad accurate picture of any changes in human functioning and were perceived to be the most direct, valid, reliable and sensitive assessment tools available. As well, they provided a numerical score for estimating the magnitude intensity or degree of the problem. The assessment scales were completed by the clients and the individual interviews also created an opportunity to obtain suggestions and comments for future group programs.

The instruments selected were the Hudson Index of Self-Esteem (Hudson; 1982), as published in The Clinical Measurement Package: A Field Manual, the Dysfunctional Attitude Scale (Weissman; 1980) as published by Corcoran and Fischer, 1987, The Lubben Social Network Scale (Lubben; 1988), letter of permission in appendix IV B, and an adapted version of the Client Satisfaction Questionnaire (Atkinson; 1979). All measurements except for the Client Satisfaction Questionnaire were completed pre and post-treatment to determine any change in psychosocial functioning and thinking. All measurements are linked to the characteristics of abused women and the objectives of the group intervention.

Evaluation

For evaluation purposes, a traditional paradigm was employed. This approach utilized questionnaires, personal interviews and the comparison of pre and post-group scores on objective measures (Lubben Social Network Scale; Dysfunctional Attitude Scale, and Index of Self-Esteem). As well, to assess personal success, each group member

designed her own goal at the initial intake process. The attainment of this goal indicated program effectiveness and each woman's personal progress and success. In short, successful criteria was based in part on the feminist evaluation concept which measures success according to criteria established by the users of the service.

The final evaluation tool was an adapted version of the Client Satisfaction Rating Scale (see Appendix II, C) developed in 1978 by Atkinson (Concoran & Fischer, 1987). This questionnaire determined the acceptability of the treatment program to the client as a consumer.

Instruments

The Hudson Index of Self-Esteem (Hudson; 1982)

The Index of Self-Esteem (ISE) is a 25-item scale designed to measure the degree, severity, or magnitude of a problem the client has with self-esteem. Self-esteem is the evaluative component of self-concept and was perceived to be applicable to this practicum as problems with self-esteem are often central to social and psychological difficulties. The ISE has a mean alpha of .93 indicating excellent internal consistency and an excellent (low) S.E.M. of 3.70. The ISE also has excellent stability with a two-hour test retest correlation of .92. The ISE has good known-groups validity and very good construct validity. The ISE has a cutting score of 30 (=5), with scores above 30 indicating the respondent has a clinically significant problem and scores below 30 indicating the individual has no such problem.

The Lubben Social Network Scale (Lubben; 1988)

Support for the administration of the LSNS is provided by research that indicates that social ties provide a buffering effect from stress thereby reducing the vulnerability of an individual to stress-related illness (Cobb, 1976; Thoits, 1982). Many other researchers (Asher, 1984; Blazer, 1974; Ell, 1984; Greenblatt, Becerra & Serafetnides, 1982; House, Robbins & Metzner, 1982) support the importance of a social network and conclude that social relationships are good for the physical and mental health of the elderly.

Having many social ties is the polar opposite of being isolated, the latter being a risk factor for many physical and psychological problems. Victims of elder abuse are often isolated from social contacts other than the immediate family and are usually hesitant to report the abuse (Breckman & Adelman, 1988). The LSNS is a 25-item scale which examines size of active network, size of intimate network, confidant relationships and frequency of contact. Reliability analysis confirms the affinity of these ten items in three different large samples ($N > 1000$) of elderly persons (Cronbach alpha = .70). Not included in the LSNS because these items may not be as relevant to elderly populations, particularly those very old and frail are membership in clubs and organizations.

The LSNS taps into three distinct dimensions of social networks and each factor might be treated independently as a specific subscale. These three factors might be labelled: family relationships, friend relationships and interdependent mutual support relationships. The LSNS score is obtained from an equally weighted sum of 10 items with the possible range of scores 0 - 50. Low scores on the LSNS indicate weaker

social networks and a score of less than or equal to 20 is indicative of social isolation.

The Dysfunctional Attitude Scale (Weissman; 1980)

The DAS was selected because it taps into cognitive distortions that may underlie or cause depression. It is linked to the findings of Gesino, Smith and Kekich (1982) that suggest that because of more traditional socialization with respect to loyalty to the marriage, the effects of variables such as poor self-image, social isolation, belief that the husband will change, are stronger for older women.

In other words, the DAS is based on the belief that a sense of helplessness may arise from the clients idiosyncratic patterns of thinking and beliefs. Cognitive clinicians maintain that maladaptive cognitive structures make individuals vulnerable to particular disorders by influencing how they see themselves and their worlds.

The Dysfunctional Attitude Scale (DAS) is a 40-item qualitative measure of the maladaptive underlying assumptions (Weissman & Beck, 1979). It represents seven major value systems: approval, love, achievement, perfectionism, entitlement, omnipotence, and autonomy. The DAS is easily scored by using zeros for items omitted, assigning a score of 1 (on a 7-point scale) to the adaptive end of the scale, and simply summing up the scores on all items. With no items omitted, scores on the DAS range from 40 to 280 with lower scores equalling more adaptive beliefs (few cognitive distortions).

The DAS has excellent concurrent validity and internal consistency with alphas reproduced ranging from .84 to .92. The DAS also has

excellent stability with test-retest correlations over eight weeks of .80 to .84.

Program Content

The group content had 3 main stages with a developmental aspect to it. It began with the socio-cultural context of abuse narrowed to family experiences and ended with the individual response to violence and self-care techniques. As such, the program content included the myths of abuse, the cycle of violence (see Appendix III, A), family of origin messages, anger and fear and self-care coping strategies. Materials by Derbyshire (1984), NiCarthy et al., (1984), and Sinclair (1985) were used to stimulate discussion and learning about domestic violence. Each session had a review of the previous group content and an opening and closing. An exercise was selected to address the main topic and maximize continuity, personal meaning and transferability of new learning. An outline of the group program is presented in Appendix III A.

Instructional media included items such as a flipchart and marking pens, handouts, and paper and pens. Pamphlets on family violence, shelters, and support services were on display and readily available for members.

CHAPTER IV

INTERVIEW PROCEDURE AND THE WOMEN'S STORIES

As established in the literature review, interpersonal contact with the elderly defies the stereotypical image of a homogenous population that represents a single culture. On the contrary, the experiential world of the older adult is as diverse as the individual who compose this subpopulation. The older adult has many variations in capabilities, interests, as well as many capacities for relationships. The individual interviews provided an opportunity to document the life experiences of some older female victims of spousal abuse and expand the literature on this topic.

Recruitment of Group Members

For individuals who met the group criterion, an intake interview was scheduled, each lasting an average of one-and-one-half to two-and-one-half hours. Although it was expected that several elders would be interviewed, only seven individuals expressed an interest. They were interviewed and accepted for the program. Most clients were agency referrals. Most clients were agency referrals.

The Interview Process

The interview process had three stages: engagement, exploration and definition of the problem, and the problem-solving stage. In fact, the first stage of the entire treatment program, engagement, began with the initial assessment interview. Specifically, it was the counsellor's task in each interview to "form a bond" with the client and create a warm and accepting atmosphere to facilitate the future group work process. A balance was maintained between objectivity and the collection of data on the one hand, and feeling and empathy on the other. Positive expectations were fostered by providing encouragement, support and validating the woman's strengths and survival skills. This approach served to challenge and counteract attempts to attribute distress to an external irreversible source and tended to mobilize hope.

The interview process also allowed for the exploration and definition of the severity of the abusive situation. The interview defined and clarified the abuse and assessed for safety issues and suicidal tendencies. When the immediate concern for client safety was eliminated, the history of the violence and demographic information was gathered and information was shared about the group.

During the problem-solving stage of the interview, the counsellors helped to identify a specific plan of action to resolve any stated concerns. This resulted in referrals to legal, medical, and financial personnel, yet allowed the client to maintain the locus of control by allowing her to be responsible for the contact. It was assumed that by

granting the client early choices, she would be encouraged to take charge of self-care activities and to overcome a sense of powerlessness.

The First Interview

The first interview of the first client (Lee), was planned to allow the client to tell her own story, gather demographic data and information on the incidents of abuse (see Table 1). The intake form initially used was developed by a community agency for younger abused women (see Appendix I, B) and with the addition of a few questions (#4. Do you have any medical problems or disabilities? #5. Do you take any medications regularly? and #82. Does your partner have any health problems that would affect his decision-making abilities?) appropriate for older women as well.

During the interview, however, my enthusiasm and excitement as an interviewer began to wane as I became aware of the clients' uneasiness with terminology such as "abuse," "violence," and "victim." I wondered, was this woman in denial? Did she not want to recall the numerous past incidents of family violence? or did she not view herself as a victim? She obviously experienced difficulty identifying violent behaviors as abusive.

As a result of her reactions, I made a conscious effort to change my vocabulary, ask open-ended questions, and validate strengths and coping strategies. However, the major change that occurred in future interviews was that a general versus a detailed account of past abusive events was obtained.

As the interviewing counsellor, my own reactions to the denigrating experiences Lee described resulted in muscle tension, shallower breathing, and a flurry of physical activity long after the interview had ended. This was experienced in spite of the fact that I believed I had come braced for any possible type of horror story of violence. The realization that her husband sat waiting for her outside the main office certainly contributed to her anxiety and haste and to my concern for her safety during and after the interview.

Although Lee maintained she was in no immediate danger from her husband, my assessment based on the literature review and her past physical abuse, differed. Consequently, the interview was ended and another one was scheduled to complete the intake. Although her husband once again drove her to the office for the second interview, he went on business which resulted in less tension for all. When the interview had almost finished he had returned to drive her back home. This woman stated that she had never used public transportation and that her husband drove her everywhere.

Looking back on this interview, I can recall my struggle to allow her to be the expert on her own situation. I thought that as the professional I should have the answers and yet was confronted with the reality that she, not I, had the past experiences and the knowledge to survive in her reality. Thus the role I adopted in future interviews was that of a student learning about the client, accepting the way she was, and validating her strengths. I reinforced her belief in herself to manage her life as effectively as possible with the recognition that she was a survivor and not a victim at all.

The struggle that I had, emphasized the limitations and scarcity of resources available for this population. I wondered how I would have helped this older women if she could not have returned to her home. The abuse she experienced was financial which posed severe restrictions on her flexibility; physical, which placed her life in danger; and psychological, which could have destroyed her sense of efficacy. Yet after 48 years of an abusive marriage, this petite, well groomed, soft spoken 75-year old Irish woman only wanted to meet other women in the same situation as hers and to share her story. That was her personal goal for the group.

Client Characteristics

The clients, seven elderly female victims of spousal abuse, were white, born in Canada except for one Irish and one English war bride. One member was of Jewish decent, another member described herself as French Canadian-Arcadian, one French Manitoban, one of mixed predominantly German/Jewish descent, and one of Scottish/Irish descent. The average age was 68 years with most ages equally distributed. Two group members were 60; two were 65; two were 75 and one was 77 years of age (see Table 1).

With reference to marital status, three were married and resided with their spouses, one separated from her spouse following the interview for the group; one separated from her spouse during the group, one received her divorce during the program and one re-united with her husband. Four women had been married for over 40 years, two for over 35

Table 1

Client Characteristics

SUBJECT	Years In Relation-ship	Age	Marital Status	Ethnic Origin	Years Of Marriage	Education/ School	Employed Outside Home	Number of Children
Agnes	13	77	2nd Marriage separated then husband returned	French-Manitoban one of nine children - cl oldest cared for others	1st-40 yrs 2nd-13 yrs	Gr. 9	No. Yes in past, worked in nursing home	3
Lee	48	75	1st relation-ship with husband	Irish war bride. one of seven children - cl middle child youngest three daughters	48 yrs	Gr. 9	No. Yes til 70 as NA in hospital	had 6 one male died at 4 months old
Florence	47	65	separated after group interview	English war bride 1 of 2 children 1 brother older 5 yrs	47 yrs	Gr. 12 + Nsg	No. Yes in nursing	had 3 boys, now has 2 sons. mid. son died of cancer at 15 yrs and youngest schizop.
Martha	45	75	divorced during group	French-Acadian 1 of 8 children cl 2nd youngest	46 yrs	Gr. 9	No Farming	4 children 2 male, 2 female 1 son schizophrenic
Vera	37	65	1st relation-ship with husband	German/Jewish 1 of 5 children 2 male 3 female 1 older brother then cl.	37 yrs	Gr. 12 some university courses	No. Worked fed. Govt. Taught	2 sons 1 son died at 22 years with melanoma
Gloria	41	60	1st relation-ship with husband	Irish/Scottish 1 of 2 children 1 male and 1 female cl youngest	41 yr	Gr. 12 some university courses	Yes. Piano Teacher	4 children 1 daughter suicide
Sadie	35	60	separated	Jewish 1 of 3 children 1 male 2 female cl youngest of female 20 yrs younger	35 yrs	Gr. 12 Secretary Sales Jobs	No. Secretary Sales in past	3 children 2 sons prof 1 died 5 hrs after birth, a daughter

Table 1

Client Characteristics (cont'd.)

SUBJECT	Income	Status Socio-Economic	Health	Major Stresses Family/ Self	Times Left Before	Type of Abuse
Agnes	OAS/GIS only	Low. Resides in Wpg regional housing	good	Lack of family in Winnipeg as support Husband has own apartment	0 x	Physical Financial Psychological
Lee	OAS/GIS/CPP	Low middle	poor heart HBP vision diverticulosis thyroid depressions	Mother of alcoholic wife of alcoholic grandmother of alcoholic son Peter died 4 mo. war bride	1 x	Physical Financial Psychological
Florence	OAS/CPP	Low	Asthmatic Colostomy in past	son's death 1 of son's health - schizophrenic war bride husband was alcoholic	2 x	Physical Psychological Financial
Martha	OAS/GS	low resides in Wpg regional housing	Good High blood pressure	son schiz. dtr husb deserted husband alcoholic	0 x	Physical Psychological Financial
Vera	OAS/GIS/CPP	middle	good	husband terrets estranged relation son son dec'd	0 x	Physical Financial Psychological
Gloria	inheritance income and earnings	low middle	poor, just overcome cancer	daughter suicide cancer grand daughter autistic alcohol abuse child fam. father alcoholic	0 x	Psychological Financial
Sadie	CPP/Welfare	low	poor bone cancer on chemotherapy	cancer 2 sons provided no instrumental support	2 x Osborne House	Physical Psychological Financial

years. One member who was in her second marital relationship for thirteen years was in her first abusive relationship.

Abuse consisted of a combination of physical, psychological and financial for six members, and psychological and financial abuse for one woman. Three reported alcohol was sometimes involved at time of the abuse but not always.

Members had no history of dissociative states of psychosis or chemical dependency. All clients had talked to or received some form of assistance or counselling from professionals (and/or friends) in the past, either from a minister, a medical doctor, the police, psychiatrist, social worker, and/or a lawyer.

The educational background consisted of Grade 12 for four members and Grade 9 for three. All the women were retired except for one who was employed as a teacher. All but one woman had worked outside of the home in the past. Past occupational status included the service sector--two had been employed as nurse aides; one had worked as a secretary and in sales--as well as the professions--one had been a nurse and two had been teachers. The majority relied on their OAS pensions as a primary source of income, three were in receipt of Canada Pension as well, one had earnings plus a small inheritance income, and one was on welfare and Canada Pension. Most could be described as low income and socio-economically disadvantaged.

Health status was almost equally divided with four members in relatively good health, although one had asthma. Two members suffered from cancer and one suffered from multiple problems such as a heart condition, poor vision, thyroiditis, depression and diverticulosis. The

number of children they had per family varied from six to two. Five of the women had children who had died, and had children die within the first year of life. Two of the women had sons die of cancer, one at 15 years of age the other at 22 years of age. One group member had a daughter of 28 years of age commit suicide. Two group members had adult sons, in their forties, with diagnosed mental health problems.

With regard to birthplace and family of origin, one client was the oldest child in a family of nine children; one was the youngest in a family of three children with an age difference of 20 years between herself and her closest sibling; two members were the youngest and only female child in a family of two children; while three were middle children in families of both gendered children.

All but one member resided in the suburbs of Winnipeg. One member travelled in from a nearby small town.

Interview Questions

To examine further the issue of elder spousal abuse and to increase my own understanding as a counsellor, specific questions guided me throughout the interview process. The questions are as follows and a summary of the responses are presented on Table 2.

1. When was the first incidence of abuse experienced? Can you describe it and has it changed over time?

This question was asked to determine if the abuse is of long duration or a recent phenomena. The description also identified if the abusive behavior changed with advancing age. The responses indicate

that the abuse began early in the marriage, two of the six women, Lee and Florence, were pregnant with their first child when the physical abuse began and for three of the women Lee, Florence and Martha, abuse was associated with alcohol (see Table 2). Over time the husbands drinking decreased and gradually stopped, however, the physical abuse continued but at a lesser degree of intensity. Both of the two women, Lee and Florence, who were abused physically in their first pregnancy, were war brides and newcomers in their new country of residence at the time. All three of the women who were geographically relocated suffered from extreme isolation and lacked any form of a social support network.

2. Did you tell anyone about the abuse and what happened as a result? This question aimed at exposing any hidden forces that influenced the woman to stay in her relationship. The responses to this question indicated that three of the women, Lee, Florence, and Sadie, had the police involved in their home life situation at an early stage in the marriage. For all three women the reason they remained in the relationship was "because of the children," because they were "financially dependent," and "because they had nowhere to go."

One woman, Gloria, who experienced financial and psychological abuse was advised by her minister to "be a good wife now and go home and make supper for your husband." Another woman, Martha, who resided in a small farming community, stated that she did not tell anyone because she felt she was the "same as all the other wives in the area who were also beaten by their husbands" and "nobody" (reference to authority figures) "would believe me anyway as my husband had a good reputation and was respected in the town." She remained because of the children and had

Table 2

Findings From Interview Questions

CLIENT	FIRST INCIDENT	TELL ANYONE WHAT HAPPENED?	COPING STRATEGIES	DRUGS/ ALCOHOL ALWAYS INVOLVED	ABUSE IN OWN FAMILY?
Lee	- when 27 years old during first pregnancy - physical	Yes. Police, an alanon sponsor, children. Grew up with it. Police pressed charges.	- go for a walk. - talk on phone. - stay quiet. - read books.	Initially alcohol with physical abuse but no alcohol now.	- not physical. - father. Verbal, psychological abuse.
Gloria	- after 13 years of marriage - affair	Minister. "Go home and make supper for husband."	- courses. - piano teacher. - made own life.	No.	No, but mother strict and father a teacher.
Martha	- 33 years ago when returned to Manitoba to live - physical	No. Same as everyone else. Nobody would believe me - husband respected in community.	- fought back. - brought stick to bed.	Mostly, but not always.	No. A loving family.
Vera	- early in marriage he left marital bed	Told sisters. Told to leave. Doctor/Psych. who helped her cope - medications.	- created own life outside relationship. - interests music, sewing, designing. - walk away.	No.	No. Father a teacher and lectured only. Not strict.
Agnes	- shortly after marriage - husband physically abused her	Yes. Neighbours saw physical abuse and warned him to stop.	- trips. - visits with friends.	No.	No.
Florence	- when 3 months pregnant with first child - physical	Yes and police called and helped. Family and friends non-supportive.	- shopping. - talks to son. - walks away. - go out anywhere.	Not always--in beginning. Yes but quit drinking.	No, but mother very, very strict.
Sadie	- on honeymoon - psychological	Yes--police and family and therapist Psychiatrists. Social Workers.	- courses. - knits. - piano. - created own life. - attends socials. - writes music.	No.	No, client doted on. Was baby in family (22 years younger than other children).

Table 2

Findings From Interview Questions (cont'd.)

CLIENT	WHY STAYED?	TYPE OF ABUSE	BELONG TO GROUPS	PERSONAL GOALS
Lee	- children. - financially dependent. - no supports.	Physical Financial Psychological	Yes Alanon Church Confidants	- share own experiences - meet others, friends from group - use a bus
Gloria	- community profile for husband, herself, family.	Financial Psychological	Yes Confidants Church Music Group COSA - Alanon	- social support. Thought intervention before emotional reaction.
Martha	- children and financially dependent. - isolated.	Physical Financial Psychological	Yes Church Confidants	- to meet others. - continue believing in myths.
Vera	- children. - financially dependent. - "didn't want to upset mother"	Physical Financial Psychological	Yes. Many. Church Dance Group Travel Group Lake Group	- to tell other abused women to create a separate life - social support
Agnes	- "I just hate being alone."	Physical Financial Psychological	Yes Church Confidant	- social support
Florence	- children. - financially dependent. - no supports.	Physical Financial Psychological	No, but confidant /friends	- to move or get husband to move out. - social support
Sadie	- children. - financially dependent. - believed husband. - no supports.	Physical Financial Psychological	Yes. Many groups. Music Group Confidant	- to move out - to deal with her anger

no supports or finances.

Another member, Vera, discussed her home situation with medical practitioners who "helped me to cope with my husband" and prescribed medications. This woman's sisters encouraged her to leave her marriage like they did but she chose to stay "not to upset my mother," but also for the sake of the children and for financial reasons. Today, Vera still resides in a psychologically abusive relationship not only because her husband has a serious medical problem but because he has value for her as her "meal ticket to mixed company" and receives a good pension. She arranged for the DVA income he receives. Vera freely admits to a fear of being alone and being "just another one of those old women."

The oldest member of the group, Agnes, who is 77 years old, is a survivor of physical abuse perpetrated by her second husband of 13 years. She was rescued by neighbours who intervened "during a (physical) fight outside." Her husband was warned that he "could not do that," and if he did not stop beating her up they would call the police. She states that he never physically abused her again, however, the financial and psychological abuse continues. She remains in her relationship because "I just hate being alone." Her children reside in the United States.

3. What did you do when the abuse started, or to prevent or try to control the abuse?

This question attempted to identify coping strategies, and determines if the behavioral patterns fit the cycle of violence. Responses generally indicate a trend towards passive behaviors, with four of the seven members leaving the house (or situation) to go for a

walk; three members "made my own life outside the marriage"; one fought back physically, and one visited friends. Generally, the women became quiet and quit talking in an attempt to control the situation. The cycle of violence pattern seemed to be generally applicable, although one woman, Florence, mentioned that the honeymoon stage had virtually disappeared over the length of the relationship. This statement, however, was discounted by the husband's current pleas to re-establish the relationship once again.

4. Was alcohol/drugs involved with each incident of violence?

This question assesses if a new dimension has been added to the abuse recently. Responses were that alcohol was associated with abuse in three out of seven abusive relationships but that over time the husbands gradually quit drinking. One of the women, Lee, described herself as "the wife of an alcoholic, the mother of an alcoholic, and the grandmother of an alcoholic," identifying an intergenerational theme of alcohol and abuse.

5. Was violence witnessed or experienced in your family of origin?

This question attempted to identify any expectations of abuse transferred through the generations. Responses were unanimously no to physical abuse, although three women, Gloria, Vera, and Florence, reported that their mothers were very strict and one woman, Lee, stated that her father was verbally and psychologically abusive. Vera, however, shared one recent family experience that indicated that her only living child, a son, had married a woman from a wealthy family who disciplined their children by using physical abuse. This woman had a

childhood history of physical abuse by her parents. Vera stated that her son told her he stayed in the relationship "for the children" who were female. He felt that if he left, the children would be placed in the custody of their mother and he would not only lose access to his young daughters but would be unable to protect them from further abuse. Thus, we hear the repeated themes of the value of the two parent family and evidence of transgenerational violence.

6. Do you belong to any groups or organizations?

This question attempted to determine if the older victim of spousal abuse is socially isolated. The response was that six out of the seven members belonged to groups while the one member who lacked a social affiliation had a confidant and friend. On the other hand, six out of seven women had confidants, yet the individual, Vera, who belonged to the largest number of social groups, lacked a confidant. A confidant was deigned to be someone who had been told of the abuse over the years, and was outside of the family membership.

7. What are your personal goals for the group?

In response to this question, six out of the seven members replied that they would like to meet other women with similar life experiences in order to share their stories. Sadie, who stated that her primary goal was to move out, accomplished her goal during the group. Florence, who stated that meeting other women was her secondary goal, achieved her first personal goal of getting her husband evicted immediately following the interview.

Additional goals were "to share own experiences"; to have "thought intervention before emotional reactions"; to continue believing in

myself"; "to tell other abused women to create a separate life for themselves." Members individually stated that they had accomplished personal goals by the end of the program in June. A goal identified by Lee, to use a bus for transportation, was assessed retrospectively as a little unrealistic (as she had poor vision and has always depended on her husband) and Sadie's personal goal of dealing with anger could be assessed as unmet as she was absent for the group session that focused on anger management. However, her anger did propel her to move out of her marital home and, therefore, her anger management was successful viewed from that perspective.

Discussion

Findings from the interviews lead to the conclusion that for some men the marriage license was perceived to be a permission for violent behaviors as the first incident began early in the marriage for five of the seven women. For two of the women, the abuse began when they were pregnant, thus posing a danger to the woman and to the unborn child.

Not all men resort/decide to use violence when experiencing the increased stresses of family life. But, the fact that some do and have not been held accountable for their actions reinforces their sense of power and control as the traditional head of the family/house and grants them freedom from outside interference. Failure to hold the man accountable continues to privatize the abuse and ensures that the cycle of abuse continues.

Inequality maintained by a traditional socialization seemed to initiate a chain reaction of power confrontations within the group members families. For example, the husband exerted force and violence

on his wife then she repeated the pattern towards someone weaker than herself like her children. In this study one of the women was relieved to admit her use of physical force to discipline her children in an attempt to control the family, while four other members referred to conflict ridden relationships with their offspring.

Friends, relatives, and police who are potentially most valuable to the abused women may insist that she leave her husband before she is ready. In doing so they may disregard her fears, loyalty, and concern for her husband and children. On the other hand, they may try to blame her and advise her to keep the marriage together at all costs. Although three group members had police intervention they lacked the social support and economic base to ensure continued independence for themselves and their children, and for five of the seven women financial dependence played a central role in the decision to remain in the relationship.

In contrast to some of the younger women of today, the older abused woman did not perceive a separation or a divorce as an acceptable solution to a violent relationship. Legal transactions of this nature were not a commonplace occurrence and the tendency to blame the woman was great. Furthermore, legal proceedings were inaccessible to those who were financially dependent and, as discovered in the literature review, prior to the 1970's, the woman was held responsible for the failure of her marriage. Basically the abused older woman was a victim of a sexist society and the complex effects of sociological and psychological interactions. A woman's mothering role within the family is devoted to care, connection and human development. Therefore, when

the woman chooses to end the relationship it is important for her to possess the necessary ego strengths, self-confidence and determination to make a successful separation and transition. She is the best person to make this decision for herself, as it is based on a resolution of emotional and economic dependence, resources and support.

Attempts to prevent or control the abuse emphasize behaviors that are passive, obedient and conform to the abuser's demands. This behavior also depicts a lack of negotiating and discussion for problem resolutions as silence and withdrawal are reinforced. Basically the older women were limited to attempting change from within, as they lacked the necessary resources for leaving and generally received negative institutional responses when they tried to get external help.

In this study, abuse occurred with and without chemical involvement. Therefore treatment should focus primarily on the abusive behavior and not on the alcohol/drug program. As well, members generally claimed to have no experiences of physical childhood abuse themselves but stated their husbands came from abusive families.

The older female victim of spousal abuse in this study did not seem to be socially isolated. Members belonged to groups and most also had confidants. However, the identification of a personal goal highlights the need to share their life experiences with someone who has had similar experiences.

Client Commonalities

The small sample size of seven clients would lead one to conclude that similarities of life experiences would be limited, but this was not the case. Rather than many differences among the women, many similarities existed, particularly with regard to losses. Specifically, physical relocations resulted in the loss of country, family and friends, community for Martha, who moved from the Maritimes to the prairies, and for the two war brides, Lee from Ireland and Florence from England. Two women, Martha and Florence, had adult sons who suffered from severe mental health problems. Both women expressed severe anxiety about adequate treatment for their loved ones following their demise.

Sadie and Lee had both suffered the death of children in infancy. Lee, whose baby boy died at four months old, still expressed some guilt about his unexpected death, while Sadie, who was struggling to survive, had almost forgotten her baby girl who died only hours after birth.

Three women, Vera, Gloria and Florence, suffered the death of children in their young adult years. Both Florence and Vera spoke of the personal horror each experienced during the slow, painful death of their sons from cancer, while Gloria shared the tragic loss of her 28 year old daughter's suicide by hanging.

However, by exploring the personal history of losses with the clients, what surfaced was the incredible inner strength and resolve each woman possessed. For example, five out of seven women had raised children who grew up to be employed as professionals, including one

medical doctor, while of the two remaining, one woman's son is a hotel manager and the other woman's son is a mechanic.

Regardless of the violence and turmoil at home, six out of the seven women worked outside of the home (all experienced financial abuse) while raising families and coping with abusive partners. One woman, Martha, worked on the farm and, therefore, could be viewed as extremely isolated as social contact with others was almost nonexistent. She did, however, manage to maintain her connection with the church.

Four of the seven women enjoyed classical music and appreciated art. They had discovered the soothing and calming effects music had and continued to value and use it over the years. Three clients were able to play the piano.

A common thread was that the male partners came from families that were large, of low socio-economic status and where abuse and violence seemed to be the norm. Particularly for the women who had been geographically relocated, exposure to the husband's family of origin resulted in shock and surprise.

It must be also recognized that for all the women, one of the losses each suffered was the loss of their traditional marital dream. As Florence describes it, "All I ever wanted was a little house with a white picket fence around it and a family. What did I do wrong?" All members stated the need for human touch and a craving for love and affection.

As implied by Florence's comment the women did blame themselves for the failure of their relationship and experienced great difficulty in identifying their strengths. This was not regarded as unusual, for

as Martha says, "After I was repeatedly called a slut and a whore, it's a wonder I didn't come to believe it myself."

Other psychological abuse that was reported included terrorizing behaviors, such as putting a fist through a wall, and for another husband, an axe through the living room wall. Abusive physical behaviors included sex on demand by a male partner who had body lice, punches in the face with closed fists, hair pulling, fingers pushed in eyes, pushing and choking attempts.

Financial abuse ranged from drinking the family income away, to bankruptcy and incurring debts to entertain female companions. Florence spoke of how her husband took $400 per month for his spending money while she asked neighbours for food money for her children and herself.

Client Differences

Some differences surfaced with regard to family of origin and the parent who was valued the most. For both Gloria and Vera, who were the most highly educated and whose fathers had been teachers, the male parent was held in more esteem and affection. This was also the case for Florence who remarked that her father used to sing to his wife to cheer her up during the war years in England. However, Lee, the other war bride, felt much closer to her mother and found her father to be non-nurturing and psychologically abusive. She commented several times on how much he enjoyed playing with his sons who were born after her and how she felt left out of his affections.

Sadie and Martha recalled that the marital relationship between their parents was warm and loving with many happy moments. On the other hand, Agnes, the oldest member, could only recall hard work. She stated that her mother was always pregnant and had many children and that she, as the oldest of nine, was charged with their care.

Agnes left home at 14 years of age and took a private housekeeping job. Today her second husband maintains his own private apartment separate from their marital residence. Agnes believes he entertains his girlfriends there which is different from Martha's ex-husband's behavior of bringing the women home for sexual interaction and different from Sadie's experience. Sadie's husband has nightly dates with a woman 30 years younger than himself. Sadie was recently asked by her medical doctor if she could blame him. "Wouldn't you want someone 30 years younger than someone like yourself who is almost in the 60's?" This woman is presently suffering and receiving treatment for bone cancer.

Both Gloria and Vera have experienced male partners who "left the marital bed" as Vera says, however, at different points in the relationship. Vera had this experience early in the marriage, while Gloria continues to pay off her husband's financial costs for affairs with younger women. Presently, and for the third time in Gloria's marriage, he is involved with a younger woman, who is in her 20's. Gloria is fully aware that this woman is "a prostitute on the streets" and that her husband "envisions himself as her saviour." Gloria presents as verbally and mentally scattered and unfocussed, and has admitted to using alcohol as a coping strategy (like her father), yet she continues to believe that her husband will change. They have now

declared bankruptcy as he has lost the family business. Gloria suffers from cancer of the bowel which was just declared to be in remission.

The difference in education became more evident over time. Martha's straight forward pattern of communication was negatively regarded by Vera who chose to intellectualize and distance herself from experiences. Martha perceived this to be a lack of acceptance and began to withdraw.

Differences were also evident with children's degree of support for their mothers. Vera's only child was married to a woman who was psychologically and physically abusive to him and their children. He seemed to hold his mother responsible for his father's well being as he only "has a dull to normal intelligence" and would "land up eating only batatoes if left alone."

On the other hand, Sadie's children wanted her to leave, however, offered no instrumental support stating they "didn't want to be put in the middle." This woman had previously left twice but had no income, no furniture, no place to stay, or the health/energy needs to survive. Her husband threatened to kill her on several occasions and has no regard for authority, and, as a result, she is intimidated and scared by him. She moved out of her marital home during the group experience.

Martha's children were supportive and her oldest daughter initially provided a place to stay. However, over time this daughter has become psychologically abusive.

Lee's children were aware of the abuse and did on one occasion take her into their home. However, Lee states that they do "point out my faults" which reinforces her dependency and the belief that she is

not easy to live with. As a result, she returned home to reside with her husband who "is ill with severe arthritis in his knees." Her family sought out the Elder Abuse Resource Centre with the hope that their parents would get back together again, as their "mother is very dependent" and they "couldn't manage to do everything for her like their father does."

Florence's children supported her in her efforts to have her husband evicted. They put her in touch with a lawyer and helped obtain the police to enforce the eviction. She states that whenever her oldest son tries to blame her for their poor family life and the mental health problems of her other son she reminds him that without her "efforts to feed, clothe, and care (for them) he'd probably have been dead by now."

Discussion

As discovered in the literature review, conditions and characteristics that create difficulties for abused women include a sense of hopelessness, isolation, low self-esteem, a lack of information, dependency, and a skills deficit in relationship-enhancing skills.

In this practicum, the group members appeared to regard the group as an opportunity to gain some measure of control over their lives. A sense of hope was instilled and was strengthened as the women slowly began to change their self-concepts from powerless to powerful and from victim to survivor. This was facilitated by the shift from self-blame to the recognition of the need for her partner's accountability and responsibility for his actions and the identification of options for change.

The isolation which results from the violence also makes women susceptible to ongoing abuse. The women in this group indicated they had to "create a life of my own" outside of the marital relationship. Thus for the majority of the members, isolation from friends, family, and the community had decreased over the duration of the marriage. However, the need "to share (their) life experiences with other women who have had similar experiences" as reflected by their personal goals was strong and emphasizes the fear that they would not be understood and would be criticized by others. From this perspective, the women could be perceived as isolated from the understanding, acceptance and support they required in order to make new life changes and assume different responsibilities. A lack of societal support served to further reinforce this isolation.

Low self-esteem characterized the group members in this study. Guilt about staying with their partner and the shame that develops from the belief they must be "bad people" both added and resulted from low self-esteem. Members frequently referred to their husbands' constant criticism about their abilities as a housekeeper, cook, or lover, etc. As one member stated, "After forty years of washing floors, my husband is now trying to tell me how to do it." The influence of the older woman's traditional orientation is important as her view of the woman's role in marriage helped to maintain her in the relationship. Over time the woman came to perceive herself as incompetent "I am courageous?", unlovable, "I am a wonderful woman?" and weak, "I am a strong person? That's a new idea" and ridden with guilt and shame.

Many cultural myths and stereotypes about abuse had been internalized by the members. The belief that the abuser would change if she would change was held and evident in the question "what could I do to prevent my husband from bringing his girlfriend home?" Alcohol was also generally accepted as the cause of most abuse. In short, a lack of information about healthy relationships, sexuality, "All men think about is sex," feelings "My husband gets so mad he can't control himself," and addiction was evident.

As well, dependency is reflected in Lee's family comment that they were unable to care for their mothers to the same degree their father could. The older woman commonly defined herself by her relationship to her partner and, therefore, was dependent upon others for her identity in society. The tendency to judge whether behavior is acceptable was based on whether their partners approved. This dependency fostered by their husbands was also an economic reality as most of the members spent the greater percentage of their lives in the traditional role of wife and mother consequently had little or no income of their own. For example, one group member became dependent upon welfare because she was not old enough to receive old age pension and had insufficient funds to cover monthly expenses on her own.

As members had learned to "stop talking", "walk away", and "be quiet" in order to control the abuse, most had not learned communication and relationship-enhancing skills. This was particularly evident with those who had less opportunity to practice their social skills. Often they trusted too quickly. For example, one member immediately disclosed in depth her abusive relationship upon first meeting while another

disclosed a dysfunctional lifelong relationship between herself and her mother. Demonstrating poor communication skills and a fear of intimacy, another tried to change the conversation to a news item when closeness became a possibility. As well, psychological boundaries were usually unknown and most members agreed that the emotional abuse they experienced had the most debilitating long-term effects.

Loyalty has been identified as a powerful motivator of behavior in all kinds of intrafamilial abuse. In this practicum, three of the members initially seemed preoccupied with taking action that is least likely to hurt their abuser, "He's not well." In work with the older female victim of abuse, loyalty and the shame that accompanies such behaviors towards their husbands seemed to be the most difficult aspects to examine. A genuine conflict about what is owed to oneself versus what is owed to others served to emphasize the consequences of women's socialization. Affiliative and caretaking behaviors were regarded as valuable female traits within the group but stress was placed on the need to balance for the well-being of all concerned not at the sacrifice of one for another.

CHAPTER V

MEASUREMENT FINDINGS

This chapter describes the individual results of the measurement tools used in the intervention. As stated earlier, to determine the effectiveness of the program upon levels of self-esteem and social network size, standardized measurement tools were administered pre and post-treatment. The results are presented and individual scores are discussed and interpreted following presentation. An analysis of the group findings are presented and analyzed in the following chapter. To facilitate the meaning of the scores as reported, I begin with the interpretation of scoring and the findings.

Interpretation of Scores

1. Lubben Social Network Scale (LSNS) lower scores indicate weaker social networks. A score of less than or equal to 20 is indicative of social isolation.

2. Index of Self Esteem (ISE) a cutting score of 30 with scores above 30 indicating a clinically significant problem and scores below 30 indicating no such problem.

3. Dysfunctional Attitude Scale (DAS) scores range from 40 to 280 with lower scores equalling fewer cognitive distortions.

Findings are presented in Table 3.

Client Scores

Lee's Results

Lee, one of the oldest members of the group at 75, the war bride from Ireland and the first woman interviewed, consistently showed improvement throughout the program. Her increased score of one on the LSNS reflects the friendship she established with Florence, the English war bride. This relationship became so strong that they visited outside the group and maintained frequent telephone contact. The home visits were an unexpected and rather unusual development. Florence (who was recently separated) reported that Lee's charming husband displayed shock when told about the abusive behavior perpetuated by Florence's husband. The physical abuse of his own wife, Lee, was not discussed and perceived to be of no relevance to anyone at the time. The relationship continues between not only the two women, but also appears to include Lee's husband as he continues to drive his wife to Florence's home for visits. Lee states her husband enjoys meeting someone who can also talk about the war years. The ISE assessment scores indicate an improvement in self-esteem. This is another surprising result as Lee reported an increase in "black feelings" and depression towards the end of the program. However, at the same time she contributed her worries to her multiple health problems. But, her husband continues to control their home environment (cleaning, shopping, and baking), while she is banished to the

Table 3

Results of Individual Measurement Scores

Pre and Post-Group

CLIENT	LNSN		ISE		DAS	
	April	June	April	June	April	June
Lee	31	32	31	22	197	169
Gloria	33	33	51	50	157	161
Martha	25	36	40	62	122	151
Vera	42	41	42	37	197	195
Agnes*	23	-	44**	-	108***	-
Florence	32	37	53	49	168	162
Sadie	41	42	17	32	207	218

* Dropped Out
** 2 Unanswered
*** 5 Unanswered

Lubben Social Network Scale (LSNS) lower scores indicate weaker social networks. A score of less than or equal to 20 is indicative of social isolation.

Index of Self Esteem (ISE) a cutting score of 30 with scores above 30 indicating a clinically significant problem and scores below 30 indicating no such problem.

Dysfunctional Attitude Scale (DAS) scores range from 40 to 280 with lower scores equalling fewer cognitive distortions.

background and a life of reading books, going for walks, and acting as a sponsor for Alanon members. Lee experienced much positive feedback, support and acceptance from other members in the group due to her ability to create warmth, humour, and own her own feelings. Therefore she may have experienced an increase in self esteem in turn.

The DAS scores identify a great improvement by a decrease of 28 points. A closer analysis reveals that the greatest change occurred in six questions where the initial score was disagree very much or totally disagree for a high of a six or seven and in June the response had been changed to a one totally agree, or two agreement very much. Three of the questions relate to perfectionism and suggest, however, a negative trend rather than a positive change. This quite possibly reflects Lee's statements about "feeling down" and the beginning realization that she is still in poor health and in an abusive relationship. However, it is also possible that the glow from her recent trip to Ireland (just prior to the group) is beginning to diminish and the harsh realities of her day-to-day life are beginning to set in.

Gloria's Results

Gloria is a 60 year old employed teacher whose husband declared bankruptcy during the course of the program. Her scores reveal she made no great improvement. Scores on the LSNS were identical pre and post-treatment, and the scores on the ISE decreased by only one.

The LSNS scores reflected no change as a result of the group experience. This woman consistently presented with fluctuations in mood, somewhat flustered and unorganized. She changed from moment to moment, for example, she elicited intimacy and closeness, and then in

the next moment vacillated to distance and intellectualizing. Consequently, members were not drawn to her and she was kept at an emotional distance. The group, however, recognized her distress, empathized with her over her daughter's suicide, and celebrated the remission of her bowel cancer. However ties outside of the program were not developed. This may have been influenced by the fact that she resided in a nearby town which meant a long distance charge was made for telephone calls.

The ISE scores indicate a significant problem with low self-esteem. This was evidenced in her verbal remarks regarding her husband's unfaithfulness and the financial value he placed on his female companion. Although alcohol played a role in her family of origin, specifically her father a teacher was an alcoholic, Gloria's husband does not drink. However, she disclosed that she was herself beginning to seek relief by the increased consumption of alcohol and her daughter who was just separated had married an alcoholic. Gloria was referred to Alcohol Foundation of Manitoba for long-term assistance in this regard.

The DAS scores reveal a small increase in distorted cognitions, however, the scoring documents a change by two on questions related to achievement, perfection and autonomy. This may reflect the conflict Gloria experiences in her marital relationship similar to her family of origin.

Gloria describes her mother as being a "true martyr joined together forever" in marriage, whose vocabulary contained several "don'ts" and whose affection was based on "conditional love." Gloria's valued father "drank" and "was one of the boys." From this perspective,

it may seem that Gloria's scattered indecisive behavior may be indicative of the conflict she is experiencing about whether to stay or leave her partner. The loss of one daughter through suicide as a reaction to a failed partner relationship, and the recent business loss coupled with her husband's promises of reform, may be contributing to her indecisiveness.

The influence of Gloria's parental role modelling upon her life cannot be overlooked however. Gloria's smiling response to the remark that her husband "does seem like a young child getting caught with his hands in a cookie jar" seems to forecast that she will continue to be "a true martyr joined together forever" like her mother.

Martha's Results

Martha, a straight forward, hard working farm woman, experienced several new friendships from the group experience as clearly reflected in the LSNS scores. The increase on the ISE and DAS, however, documents many family concerns this woman is experiencing.

With regard to the last LSNS score, Martha included friendships with group members but also recalled individuals (her family members) who had always acted as confidants for her. This was in marked contrast to her initial scoring which indicated a total lack of supports. A strong friendship was developed with Florence who also had a son with a mental health problem and who had many similar marital experiences.

When interviewed for the program, Martha seemed somewhat elated, although she stated it had been extremely difficult to come to the office. She stated that she wanted to reinforce her belief that there were other women just like her in abusive situations. Midway through

the program, Martha received her final divorce which was celebrated with her by the group. Rather than experiencing positive family support, however, Martha stated that her oldest daughter was extremely upset about the financial settlements. Martha described this interaction as hostile "another attempt to control my life" and "she thinks I'm to blame for the way the family was made to suffer."

Martha also pointed out that her son had suffered with mental health concerns because of her marital relationship, "look what happened to my son." Her distress was increased by his current prolonged hospital stay and her husband's continuing destructive behaviors. The loss of another group member, Agnes, who travelled with Martha on the bus, resulted in Martha's tendency to withdraw. Martha required the encouragement and support on a one-to-one basis in order to re-establish her group attendance. The negative trend noted on the ISE and DAS may reflect her continuing struggles outside of the group and some doubts that she transferred into the group about being accepted.

Vera's Results

In contrast to Martha's scores, Vera's results reveal a decrease in the LSNS, but an improvement in ISE.

Vera was a well groomed, well dressed member who wanted "to teach other women in similar situations not to blame themselves and how to create a life of their own outside of the relationship." She continuously interacted on a distant, intellectual plane until she experienced psychological abuse at home that led her to break down and cry on two separate group occasions. Following this last behavior she did not return to the group despite numerous counsellor attempts. This

was not unexpected as her fear of intimacy had been demonstrated on several occasions by her intellectualizing, and distancing reactions.

The scores on her LSNS quite possibly mark the loss of a valued male friendship. This friend suffered a stroke which impaired his ability to communicate with her. This may have resulted in her loss of a hope for the future and obviously caused her much distress.

The increase in her feelings of self-esteem could have resulted from the interaction with other group members. As she consistently looked like a fashion model and was selective in her vocabulary, she received many positive comments. Her presence in the group gave a certain middle class atmosphere that otherwise may have been missing. During the program, Vera compared herself to other members and decided that she was doing quite well, particularly with regard to finances and access to "social activities with a mixed crowd." On several occasions she spoke of the weekly dances she and her husband (who suffered from Terret's syndrome) attended and how she valued male company.

With regard to the DAS improvement, some distorted beliefs were dispelled due to the educational component about the myths of violence. Vera became confronted with the reality that she was not to blame for her husband's abuse. She also learned that she was not much different from other abused women and thus she felt her presence at the meetings was not crucial.

Agnes' Results

Agnes was the oldest member of the group and at the age of 77 was in her second marriage of 13 years. This couple resided in subsidized housing despite an earlier married life that had been free of financial

concerns. At the time of her personal interview, her husband had "once again walked out" over an argument about money and she was very distraught. Her scores indicate she suffered from low self-esteem. This woman repeatedly stated "I just hate being alone" and when her husband once again returned to take her out for lunch, move back home, and take her on the trip to California to visit her family, she quit the group. Follow-up contact revealed she enjoyed the group and stated "You were just wonderful--just what I needed at the time."

Florence's Results

Florence, an asthmatic and an English war bride, shows consistent improvement across all scores. She made many friends through the group and felt at ease with all of them except for Vera, who had not been receptive to Florence's attempts to join her dance group. Florence was the client who immediately following the intake interview, called the police and had her husband evicted.

The LSNS reflects an increase of five, which likely represent members Lee, Martha, Sadie, Gloria and a female friend in Kenora, Ontario who lent Florence money to purchase a small car. This woman, previously a nurse during her working years, became tiresome to some members due to her tendency to verbalize and grieve her "wasted years." However, her portrayal of herself as poor little me became challenged when Sadie shared her problems with cancer and a physically violent husband.

The ISE scores indicate an improvement in self-esteem. This may have resulted from having mutual social support from the group as well as the support from counsellors to continue her independence. The

improvement may also reflect the reality that Florence is no longer subjected to the psychological verbal abuse perpetuated by her husband during his monthly drive to her doctor appointment. At her request, the group sessions will continue to be offered monthly by the agency and with more publicity.

The DAS scores also indicate a positive change and a decrease in distorted thinking.

Sadie's Results

The score on the LSNS reflects an increase while the score on both the ISE and the DAS indicate a downward trend.

The increase of one on the LSNS most likely recognizes the strong friendship Sadie developed with Florence. Outside the program Florence provided transportation to and from pension offices and medical appointments. Later Florence supplied a physically healthy son to assist Sadie with moving activities. Sadie stated that when she became hesitant about moving, Florence also provided "a good talking to, which I needed. She was just wonderful."

With regard to the downward trend on the Index of Self-esteem score and the Dysfunctional Attitude Scale it is important to know that midway through the program Sadie moved out from her marital home to her nieces until she could find a permanent place to stay. The move referred to above reflects behavior two weeks after the program when Sadie returned to a physically/psychologically violent marital home to gather some apartment furnishings. The last scores may reflect the influence of her husband's violence by way of continual threats to kill her in an attempt to coerce her to return home. Her feelings of low

self-esteem may also document the reality that she was forced to turn to welfare for financial assistance. This reality reinforced her belief that she had low self-worth, little power and few resources available to her.

Discussion

An analysis of individual scores, would lead one to conclude that the program had few benefits for its members. However, changes of great magnitude and intensity were made by two members of the program who decided to end their relationships and then took the necessary action to ensure future independence. Therefore, the scores rather than just comment on program objectives, tend to document the member's personal context and reveal the ongoing struggle for autonomy that each member experienced in her day-to-day life.

The women in this sample suffered extensive, severe violence over many years. Physical, financial, and psychological strategies that frequently resembled brainwashing in its most extreme form were used by husbands to dominate the women and their children. Therefore, it is doubtful if any short-term program could result in any long lasting change. For whatever the cause of their husband's behavior, and the resultant problems for the wives and their children, it would seem reasonable to assume that the seriousness of the situations required professional help in order to be solved. However, it is important to recognize that this assumption is clearly incorrect as five out of the

seven women in the sample had had contact with professionals in the past and had continued in their relationships.

As evidenced by the self-esteem scores, the women who were subject to physical, psychological, and financial abuses over an extended period of time suffered from several negative changes. Significant negative changes occurred in their self-image and the confidence to effectively fight to retain a modicum of control over their own lives.

The feminist power and control theory sheds light on the interacting variables that influenced the older woman's marital relationship. An imbalance in power differentials, dependence in the marital role, a lack of control, societal value of men and devaluation of women, a post-war atmosphere, and limitations on achievement combined with the pervasive socialization into a traditional role worked together to reinforce feelings of low self-esteem.

It seemed that the more severe the abuse is and the longer it goes on, the poorer the self-image becomes. Ultimately the woman may begin to believe she is all the names she is called, she may feel old, and useless, and unattractive and disengage from society. Most humiliating for her is that the person she chose to be her husband, who was supposed to love, honour and cherish her, betrays her by abusing her.

This humiliation and embarrassment keep her at a distance from others. Her few friends and social acquaintances are unlikely to know about the abuse at home. Thus the battered woman is isolated and rarely meets other battered women.

Her imposed isolation is reinforced by her husband who sabotages her efforts by controlling her activities and limiting any contacts

outside of the marriage. This social isolation limits opportunities for the realistic feedback and support that might alter her perceptions of the situation. Thus her loneliness increases her dependence on her husband who promotes the isolation.

In the next chapter I will discuss the group experience.

CHAPTER VI

THE GROUP

As stated, the 10-week group began April 17, 1992 and ended June 16, 1992. It was extended by two weeks due to the weather and poor health of this counsellor. During the spring of 1992 and the start of the group, the federal government conducted hearings across Canada on family violence and three members of the group volunteered to meet with the federal Family Violence Panel on April 13, 1992 to share their life stories. When members were asked what they recommend the government do to change things the group hesitantly replied, "Teach the men how to act properly." Warming to the task at hand, they also shared their concerns about the lack of shelters for the older abused woman, the ecology, and the need for recognition and respect of aboriginal peoples of Canada. All comments reflected women's continuing concern and sense of caretaking and responsibility towards others in the larger society. The value of independence and self sufficiency was indicated by an initial hesitation about asking the government to do anything to help them out.

Group Development

As outlined by Toseland and Rivas (1984), the group travelled through the developmental stages of beginning, middle, and end. A planning stage for the counsellors allowed for the preparation which needed to be done before the group met for the first time. For this

practicum, planning consisted of weekly to bi-weekly meetings for approximately six months prior to the start of the group experience.

The beginning phase created the atmosphere for the balance of the group sessions. The counsellors' main task was to develop communication, interaction, and task accomplishment patterns. The middle phase concentrated on goal achievement, while the last phase focused on the ending/termination phase.

During the last phase it was expected that the pain of separation, guilt about leaving the group, and feelings of anger would surface (Shulman, 1984). Behaviors such as premature emotional or physical detachment, denial that the end was near and/or regressive behaviors (Wickham & Cowan; 1986) were anticipated.

Group Structure

Group structure involved the consideration of aspects such as homogeneity or heterogeneity; size; open or closed group; and leadership. As expected, group members discovered similarities in life experiences and in coping skills. Diversity was created by the age, knowledge, and expertise individuals contributed as members were at different stages in their relationships.

The group was composed of seven members which, as suggested by Wickham and Cowan (1986), falls within the best working size of five to nine for a treatment group. This size allowed for a greater level of intimacy and member interaction.

An important dimension of group structure was whether to develop an open group with members constantly joining or leaving, or a closed group with the same members throughout. The counsellor's decision of a closed group was quickly overturned in the first session as members emphasized the need to extend assistance to women in distress upon request. The group stressed that in addition to helping the woman herself, new members would bring in new ideas and resources. They agreed to ease in new members and help them achieve the same level of acceptance and openness that they possessed. This process, according to Shulman (1984) and Toseland and Rivas (1984), is important to the development of group structure. However, due to the generally low response rate the group did not acquire new members after the interviews were conducted. In this way it may be best described as a closed admission group with accepted members joining when they were able to do so.

A main disadvantage of this group was that the ability to work on problems in depth for old members was disrupted as new members joined. As well, each session required more work from the leader not only in introducing the new member but also in summarizing and reviewing the past group content. As educational content was progressively structured for the full extent of the program, a need to review past learning was essential. A benefit of this process was that new learning was reinforced.

Another disadvantage was that member-to-member communication patterns changed as members came and went and group rules were easily forgotten. Although one would expect that on a week-to-week basis each

group member's position and role in the group would change (Corey & Corey, 1977; Shulman, 1984; Toseland & Rivas, 1984), this was not the case. On the contrary, individuals seemed to gather strength with practice and as time progressed positions and roles became more entrenched. As at least one member was perceived to be in crisis during each session, this entrenchment was regarded as an advantage rather than a disadvantage to group structure as it tended to lend stability.

Co-leadership, for the purposes of this practicum, meant that two people led the group together. Each leader maintained a different therapeutic style which meant that a variety of techniques were available for facilitating work on individual goals. The group interaction and process was led by one leader while the other provided back-up support, assistance in providing resources, and in setting limits. The presence of a co-leader to provide structure and guidance to the group enhanced a sense of safety for members testing their ability to control and express feelings. In this way a safe atmosphere for practising communication skills and sharing life experiences was developed. As a co-leader, I found the presence of another leader to be anxiety reducing and felt reassured that should I become at a loss for words, my co-leader would keep the group process on track. A genuine respect, collaboration and friendship developed inside and outside of the group setting between leaders.

The Beginning Stage

The beginning stage was characterized by excitement, energy and laughter. This was triggered by the sense of relief that there were other women who had similar life experiences, the shattering of

communication barriers and the awareness of available support systems. Group discussions evidenced a power and control stage between leaders and members as conversation moved off topic, member-to-member interaction occurred in dyads and individual members monopolized group discussions. The emotional challenge of intimacy (Garland, Jones, Kolodney, 1976) was demonstrated by self-disclosure which was at a maximum. Trust was established upon contact as members immediately shared life experiences and offered knowledge and resources to each other. Leaders worked hard to focus discussions on the topics.

The Middle Stage

The middle stage began from the third week of the program. The goal for this stage was to move members into an awareness of group process and to begin an internalization of the group. The addition of a new member and the absence of three old members created new dynamics and a highly complex group process.

Sadie's presence in the group for the first time after a long awaited delay (due to chemotherapy treatments) became a cause for celebration. This celebration was marked by increased noise and laughter, which caused agency remarks such as "what are you doing in there?" While Sadie's presence was rejoiced in, the absence of the other members (Gloria, Martha, and Agnes) was met with exaggerated fear, worry, guilt and blame. Counsellors reminded the group of Gloria's medical appointments for her cancer, while Florence stated that Martha had phoned her about emergency grandchild care, and the message Agnes had left stating that her husband had returned home was shared. Both Gloria and Martha returned to the group for the following session.

The group structure became evident in its growing importance to its members. Its strength and degree of acceptance of its members was tested in attempts to focus in on the counsellors. Negative past experiences with social workers and professionals were shared but counsellors listened and understood rather than defended or argued as expected. Sadie openly questioned the group and counsellors' reactions towards her husband's life threatening behaviors and repeatedly was told that any form of violence is not acceptable. Then after much anger directed at the counsellors about "not doing anything to help us," Sadie asked, "Can you help me?" She was reassured that it was the purpose of the agency, the group and the counsellors to do so. From this point on anxiety lessened, trust increased, and warmth grew more quickly. At the termination of this session, the group became our group, the counsellors became our counsellors, and Sadie repeatedly stated "You can help me," "I'm so glad I came." This group marked the client-initiated closures with hugs, tears, and kisses.

During this stage members struggled with achieving individual and group goals. Members consistently used self-disclosure for the emotional challenge of intimacy and to satisfy dependency needs (Garland, Jones, Kolodney, 1976). Group cohesion, mutual aid, and member to member communication characterized this developmental stage. By exchanging information and expressing feelings with others the women found support and understanding from each other. At the same time counsellors facilitated change through problem-solving, e.g., "take someone with you when you go to the house to pack," activities, education, and using themselves therapeutically. Each member in

completing a stage of differentiation ensured that the counsellors accepted her individually and her badness, "I took a stick to bed to hit him on the head with," which formed part of her self-disclosure. She then began to solidify her relationship with the other members, build cohesion and move to internalize the group, finding membership in it desirable.

The End Stage

The group was reminded in the seventh session that the end of the program was drawing near. Prior to the tenth and final session, each member had started a process of differentiation, "I have visitors coming from British Columbia," "My husband and I are taking a trip to visit our daughter up north," and although the group was still regarded as extremely important, the investment and energy differed. The group was no longer the sole occupant of thoughts and energies. Members were quieter as a shift to the outside world occurred and comments about feeling better were common. Discussions focused on outside activities, holidays, visitors, "My son is coming from Nova Scotia," new friends, and plans for the future, "I'm getting my own apartment."

The initial statement of termination, however, had evoked differing but equally strong separation reactions and coping devices. Reactions included denial, anger, "why weren't more women included?" regression as the members talked simultaneously, relief, "my husband will not have to drive me downtown anymore" and were spread throughout the last few sessions. In deciding how to best respond to the group it was agreed upon that two summer meetings would be held and regular

weekly sessions would resume in the fall for those interesting in continuing.

The tenth session created an opportunity to reminisce and review experiences. One member chose this time to recall another ending in her life, the suicide death of her daughter. The acceptance and support she received from the group served to consolidate new ego strengths and improved functioning that had been gradually taking place throughout the group process. It also was evidence that the group had made considerable gains in its ability to tolerate the grief and anguish of each other's experiences.

Group Dynamics

Roles, interaction, group attraction, mutual aid, norms, and culture were the elements examined. During the life of the group, communication patterns exposed the need for members to share individual concerns and the struggle of the leaders to complete the agenda and share educational materials. The input and support of two co-leaders were required to complete the content of each session. Members had been expected to be quiet and withdrawn but instead were happy, vocal and self-disclosed easily.

Roles

Several major task roles surfaced over time, such as: information giver, Vera; information seeker, Sadie; expediter, Martha; and analyzer, Florence and Vera. Maintenance roles such as supporter were filled by Florence; harmonizer, Lee; gatekeeper, this counsellor. Negative roles

such as aggressor were not filled; the joker role was not filled, rather than minimizing experiences or making fun of individuals, problems were dealt with in a serious manner; withdrawer, Martha and Marie, occasionally withdrew but only for a temporary period of time within sessions, and Florence tended to fill the role of monopolizer. Co-leaders alternated and assumed all roles depending on the situation at hand.

Over the duration of the group, Florence became the supporter/informed group leader, as she was the only member to attend all sessions. When members were absent she unofficially assumed the responsibility for contacting the member by phone and providing information on the latest group happenings. In this way, members usually returned to the group aware of current events. This enhanced group cohesiveness, a sense of belonging, and the desirability of the sessions.

Lee, who was experienced in the group process due to her involvement with Alanon, became the peace keeper or harmonizer in the group. She identified and owned her own feelings and generally ensured that members seemed satisfied with the group experience. She frequently brought in jokes to share prior to the group and thus used humour to create a warm group climate.

Martha and Gloria vacillated between the role of lost member/withdrawer. They had a tendency to contribute to the process in depth and then to withdraw into a listening role. Vera assumed the role of advocate and ensured members got information and active assistance with problem solving. Sadie, who was suffering from active cancer and a

physically violent relationship, presented as helpless and was seen as pathetic by other members. However, rather than accepting or being assigned the role as group scapegoat, the group rallied around her and she became the information seeker to solve her immediate problems. As Sadie had identified her goal as wanting to move out, the group assumed the role of her family, her friends and her advisors for the crisis period. The feminist theory advocates this individual and collective use of power and contends that the best place for women to seek emotional support and instrumental assistance is from other women.

Interaction

Member-to-member communication was high due to the strong sense of cohesion and belonging. As stated, this was particularly evident when problem-solving to help a member. However, the usual pattern consisted of speaking directly to the member first, then leaders, then turning to the other members for support and validation. There was some individual resistance on the part of Martha and Lee to the family of origin material which may have necessitated the recall and pain of multiple losses of long duration. Pairings in the group were common as there were many commonalities of life experiences. These dyads did not interfere with group identity but rather seemed to help create positive group dynamics.

Group Attraction

The desirability of the group was demonstrated by members returning to the group in spite of many personal barriers. Barriers to attendance consisted of a lack of energy, due to chemotherapy treatments and/or medical tests, emergency grandchild care, and visitors from out

of town. Distance was also a barrier for one member who travelled from a small town and another who travelled by bus for almost one hour within the city. Group attraction did not appear to be affected by which members attended the session.

The group was cohesive, characterized by a sense of caring as members listened to and helped each other and enjoyed each other's company. This cohesiveness increased over time and with frequency of meeting.

Group attraction was diminished by the videotaped recording (see release form in Appendix IV, D) of the sessions. One member, who perceived this as yet another invasion of her privacy refused to be filmed and sat with her back to the camera. This did not interfere with attendance, however. The sessions were video taped for educational purposes only and destroyed afterwards. On this basis members generally consented to help me as an abuse counsellor to increase my group skills. The negative reaction towards filming may reflect this shame and embarrassment the older abused woman has internalized from the many years of denigration and name-calling. From this perspective the camera could be viewed as yet another transgression of personal rights. This could be counterproductive for practice. One member expressed a reluctance to work on family-of-origin issues. Martha perceived a review of her childhood to be emotionally painful as it required reflection and stated, "I don't want to think about that anymore." Reactions to this work varied widely from Martha's reluctance to Sadie and Vera's enthusiastic participation. Due to the differing reactions with some group members making light of the exercise while others began

to self-disclose rapidly, I increased control to prevent any revelations such as incest, sexual abuse, and later embarrassment. As a result, more communication took place from member to this leader as I used self-disclosure to increase safety and develop objectivity. Practice implications are that if the older woman has had a good childhood experience, the response to family of origin work will be positive. However, in a troubled childhood characterized by violence where children were victims or were powerless to intervene a review of these experiences may be counter-productive in a short-term group and more suitable to long-term counselling.

Mutual Aid

The two main commonalities of a more mature age and the experience of abuse, formed the basis for mutual aid. This homogeneity and sense that "we're all in the same boat" strengthened the degree of commitment as well as the desirability of the group. Leaders worked to create positive and meaningful group experiences for the members, thereby drawing members back to the group.

Members felt connected to each other. Individual stories and problems were listened to non-judgmentally with advice shared openly to resolve problems. Conflict within the group did not surface, rather mutual aid became the norm. Cohesion was facilitated by the high levels of self-disclosure which resulted in strong care and concern among members. Members not only gave each other complements but also celebrated individual achievements and recoveries. For example, when Martha received her final divorce decree, the group cheered her on; when Sadie left her husband, the group celebrated her courage; and when

Gloria shared the news that her cancer was in remission, the group shared her sense of relief.

Group Norms

Group norms were established by the group during the first session. They consisted of the following:

1. Attend all group sessions. If unable to do so call the office and leave a message.

2. Arrive on time for each group session and not under the influence of any alcohol.

3. Keep the proceedings of each group meeting confidential.

4. Participate fully in the group interaction.

5. Allow other members to finish a thought when they are speaking.

6. Do not dominate the group discussion.

Group leaders agreed to:

1. Be prepared for each group meeting.

2. Begin and end all group sessions on time.

3. Be respectful of each member's unique contribution to the group.

4. Each member's attitudes, opinions and life experiences were honoured as for personal validity. This affirmed and recognized one's ability to think and make decisions. By honouring each other the need to decide who is right or wrong was eliminated and the group was protected from competitiveness when members disagreed.

5. Keep the proceedings of each meeting confidential.

6. Help members to get the most out of their participation in the group.

When rules of group conduct were breached, members seldom confronted each other. When monopolizing occurred, no one ever interrupted or complained. To decrease the tendency to monopolize the group, a small bell was introduced to signal the end of the time allotted for each member to share experiences. This was used hesitantly and with much reluctance by members and eliminated from future group sessions.

Group Culture

The first group session set the tone for the balance of the program. As individual members arrived for the first meeting, Florence, who was the first to arrive, asked if the woman was there for the group. When the response was "yes," she immediately introduced herself and took the risk of disclosing intimate details of her life to the other woman. This sparked an immediate connection and energy, excitement, and hope filled the reception area. This energy and excitement continued throughout the group meeting and was in marked contrast to the expected withholding of feelings that the literature had led this student to believe was normal for this population.

By starting at this point, members were able to identify and express feelings such as fear, anger, self-pity and loneliness, quite easily. Sensitive issues such as the anticipation of their own deaths, loss, and past and present relationships were discussed with empathy, compassion and encouragement. In brief, members were able to develop a

culture that nurtured intimacy and self-care through personal disclosure.

Group Evaluation Results

This section will evaluate the results of the group program. Scores on the LSNS, ISE, DAS instruments will be examined first. Then the feedback provided from completion of the adapted version of the Client Satisfaction Form will be discussed. The section will conclude with a discussion.

Instrument Results

A comparison of pre and post-group scores on each instrument are presented in Table 4. An overall increase occurred on the Lubben's Social Network Scale (LSNS) from a pre-group score of 204 to a post-group overall score of 221. This is indicative of success in meeting the specific objective to increase social support.

The scores on the Index of Self-Esteem (ISE) reveal a score of 234 pre-treatment and an increase to 252 post-treatment. As discussed in Chapter 3, there were many negative experiences occurring during the group program. Members were harassed by ex-husbands (Sadie, Florence)

Table 4

Results of Pre and Post-Group Measurement Scores

INSTRUMENT	PRE-GROUP SCORE	POST-GROUP SCORE
LNSN	204	221
ISE	234	252
DAS	1048	1056

while others were not supported by a family member (Sadie and Martha). All members of the group, except Sadie, who had an ISE score of 17 pre-treatment, had a score over 30, which indicates a clinically significant problem with self-esteem. As noted by Kazdin (1982), relationships between independent variables (the group) and dependent variables (self-esteem) are difficult to discern in case studies as threats to internal validity cannot be ruled out. Vera's premature termination of the group may have also exerted a negative influence on members' fragile self-esteem.

Client Satisfaction Form

At the end of the group program, the seven members were asked to complete a Client Satisfaction Rating Scale. The replies are indicative of overall satisfaction and are tabulated and reported in Table 5. With regard to Question 1, "How would you rate the quality of service you received?" six out of the total number of 7 stated that they found the quality of service to be excellent. One responded the quality of service was fair. Question 2 which asked, "Did you get the kind of service you wanted?" received an answer of "yes" five times, one "yes, definitely" but one "no, not really" was received. This was from Lee who was interviewed for the group in January and had to wait until April for it to start. As discussed earlier, this was due to the difficulty of this population to reach out for help and/or identify themselves as abused. Question 3, "To what extent has our program met your needs?" received a six for most needs were met, while one member felt that only a few were met. This was clarified in the remark section on this questionnaire which identified several unmet needs, such as the need to

include more people in the group, shelters for seniors, have some funds available for those who must leave an abusive partner, have the program more publicized and reach out to ethnic women. Question 4, "If a friend were in need of similar help, would you recommend our program to her?" received "yes" three times, and "yes, definitely" four times for a total of seven. Question 5, "How satisfied are you with the amount of help you have received?" was scored once for mostly satisfied and six times for very satisfied. Question 6, "Have the services you received helped you to deal more effectively with your problems?" received "Yes a great deal" replies five times and the response "helped some" received two replies. Question 7, "In an overall general sense, how satisfied are you with the service you have received?" received very satisfied six times and indifferent once. This indifferent reply was from the member who clarified her response in the remark/comment section which referred to the overall lack of resources to assist the older victims of abuse rather than the group itself. Question 8, "If you were to seek help again, would you come back to our program?" received two yes replies and five yes definitely responses. In brief, the responses indicated the members' satisfaction with the group.

Table 5

Results of Client Satisfaction Rating Scale

QUESTION	RESPONSE		
1. How would you rate the quality of service you have received?	Excellent 6	Fair 1	Poor 0
2. Did you get the kind of service you wanted?	No, not really 1	Yes 5	Yes, definitely 1
3. To what extent has our program met your needs?	Most need met 6	Only a few 1	None met 0
4. If a friend were in need of similar help, would you recommend our program to her?	No, I don't think so 0	Yes 3	Yes definitely 4
5. How satisfied are you with the amount of help you have received?	Dissatisfied 0	Mostly satisfied 1	Very satisfied 6
6. Have the services you received helped you to deal more effectively with your problems?	Yes, a great deal 5	Helped some 2	Didn't help 0
7. In an overall general sense, how satisfied are you with the service you have received?	Very Satisfied 6	Indifferent 1	Dissatisifed 0
8. If you were to seek help again, would you come back to our program?	No, I don't think so 0	Yes 2	Yes, definitely 5

Discussion

The overall effectiveness of the women's group was evidenced by Florence's remark, "You can just hear the healing going on." The group experience helped its members to improve their self-images to the extent at which they could once again determine their own courses of action. The mutual support catalyzed two of its members, Florence and Sadie, to enlist the aid of social service agencies, lawyers and police to increase the pressure on their husbands and obtain freedom.

For two of the three married women, the group altered the power balance in their marriage as Lee told her husband, "I'm not going to cover for you anymore." The third woman, Gloria, was beginning to accept her ability to think before reacting emotionally. In doing so, she has begun to identify the pros and cons of remaining in her relationship, while Vera hoped that the deteriorating health of her husband would resolve her problems in time. Martha, who was divorced, discovered that she was not alone and that she had knowledge and experience to share that contributed to the well being of the other members of the group.

The protective effects of a social support network as represented by the mutual-help group operated through the facilitation of coping and adapting to their personal environments. Coping involved the manipulation of the environment to meet one's needs, and the adapting of one's self to be a more effective, self-caring individual. Both behaviors complemented each other in the movement towards problem definition and solution.

Mutual help for the older abused woman is based upon feminist ideas that women are the best experts on their own lives and are safer in relying on others like themselves rather than authority figures. By speaking honestly and directly, the women in this group taught each other that their problems weren't merely their own personal problems but are social, political and shared by many others. In short, the best place for the older abused woman is to look for emotional support and instrumental assistance is often from other older women with similar life experiences.

CHAPTER VII

IMPLICATIONS, RECOMMENDATIONS AND CONCLUSIONS

In the first part of this chapter, I will discuss findings that relate to myself. In the second part, I make recommendations for further study and conclude.

As a beginning counsellor in the area of abuse, I became aware of the interlinking loops of personal and professional development. It was a process whereby group members continued to teach me and I continued to make the counselling more meaningful with the contribution of my own experiences.

By focusing on women's experiences, I began to better understand the socio-cultural context and the broader social forces which lock women and men into self-limiting roles and mutually destructive patterns. I also learned to recognize and to tolerate my own and my clients' feelings of rage, fear, depression, powerlessness, and ambivalence.

I felt a strong connection to these victims of male violence, having experienced the very real psychological battering of all women in our society. I recognized the victim blaming, the ambivalence of allegiance and identity, and the self-devaluation that are experienced by all members of any devalued and subordinate class or group. I also became aware of the fragility of the members' mental health and the need for extensive support for the victims of long standing abuse.

From this practicum experience my major learning has been an awareness of the importance of focussing on strengths versus weaknesses of the individual victim of violence. This counselling stance is in recognition of how damaging institutionalized sex-roles are to women and the first step in changing them is to understand them. A second learning is that although women have power individually, collectively their power can be great. A mutual-help group enabled the older women to break the silence, thereby reducing their isolation and feelings of being different, abnormal, at fault, etc. A group where the emphasis is on helping each other can create an atmosphere of acceptance, of community, even of laughter and fun that no individual counsellor can duplicate. A group of this nature can truly change its members from victims to survivors.

Implications for Practice

Based on the literature and my cumulative experience during the practicum, I offer some suggestions for practice.

1. Two different types of abuse counselling should be available to older adult victims. A crisis-oriented or first stage counselling is required to handle emergencies/crisis situations and to provide instrumental assistance. In addition, a second stage therapeutic approach is needed to remedy the long-term psychological effects of the abuse. Any attempt to fulfill both needs in one group program creates an overwhelming task for its leaders and prevents in-depth self-development work for its members.

2. Critical to improving the lives of older abused adults is education and awareness. Staff of institutional facilities, service providers, the medical, legal and religious community, and social service agencies must be made aware of the severity of this abuse. Workshops, seminars, conferences, and research are mandatory in order to make a serious effort at preventing or alleviating abuse.

3. An older adult victim of abuse in the role of a peer counsellor within the group is of utmost importance. This would increase the visibility of the older adult in society, integrate them into the mainstream, and serve as a role model for others.

4. Organizations, like the Elder Abuse Resource Centre, working to advance the needs and concerns of older abused adults must continue to be funded. The primary agency role should be to educate agencies and the general public as to prevention, causation and recognition of elder abuse. A secondary role should be to act in the capacity of consultants and resource/referral persons for the client in crisis, the general public and professionals. As the actual prevalence of elder abuse is unknown, it is difficult for any one agency and a small core of staff to fulfill all the demands for service. This distribution of information is also consistent with a feminist orientation which perceives power to be knowledge and advocates that resources should be shared based on need.

5. Professional awareness of and sensitivity to issues the older abused women face is necessary. This practicum clientele presented much like an expanded version of the television success "The Golden Girls." The happy faces, however, seemed to reflect a sense of relief at finding

others and being accepted in a group rather than a sense of life satisfaction. This behavior had a tendency to cover and minimize the tragic multiple losses each member had suffered. As a result, a concentrated effort was made to preserve and enhance dignity by listening for the many themes of loss that echoed repeatedly throughout the sessions, e.g., "wasted lives"; "no future"; "I'm trapped."

6. Material on family-of-origin, specifically family messages, childhood experiences, influence of same sexed role models should form the content of second stage personal development/long-term therapeutic counselling. Counsellors should be prepared to cope with any childhood abuse issues such as incest, the grief and despair of witnessing violence and the sense of being powerless that may surface as a result.

7. The adaptation of the group to accommodate for communication are required in groups for the older victim of abuse. This is needed as members have a strong desire to control and test limits.

8. Practitioners should support the older adult in the search for personal meaning and the identification of personal goals as part of this process of empowerment. For if joy, service, and personal meaning can be found, the elder may encourage younger people to reevaluate elderhood, seeing its promise for the future as well as its problems.

9. Separation from a spouse after many years of their life together traumatizes the older woman. The range of emotions may include grief, depression, anger, loneliness, and deprivation of affection. As well as the loss of a partner, usually the woman experiences isolation from friends she associated with as part of a couple. This may require assistance with adjustment to a single life style, problem-solving,

emotional guidance, and creative reintegration into the community. This may be best achieved by a combination of individual and group therapy.

10. Relationships between middle-aged children and their abused parents are often torn by conflicting motives and emotions. There is a need to reconcile conflicting sentiments within a therapeutic family counselling setting which will ensure a long lasting support network for the elder. This should not be the treatment of choice at the point of entry.

11. Three of the four married group members openly stated that "they did not believe that their spouses would be able to manage (living) alone." Thus they choose to take action that was least likely to hurt their abuser and in doing so demonstrated a conflict about what is owed to the self and what is owed to others. It is important for professionals to recognize loyalty and the shame which accompanies it as a powerful motivator of behavior.

12. The first priority in any counselling with the older abused adult woman must be to elicit the story of her experience on her own terms. Early in the counselling, which continually focuses on strengths, it is important to begin to nurture any small act on the part of the client to take more control of her situation.

13. The abuse must be discussed openly and its reality confronted. The counsellors must give a clear message that violence, force and coercion are unacceptable ways of relating on any basis.

14. The provision of shelters for the older adult who may or may not be a physically infirm victim of abuse, peer counsellors, a crisis

hot-line, and the continuation of mutual-help group intervention strategies are mandatory for practice in the area of elder abuse.

Recommendation for Further Study

1. General cross-cultural differences and sibling abuse must be studied as categories of analysis for elder abuse. Very little research examines the variables of their role in networking or determining the form and content of elder abuse.

2. An examination of the dynamics of marital power and its relationship to wife-beating should be completed. Does a change in the marital power balance towards the wife tend to precede wife-beating? Among couples who have become violence-free and remained together, what long-term adjustments were made in the power balance?

3. Further research on the abuse of elderly women in couples is required as the victims of physical abuse in this practicum appeared to be women caught in their husbands' life-long cycle of violence.

4. A study of the subculture of violence which supports many batterers in their abusive situations should be completed. Two of the clients in this practicum were war brides, which served to heighten awareness of how the larger socio-cultural context of war may have influenced male behavior at that time.

Conclusion

Older adult females have been discouraged in their attempts to develop the kinds of behaviors and attitudes that promote optimal functioning. Cognitive therapy encourages women to set their own goals, and to conceptualize and solve both practical and emotional problems, while women's groups offer a highly effective paradigm for empowerment and growth. Group therapy can provide a resolution of the problems of isolation, shame, secrecy, denial, and low self-esteem which are common after-effects of the abuse experience.

The abuse of older adults is a serious and hidden problem and the work of counselling the abused older adult is demanding, exhausting, and emotionally draining. It is also an extremely rewarding experience as the counsellor shares the pain of abuse and multiple losses, celebrates the strength of surviving, and the joy of growing and connecting with other women.

Through the similarity of experience of womanhood, a fifteen to twenty year age gap which existed between counsellors and members was diminished as each valued and respected the other's experiences and viewpoints. As one member remarked at the end of the group "I am so glad people as young as you are beginning to get involved in solving this problem. To be fortunate enough to be part of this inspirational experience is truly a gift."

This group intervention strategy empowered elderly female victims of spousal abuse. The process of empowerment centred on recognizing the clients courage, strength and survival skills. By reframing, personal

defeats and fears became successes. The women slowly begin to understand, to accept, and to believe in options for themselves. However, for the victim of abuse this requires a long therapeutic process which demands not only individual and mutual-help group counselling but also the availability of shelters, finances, and legal protection. The elimination of abuse requires changes in the cultural norms, and in the organization of the family and society which underlie the system of violence on which so much of North American society is based.

This practicum was assessed to be successful by members who pointed out that they confronted self-defeating attitudes; increased self-esteem; and increased social support by attending the group sessions, "We are doing all of that by coming here." Indeed the group served as an excellent preventative measure, increased self-esteem by valuing individual worth, created greater independence and provided a setting for friendships with other women. In this way it was deemed to be an empowering process for all.

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APPENDICES

APPENDIX I

Announcement Notice

and

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APPENDIX II

Evaluation Tools

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APPENDIX I

Announcement Notice

and

Intake Form

APPENDIX A

ANNOUNCEMENT

In late January, 1992 the Age And Opportunity Elder Abuse Resource Centre will be starting a group for women aged 60 and over who have been abused by their male partners. The group will be limited to a maximum of 10 participants and sessions will take place weekly over a 10-week period.

If you know of anyone who would be interested in participating in such a group or would like some additional information, please contact Maria Wasylkewycz at

APPENDIX B

WOMEN'S INTAKE - PART I

DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

TELEPHONE: (Home) _____

In the event that you do not wish to be called at home, please provide the name and telephone number of a contact person.

PARTNER'S NAME: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

TELEPHONE: (Work) _____ (Home) _____

1. How did you find out about our Program? Enter # here: _____

Self	1	Shelter	7
Spouse/Partner	2	Media	8
Other family member	3	Community Agency	9
EVOLVE client	4	Family Services of Wpg.	10
Phone crisis lines	5	Police	11
Courts	6	Other (specify)	12

_____

Name of Agency/person: _____

2. Your date of birth: _____ _____ _____
Month Day Year

3. What is the highest level of education that you have completed?

Elementary School	1	2	3	4	5	6	Vocation School or			
Junior High School	7	8	9				College	13	14	15	16
Senior High School	10	11	12				Post College	17	18	19	
							20 or more				

Enter number here: _____

4. Do you have any medical problems or disabilities?

Yes_____No_____. If "yes" please specify:

5. Do you take any medication regularly? Yes_____ No_____
If "yes", please specify:

6. What is your current occupation? (Enter # if applicable)
Primary occupation_____ Secondary occupation_____

Homemaker..... 1
Degree Professional (nurse, physician, teacher, etc.)..... 2
Laborer (dishwasher, etc.)..... 3
Student..... 4
Skilled labor (factory worker, cashier, etc.)..... 5
Tradesperson (carpenter, hairdresser, etc.)..... 6
Clerical person..... 7
Non-degree professional (real estate, sales, etc.)..... 8

7. What is your current level of employment outside the home?
Enter # here:_____

Not employed..... 1
Employed part-time..... 2
Employed full-time..... 3

8. What is your current relationship status? Enter # here:____

Married..... 1
Single (never married).. 2
Widowed..... 3
Other..... 4
Divorced..... 5
Separated..... 6
Living with partner..... 7
(Please specify)_____

How long has this been your marital status?_____

9. What was your own approximate income last year before deductions? (Include all sources) Enter # here:_____

Less than $5,000..... 1
$5,001 to $9,999..... 2
$10,000 to $14,999..... 3
$15,000 to $19,999..... 4
$20,000 to $24,999..... 5
$25,000 to $29,999..... 6
$30,000 to $34,999..... 7
$35,000 or more..... 8

10. How many dependents are you supporting with this income?____

11. If you are married or living with a partner, what was that person's approximate income level last year?

Enter # here:_____

WOMEN'S INTAKE PART II

Intake Counsellor:_____ Date:_____

Name:_____

*Intake Counsellor:
1. Part 1 completed? Yes____ No____
2. Check client's feelings of safety/ensure confidentiality.

INITIAL CONTACT INFORMATION

1. Why would you like to join our group?

   Have you been involved in any groups in the past? What was your experience like?

   What has made you seek help at this time?

2. Are you now receiving/have you ever received prior counselling? Yes____ No____. If "yes" please provide the name of the Agency, dates of contact and issues dealt with.

3. Was this a positive experience? Yes____ No____. If "no", please explain.

4. How old were you when you were first hit by a partner? _____

HISTORY OF ABUSE

5. Are you presently in an abusive relationship? Yes___No___
   If "yes", are you living with this person? Yes___No___
   Have you ever lived with this person? Yes___No___

6. How long have you been in this relationship? _____

7. Have you been in past relationships that have been abusive? Yes___No___. If "yes", detail when, with whom and length of relationship:

8. Are you presently separated from your partner? Yes___No___
   If "yes", when did you separate? _____

9. Have you been separated before as a result of abuse? Yes___No___
   If "yes", please detail:

10. How long after this relationship began did the first incident of abuse occur?_____

11. When did you recognize that abuse was taking place?_____
    _____

12. Are you in immediate danger? Yes____No ____If "yes", please explain:

13. What do you feel you would need in order to feel safe?

14. Have you ever sought shelter for abused women? Yes____No____
    If "yes", where and when?

    How was this experience? Please explain:

15. Are you presently considering alternate living accomodations due to abuse? Yes____No____

16. When was the last incidence of violence with your most recent partner/ ex-partner? Date: _____

Less than one week	____	Three to six months ago	____
A week to a month ago	____	Six months to a year ago	____
One to three months ago	____	More than a year ago	____

17. Where did it happen?
Couple's residence: _____, Woman's home: _____, Public place: _____

Other: (specify) _____

18. What events occurred before and during the violence?

19. Please describe the violence: Verbal: Yes____No____: Sexual: Yes____ No____;Physical: Yes____No____; Psychological: Yes____No____. Financial: Yes____No____

20. Were you injured? Yes____No____. If "yes", please detail. (Counsellor, check if client needs medical attention)

21. Have you ever received medical attention because of violence? Yes____ No____. If "yes", please detail, where, when and from whom:
Family doctor: Yes____No____ _____

Hospital emergency: Yes____No____ _____

Other: Yes____No____ _____

Was the abuse identified? Yes____No____. By whom_____
How were you responded to:

22. Were you ever hospitalized because of violence toward you? Yes____ No____. If "yes" please detail when, where and what injuries: (Check psychiatric institutionalization)

Have you ever been treated for "bad nerves"? (please explain)

23. Have the police ever been called because of violence toward you? Yes____No____. If "yes", please detail:

When was the last time that police were called?

How often had they been called in the past?

24. Have you ever pressed charges? Yes____No____.

25. Have the police ever pressed charges? Yes____No____Charges pending? Yes____No____. Type: _____

_____

_____

Hearing date: _____ Past charges? Yes____No____.

Type: _____ Hearing date: _____

Was he convicted? Yes____No _____. What was the sentence? _____

_____

26. Do you currently have a restraining order?
Have you ever had a restraining order?
Has he ever broken a restraining order? Yes____No____
Has he been charged with breaking a restraining order? Yes____No____

27. Has your partner/ex-partner(s) ever been charged for sexual assault? Yes____No____. If "yes", please detail:

Convicted? Yes____No____.

28. Are you presently in need of legal advocacy or consultation? Yes____No____

29. Are you presently involved in any legal proceedings? Yes____ No____.
If "yes", please explain:

30. Are there other people to whom your partner/ex-partner has been violent?

Yes____No____. If "yes", please specity who: _____

31. What do you remember as the worst incident?

32. What do you usually do during the violence?

33. What do you usually do after the violence?

34. Have you talked to anyone before coming to this program about the violence in your life? Yes____No____. If "yes", please specity who:

_____

_____

* Counsellor: Is this the first time she has disclosed her experience of abuse? Yes_____ No_____.

35. Do you receive support for your struggles through family, friends, or other service providers? Yes____ No____.
Do you feel blamed by your support system? Yes____No____

36. How do you cope with crisis in your life? (Check Coping strategies and defense mechanisms)

37. It would be helpful for us to understand the types of abuse you have experienced in your life. The following are types of abuse commonly reported by women. These are violent behaviors your partner/ex-partner)s may or may not have commited. You are not alone if you have experienced these forms of violence (counsellor: do list together). Taking your time, please tell me if any of these behaviors occurred: 1 - Never, 2- once or twice, 3 - sometimes, 4 - a lot

Did your partner/ex-partner(s):

PSYCHOLOGICAL ABUSE

1. Refuse to express his feelings?.....____
2. Jump to conclusions before gathering more info?.....____
3. Not listen to you?.....____
4. Refuse to take your opinions into account?.....____
*5. Sulk, refuse to talk, withdraw affections or sex to punish?..____
6. Refuse to leave the situation to calm down?.....____
*7. Stomp out in order to punish you?.....____
*8. Scream, insult, or swear at you?.....____
9. Belittle you?.....____
10. Threaten punishment other than physical?.....____
i.e. withholding money, taking away children, having an affair)
*11. Threaten to leave the marriage or relationship?.....____
12. Threaten to get a divorce of have an affair?.....____
13. Told other people untrue or secret things about you?.....____
14. Make you obey his orders?.....____
*15. Intentionally interrupt you from eating or sleeping?.....____
16. Insist you were crazy, demented.....____
17. Tell you that you were seeing or hearing things not here?....____
18. Place pets in danger to frighten you?.....____

SOCIAL

*19. Prevented you from leaving or seeing certain people?.....____
20. Followed you or spied on you?.....____
21. Telephoned to check up on you?.....____
22. Would not support/did not allow you to work/study/ take classes outside the house?.....____
23. Humiliate you in public?.....____
24. Embarrass or proposition your friends?.....____

FINANCIAL

25. Make you get permission to spend money?.....____
26. Make you justify any spending?.....____
27. Keep all the family income including money you earned?.....____
28. Force you to support him financially?.....____
29. Incur debts, spend all the family income?.....____
30. Refuse to give you money?.....____
31. Keep control of household finances by withholding information?____

SEXUALIZED VIOLENCE

*32. Verbally pressure you to have sex?.....____
33. Make sexually vulgar remarks about you?.....____
34. Pressured you to have sex with others?.....____
35. Accuse you of having affairs with others?.....____
36. Mutilation of parts of your body?.....____
*37. Physically forced sex on you?.....____
38. Force you to perform sexual acts you didn't want to?.....____
39. Took sexual pictures/videos of you?.....____
40. Physically hurt you before, after or during sex?.....____
41. Forced you to imitate pornographic material.....____

DIRECT THREATS OF VIOLENCE

*42. Direct anger at or threatened the children?.....____
*43. Direct anger at or threatened the pets?.....____
*44. Threaten you with a knife, gun or other weapon?.....____
45. Threaten to kill himself if you left?.....____
46. Threaten to kill you or your children if you left?.....____
*47. Threaten to hit or throw something at you?.....____
*48. Threw, hit, kicked something?.....____
*49. Drive recklessly to frighten you?.....____
50. Threaten your family or friends with violence?.....____

DIRECT VIOLENCE

51. Physically hurt your children?.....____
52. Physically hurt your pets?.....____
53. Destroyed your personal belongings or cherished possessions?..____
*54. Threw something at you?.....____
*55. Pushed, carried, restrained, grabbed, shoved or wrestled you?.____

*56. Slapped or spanked you?.....____
57. Pinched you?.....____
*58. Bit or scratched you?.....____
59. Spit at you?.....____
60. Hit you with something?.....____
61. Physically forced you to do something you didn't want to do...____
*62. Pulled your hair?.....____
*63 Punched or kicked you?.....____
*64. Punched or kicked you in the stomach when you were pregnant?..____
*65. Choked or strangled you?.....____
*66. Burned you?.....____
*67. Beat you unconscious?.....____
*68. Locked you in a room or dwelling?.....____
69. Forced bondage?.....____
*70. Used any weapon against you?.....____
71. Twisted your arms or legs or other parts of your body?.....____
72. Other (specify).....____

FAMILY OF ORIGIN

38. Who was in your family when you were growing up? Use family diagram.

39. What was it like for you growing up in your family? Relationships of family members, significant nurturers, significant losses, chemical abuse, etc.

40. What kind of discipline was used in your family?

41. Did you witness physical violence in your family? Yes___ No___
By whom? Towards whom?

42. Did you witness verbal or psychological abuse in your family?
Yes___ No___. By whom? Towards whom?

43. Were you threatened with physical punishment? Yes___ No___
By whom?

44. Were you physically abused by anyone in your family? Yes___ No___
By whom? Please describe (objects, weapons, injuries involved).

45. Did you feel verbally or psychologically abused by anyone in your family? Yes___ No___. By whom? Please describe (name calling, neglect, put-downs).

46. Were you touched by anyone in your family in ways that were sexual or made you uncomfortable? Yes___ No___. By whom? What happened?

Do you feel you were sexually abused? Yes___ No___.

47. Did you tell anyone? Yes___ No___. What happened?

48. Did you witness or have knowledge of sexual abuse of other family members/siblings? Yes___ No___.

49. Did you tell anyone? Yes___ No___. What happened?

50. As a child, did anyone outside your family touch you in ways that were sexual or made you uncomfortable? Yes___ No___. By whom? What happened?

51. Did you tell anyone? Yes___ No___. What happened?

SEXUAL ABUSE AS AN ADULT

52. During your adult years has anyone forced you to participate in unwanted sexual activity? Yes___ No___. By whom? When?

53. Have you told anyone? Yes___ No___. What happened?

54. Do you ever feel sexually abused by partner/ex-partner? Yes ___No___. If "yes", please detail:

55. Did/does your partner use sexually explicit materials? Yes___No___ (Penthouse, Playboy, Hustler, films, videotapes)

56. Does he force you to buy it? Yes____ No____
Does he force you to read/view it? Yes____ No____
Does he force you to re-enact it? Yes____ No____

57. How did the above affect you?

58. Has your partner/ex-partner(s) ever insisted you have sex with other people? Yes____ No____. If "yes", please explain:

COPING AND SUICIDE INFORMATION

59. Have you ever attempted to hurt yourself? Yes____ No____ If "yes". please explain (for example, any self-abusive behavior including starvation, over-eating, self-mutilation):

PAST SUICIDAL BEHAVIOR

None ____ Frequent/persistent suicidal thoughts ____
Isolated suicidal thoughts ____ History of previous attempts ____

If there has been a history or previous attempts, get the following information:

	DATES	MEANS USED	WHAT HAPPENED FOLLOWING YOUR ATTEMPT?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

60. Are you currently considering suicide? Yes____ No____

CURRENT SUICIDE IDEATION

None ____ Frequent/persistent suicidal thoughts ____
Isolated suicidal thoughts ____ Threatening suicide ____

DEATH INTENTION

Doesn't want to die _____
Not sure _____
Doesn't want to die, it's the only choice _____
Really wants to die, but..... _____
Really wants to die _____

SUICIDE PLAN

Client has detailed suicide plan. Yes _____ No _____

If client has detailed suicide plan, what are the means?

Unspecified	_____	Vehicle collision	_____
Overdose	_____	Firearms	_____
Slashing	_____	Jumping	_____
Hanging	_____	Other (specify)	_____

61. Are means available? Yes_____ No_____. Intake counsellor Assessment of Suicidal Lethality: High_____, Moderate _____, Low_____.

62. Are you currently thinking about hurting your partner/ex-partner(s) or children? If "yes", check plan and lethality.

63. Were you ever hospitalized as a result of self-abuse or psychological trauma? Yes_____ No_____. If"yes", please detail when and where:

CHILDREN

64. Do you have any children? Yes_____ No _____

NAME AGE

1. _____

2. _____

3. _____

4. _____

5. _____

Do any of your children live with you? Yes_____ No_____

65. What is your relationship like with each of your children?

66. Have your children/child ever witnessed or heard the violence? Yes____No____. Please detail:

67. Are your children currently involved in individual or group counselling?
Yes____No____. If"yes", please detail::

68. How did you discipline your children?

69. How frequently did you use physical punishment?

70. Did your partner use physical punishment or the children? Yes___No___. If "yes", please detail:

71. Had your partner's behavior toward your childen ever seemed inappropriate or sexual? Yes____No____

72. Have your children ever expressed to you fears or uneasiness about being with your partner? Yes____No____

73. Had Children's Aid ever been involved with your family? Yes____No____

CHEMICAL USE

74. Are you currently on any medications? Yes____No____. If "yes", please detail:

75. Do you use alcohol or drugs? Yes____No____. What kind, how often?

76. Has anyone ever expressed concern about your use? Yes___No____.
If "yes", please describe:

77. Are you concerned about your use? Yes____No____

78. Have you ever received treatment for alcohol or other drug dependency problems? Yes____No____
Where:
When:

79. Have you ever had legal involvements as a consequence of your use? Yes____No____. If "yes", please detail:

80. Has your partner/ex-partner ever had legal involvements as a consequence of his/her use of alcohol or drugs? Yes____No____

81. Where there has been violence, had your partner been drinking or using drugs? Yes____No____.
If "yes", what percentage of time:

82. Are you concerned about your partner's use? Yes____No____
Does your partner/ex-partner have any health problems that would affect his decision making abilities?

CONCLUDING INTAKE INFORMATION

83. What do you think contributes to the violence in your life?

84. What do you see as your strengths?

85. What expectations do you have of the group?

86. What would make it difficult for you to attend our group?
What do you need to make the Program more accessible?

87. What goals or hopes would you bring to a group?

88. Do you have any questions or concerns?

APPENDIX II

Evaluation Tools

APPENDIX A

LUBBEN SOCIAL NETWORK SCALE

Family networks

Q1. How many relatives do you see or hear from at least once a month? (NOTE: Include in-laws with relatives.) Q1 _____

0 = zero
1 = one
2 = two
3 = three or four
4 = five to eight
5 = nine or more

Q2. Tell me about the relative with whom you have the most contact. How often do you see or hear from that person? Q2 _____

0 = < monthly
1 = monthly
2 = a few times a month
3 = weekly
4 = a few times a week
5 = daily

Q3. How many relatives do you feel close to? That is, how many of them do you feel at ease with, can talk to about private matters, or can call on for help? Q3 _____

0 = zero
1 = one
2 = two
3 = three or four
4 = five to eight
5 = nine or more

Friends networks

Q4. Do you have any close friends? That is, do you have any friends with whom you feel at ease, can talk to about private matters, or can call on for help? If so, how many? Q4 _____

0 = zero
1 = one
2 = two
3 = three or four
4 = five to eight
5 = nine or more

Q5. How many of these friends do you see or hear from at least once a month? Q5 _____

0 = zero
1 = one
2 = two
3 = three or four
4 = five to eight
5 = nine or more

Q6. Tell me about the friend with whom you have the most contact. How often do you see or hear from that person? Q6 _____

0 = < monthly
1 = monthly
2 = a few times a month
3 = weekly
4 = a few times a week
5 = daily

Confidant relationships

Q7. When you have an important decision to make do you have someone you can talk to about it?

Q7 _____

Always	Very Often	Often	Sometimes	Seldom	Never
5	4	3	2	1	0

Q8. When other people you know have an important decision to make, do they talk to you about it?

Q8 _____

Always	Very Often	Often	Sometimes	Seldom	Never
5	4	3	2	1	0

Helping others

Q9a. Does anybody rely on you to do something for them each day? For example: shopping, cooking dinner, doing repairs, cleaning house, providing child care, etc.

NO - If no, go on to Q9b.

YES - If yes, Q9 is scored "5" and skip to Q10.

Q9b. Do you help anybody with things like shopping, filling out forms, doing repairs, providing child care, etc.?

Q9 _____

Always	Very Often	Often	Sometimes	Seldom	Never
5	4	3	2	1	0

Living arrangements

Q10. Do you live alone or with other people? (NOTE: Include in-laws with relatives.)

Q10_____

5 Live with spouse
4 Live with other relatives or friends
1 Live with other unrelated individuals (e.g., paid help)
0 Live alone

TOTAL LSNS SCORE: _____

SCORING:

The total LSNS score is obtained by adding up scores from each of the ten individual items. Thus, total LSNS scores can range from 0 to 50. Scores on each item were anchored between 0 and 5 in order to permit equal weighting of the ten items.

INDEX OF SELF ESTEEM (ISE) Today's Date _____

NAME:_____

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

1 Rarely or none of the time
2 A little of the time
3 Some of the time
4 A good part of the time
5 Most or all of the time

Please begin.

1. I feel that people would not like me if they really knew me well _____
2. I feel that others get along much better than I do _____
3. I feel that I am a beautiful person _____
4. When I am with other people I feel they are glad I am with them _____
5. I feel that people really like to talk with me _____
6. I feel that I am a very competent person _____
7. I think I make a good impression on others _____
8. I feel that I need more self-confidence _____
9. When I am with strangers I am very nervous _____
10. I think that I am a dull person _____
11. I feel ugly _____
12. I feel that others have more fun than I do _____
13. I feel that I bore people _____
14. I think my friends find me interesting _____
15. I think I have a good sense of humor _____
16. I feel very self-conscious when I am with strangers _____
17. I feel that if I could be more like other people I would have it made _____
18. I feel that people have a good time when they are with me _____
19. I feel like a wallflower when I go out _____
20. I feel I get pushed around more than others _____
21. I think I am a rather nice person _____
22. I feel that people really like me very much _____
23. I feel that I am a likeable person _____
24. I am afraid I will appear foolish to others _____
25. My friends think very highly of me _____

3,4,5,6,7,14,15,18,21,22,23,25

APPENDIX C

DYSFUNCTIONAL ATTITUDE SCALE (DAS)

1 = Totally Agree
2 = Agree very much
3 = Agree slightly
4 = Neutral
5 = Disagree slightly
6 = Disagree very much
7 = Totally disagree

___1. It is difficult to be happy unless one is good looking, intelligent, rich,, and creative.
___2. Happiness is more a matter of my attitude towards myself than the way other people feel about me.
___3. People will probably think less of me if I make a mistake.
___4. If I do not do well all the time, people will not respect me.
___5. Taking even a small risk is foolish because the loss is likely to be a disaster.
___6. It is possible to gain another person's respect without being especially talented at anything.
___7. I cannot be happy unless most people I know admire me.
___8. If a person asks for help, it is a sign of weakness.
___9. If I do not do as well as other people, it means I am a weak person.
___10. If I fail at my work, then I am a failure as a person.
___11. If you cannot do something well, there is little point in doing it at all.
___12. Making mistakes is fine because I can learn from them.
___13. If someone disagrees with me, it probably indicates he does not like me.
___14. If I fail partly, it is as bad as being a complete failure.
___15. If other people know what you are really like, they will think less of you.
___16. I am nothing if a person I love doesn't love me.
___17. One can get pleasure from an activity regardless of the end result.
___18. People should have a chance to succeed before doing anything.
___19. My value as a person depends greatly on what others think of me.
___20. If I don't set the highest standards for myself, I am likely to end up a second-rate person.
___21. If I am to be a worthwhile person, I must be the best in at least one way.
___22. People who have good ideas are better than those who do not.
___23. I should be upset if I make a mistake.
___24. My own opinions of myself are more important than others' opinions of me.
___25. To be a good, moral, worthwhile person I must help everyone who needs it.
___26. If I ask a question, it makes me look stupid.
___27. It is awful to be put down by people important to you.
___28. If you don't have other people to lean on, you are going to be sad.
___29. I can reach important goals without pushing myself.
___30. It is possible for a person to be scolded and not get upset.
___31. I cannot trust other people because they might be cruel to me.
___32. If others dislike you, you cannot be happy.
___33. It is best to give up your own interests in order to please other people.
___34. My happiness depends more on other people than it does on me.
___35. I do not need the approval of other people in order to be happy.
___36. If a person avoids problems, the problems tend to go away.
___37. I can be happy even if I miss out on many of the good things in life.
___38. What other people think about me is very important.
___39. Being alone leads to unhappiness.
___40. I can find happiness without being loved by another person.

APPENDIX D

CLIENT SATISFACTION RATING SCALE

Please help us improve our program by answering the following questions. We are interested in your honest opinions and welcome your comments and suggestions.

Please check ( ) your answers and comments if desired.

1. How would you rate the quality of service you have received?

   Excellent _____ Fair _____ Poor _____

2. Did you get the kind of service you wanted?

   No, not really _____ Yes _____ Yes, definitely _____

3. To what extent has our program met your needs?

   Most of my needs have been met _____ Only a few of my needs have been met _____ None of my needs have been met _____

4. If a friend were in need of similar help, would you recommend our program to her?

   No, I don't think so _____ Yes _____ Yes, definitely _____

5. How satisfied are you with the amount of help you have received?

   Dissatisfied _____ Mostly satisfied _____ Very satisfied _____

6. Have the services you received helped you to deal more effectively with your problems?

   Yes, they helped a great deal _____ They helped somewhat _____ No, they really didn't help _____

7. In an overall, general sense, how satisfied are you with the service you have received?

   Very satisfied _____ Indifferent or Mildly dissatisfied _____ Quite dissatisfied _____

8. If you were to seek help again, would you come back to our program?

   No, I don't think so _____ Yes _____ Yes, definitely _____

COMMENTS: _____

_____

_____

APPENDIX III

Program Outline &

Educational Tools

APPENDIX A

Program Outline

Group 1 - General Objective/Purpose

Introductions

To create a safe environment where members can openly share their concerns and learn from the experiences of others in the group.

Specific learning objectives:

To describe the group, its purpose and its philosophy.
To identify the basic structure and ground rules of each person.
To communicate the importance of confidentiality and safety.
To facilitate connections between group members.

Group 2 - General Objective/Purpose

To understand what abuse is and analyze its causes.

Specific Learning Objectives

To identify different types of abuse and personal responsibility for behaviors.
To confront the myths of abuse, e.g. alcohol abuse, victim blaming, hereditary gender predisposition, abuser sick/can't control himself.
To describe the role of the sociocultural context upon behavior.

Group 3 - General Objective/Purpose

To identify and express safety and survival issues.

Specific Learning Objectives

To understand the cycle of violence.
To recognize danger signals, e.g., behavior cues, feelings of fear.
To articulate the use of denial and the right for safety.
To identify strengths and a protection plan for safety.

Group 4 - General Objective/Purpose

To evaluate the extent and application of new learnings (by utilization of a folkstory as a case study).

Specific learning objectives:

To analyze motivations and behaviors of abusive individuals.
To normalize abusive experiences by exposing duration of violent behaviors in society.
To begin the process of problem-solving.

Groups 5 and 6 - General Objective/Purpose

To understand how one's family of origin has influenced one's life (by utilization of a family tree/genogram).

Specific Learning Objectives:

To identify childhood messages of: appropriate female sex-role behaviors, disciple, affection.
To identify influence of role models upon expectations of marital partners.
To reduce the fear about discussing family openly.

Group 7 - General Objective/Purpose

To integrate the past with the present and to begin goal-setting for the future (by utilization of a lifeline exercise).

Specific Learning Objectives:

To eliminate feelings of self-blame and responsibility.
To develop a sense of power through the power of choice.
To identify future goal and a sense of individual control.

Group 8 & 9 - General Objective/Purpose

To learn non-violent ways of managing anger.

Specific Learning Objectives:

To learn to express feelings through the use of words.
To accept that it is normal to feel angry.
To identify health methods for coping with anger.

Group 9 - General Objective/Purpose

To identify fear blocking the pursuit of self-care.

Specific Learning Objectives:

To identify fears and barriers to self-care.
To reclaim strengths and courage.
To identify self-nurturing strategies.

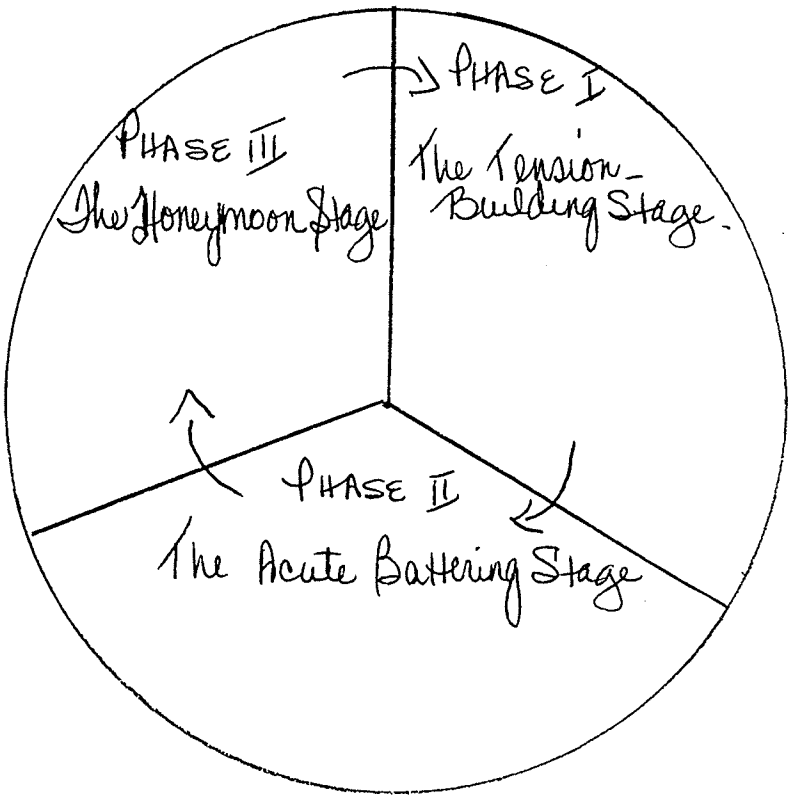
Group 10 - General Objective/Purpose

Terminations/Endings.
To solidify new learnings about violence and evaluate the group experience.

Specific Learning Objectives

To review previous content.
To identify resources/coping strategies for future use.
To reinforce new learnings.

APPENDIX B



THE CYCLE OF VIOLENCE

Adapted for use from materials in The Battered Woman by L.E. Walker (1979)

need more margin at the bottom of Page

The Flight of the Birds
(British Folktale)

A farmer living in a wild part of the country had a good and beautiful wife whom he loved deeply, and he was therefore very jealous. One night the farmer offered hospitality to a fine-looking stranger who sought refuge from a raging storm. Noticing the stranger glancing at his wife, the husband felt that anyone looking at them would think the guest and his wife made a very handsome pair, and that he, the farmer, made a poor appearance in comparison. When both started to yawn at about the same time, the husband was convinced that the two had been having an affair. Much as the farmer would have liked to kill the stranger, still he was a guest and therefore could not be harmed. When the stranger retired for the night, the husband grabbed his wife and took her out into the stormy night to kill her. He explained that to keep her a true and honest wife, he would have to hang her. Nothing the wife could say changed his resolve.

His efforts to hang her on nearby trees were repeatedly thwarted by a flock of birds, who followed them from tree to tree. He tried to escape the birds by going to a lone tree some distance away. But when he tried once more, the birds again appeared and prevented the hanging. As dawn was breaking, the continual interference of the birds combined with his wife's understated protests and her beauty in the early morning light made him realize tearfully that his wife was innocent. He then knew that the birds would have given him no peace had he succeeded out of anger and jealousy in murdering his wife. He took her home, holding hands with her, and never mistrusted her again (Briggs, 1977).

APPENDIX D

BILL OF RIGHTS FOR ASSAULTED WOMEN*

- o I have the right not to be abused.
- o I have the right to anger over past beatings.
- o I have the right to change the situation.
- o I have the right to freedom from fear of abuse.
- o I have the right to request and expect assistance from police or social agencies.
- o I have the right to share my feelings and not be isolated from others.
- o I have the right to want a better role model of communication for my children.
- o I have the right to be treated like an adult.
- o I have the right to leave the abusive environment.
- o I have the right to privacy.
- o I have the right to express my own thoughts and feelings.
- o I have the right to develop my individual talents and abilities.
- o I have the right to legally prosecute the abusing spouse.
- o I have the right not to be perfect.

Sinclair, D. (1984). Understanding Wife Assault.

APPENDIX IV

Letters of Permission

APPENDIX A

February 2,1992

Dr.J.E. Lubben
University of California
Social of Social Welfare
Los Angeles, California

RE:Lubben Social Network
Scale

I am a Master's student in the Faculty of Social Work completing a practicum in the area of elder abuse. This practicum has been undertaken in conjunction with The Elder Abuse Resource Centre a demonstration project sponsored by the Age and Opportunity Centre Inc., an agency that has provided service to the City of Winnipeg's elder population since 1957.

The purpose of my practicum is to develop a group counselling program that will empower participants to act self-protectively against further spousal abuse. I believe that this assessment tool will be helpful in evaluating program and client success. I am therefore requesting your written permission to use this instrument in my studies.

Should you request further information I would be pleased to reply to any areas of concern you may have. Thank you for your consideration of this request and an early reply would be appreciated.

Yours truly,

Janice Christie
227 Edgewater Dr.
Wpg. Man.
R2J2V4

UNIVERSITY OF CALIFORNIA, LOS ANGELES

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SCHOOL OF SOCIAL WELFARE
405 HILGARD AVENUE
LOS ANGELES, CALIFORNIA 90024-1452

February 10, 1992

Janice Christie

Dear Ms. Christie:

I appreciate your interest in my research. Among other publications, I am enclosing one that describes the Lubben Social Network Scale (LSNS). You certainly have my permission to use the LSNS in any research project and please feel free to call me should you need any clarification on use or scoring of the LSNS. Enclosed are some recent articles which describe the Lubben Social Network Scale (LSNS). These articles illustrate analyses which used individual items from the LSNS as well as those which used the composite score. More recent work has demonstrated the validity and reliability of the LSNS among diverse elderly populations. For example, a recent paper at the APHA meeting reported analyses using the LSNS in a large HMO study in Los Angeles. Dr. Iris Chi and I are also working on an article where we successfully used the LSNS in a study of Hong Kong elderly. I am also working an article which describes the LSNS factor structure which has remained stable among these diverse study populations.

Should you publish the results of your study, I would appreciate your providing me with appropriate citations or reprints of your articles. Because I am collecting data on the generalizability of the LSNS, I would especially appreciate your sharing with me selected statistics of the LSNS that you may calculate using your data (e.g., means, standard deviations, Cronbach Alphas, etc.). Accordingly, I will periodically provide you with similar data from other studies. By forming this informal network of researchers using the LSNS, I can inform each of similar applications of the LSNS as well as any further refinements in the scale. Thank you again for your interest in the LSNS and I look forward to hearing about your results.

Sincerely,

James E. Lubben, MPH, DSW
Associate Professor and Director,
California Geriatric Education
Center Social Work Faculty
Development Program
(310) 206-6044

APPENDIX C

CLIENT VIDEOTAPE AGREEMENT

This is to certify that I _____ agree to a videotape recording of
name

this program. It is my understanding that it will be used for educational purposes only and destroyed immediately thereafter.

_____ _____
Date Co-Facilitator

_____ _____
Signature Co-Facilitator

APPENDIX D

CONSENT FOR CLIENT PARTICIPATION IN RESEARCH

I/We consent to participate in research conducted by Janice Christie, B.A., B.S.W., M.A.Ed., and/or Age & Opportunity Elder Abuse Resource Centre. I/We understand that any data pertaining to ourselves will be held confidential and any descriptive outcome of this research will not disclose my/our identity in any way.

I hereby authorize Elder Abuse Resource Centre (Age and Opportunity) and Janice Christie access to confidential materials/data, e.g., presentations, evaluation forms, assessments, etc., pertaining to myself.

_____ _____

Date Co-Facilitator

_____ _____

Signature Co-Facilitator