GROWING OLDER - STAYING WELL:
A FEMINIST HEALTH PROMOTION
GROUP WORK INTERVENTION WITH WOMEN

A PRACTICUM REPORT

SUBMITTED TO

THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS

FOR THE

DEGREE MASTER OF SOCIAL WORK

BY

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OCTOBER, 1993

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GROWING OLDER-STAYING WELL

A FEMINIST HEALTH PROMOTION

GROUP WORK INTERVENTION WITH WOMEN

BY

SHERRY FAYE MOONEY

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

MASTER OF SOCIAL WORK

ACKNOWLEDGEMENTS

Many people have contributed to this practicum. Of special importance are the women who agreed to be group members. They provided me with the opportunity to learn, to grow, and to be empowered as a feminist and as a woman.

I would like to offer special thanks to the staff at the Women's Health Clinic. Many of them contributed their time and knowledge to aid me in carrying out this exercise.

Special thanks to my advisor Joe Kuypers and to my committee members Sheila Rainonen and Kim Clare. Their support, guidance, and patience were greatly appreciated.

I would like to thank my supervisor Doris Alaire, who went out of her way to provide me with as much support and flexibility as she could with my employment commitments. My work partner, Carol Martin, also deserves special thanks. Carol took on extra responsibilities willingly and encouraged me to take the time I needed to complete this practicum.

I would also like to extend sincere thanks to Pam Goundry who assisted me with her computer expertise to prepare all the written material. Pam, I thank you for your patience, your support, and most importantly your friendship.

To my husband, Doug Taylor, my life partner, my thanks for all your love and support.

This practicum is dedicated to my parents, Dave and Shirley Mooney, who taught me to question, to learn, and to grow. They encouraged in me a love of learning which is what this practicum is all about.

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GROWING OLDER - STAYING WELL: A FEMINIST HEALTH PROMOTION GROUP WORK INTERVENTION WITH WOMEN

Part I Introduction

I have worked in the health care field for eighteen years. Over this eighteen year period I have been made aware of how badly women are treated by the health care delivery system. I witnessed women's experiences with this system which contributed to my awareness of the problem of the inadequacy of traditional health care services for women. In the early years of my nursing career I did not understand the political meaning of my observations nor did I understand that these observations had meaning for women collectively. After I began my social work education I began to understand the broader meaning of oppression. I also became interested in feminism. Feminism for me is an ideological commitment to gender equality in all aspects of life. As my interest in feminism grew so too did my interest in working with women. In my present paid employment I work with individual health care consumers on health care issues. In my paid employment I have never had the opportunity to work with women in groups. This was an area of social work practice which I identified I would like to develop skill in. I felt my lack of group work skill limited my practice options as well as my personal involvement in community organization groups.

This practicum is a beginning step to integrate my feminist beliefs into my social work practice with groups of women. The practicum provided the opportunity to develop

group work skills in a feminist approach to health care issues. This group work approach not only allowed me to address the problem of the inadequacy of health care services for women in a formal way but it also allowed me to attain skill development in group work to aid my social work practice.

The report of this practicum consists of four parts. In part one I identify the practicum objectives, the benefits for me the student and I define several terms used throughout the report. In part two I provide a discussion on the literature reviewed to address the questions I posed about the problem of the inadequacy of traditional health care services to meet the needs of aging women. The review of the literature resulted in an incremental process to gain a clearer understanding of the origin of the problem and to identify potential solutions. Part three is a discussion of the practicum itself and part four is a discussion of the evaluation of the practicum intervention. The ultimate goal of this practicum was to further my knowledge and practice base regarding viable approaches in working with aging women on health related issues.

Chapter 1 Objectives of the Practicum

The objectives of this practicum are both personal and practical. My interest in learning how to facilitate health

promotion strategies in a group setting from a feminist approach has arisen out of my need to develop practice skills that integrate my experience and skills as a social worker with my personal and professional interest in working with women. My awareness of the experiences of women with the health care system have led me to a desire to facilitate the empowerment of women to take control of their own health and wellness.

My personal objectives are:

-to increase my theoretical knowledge about health promotion strategies and about feminist group work methods by reviewing relevant, current literature.

-to increase my practical skills in group work with women.

-to develop a practice framework that integrates health promotion strategies and a feminist framework.

-to facilitate an increased consciousness and sense of empowerment for women to take control of their own bodies to promote wellness.

My practice objectives are:

-to develop an innovative way of facilitating processes to meet the needs of women clients on health related issues.

-to evaluate the usefulness of health promotion strategies in a feminist approach to practice in a group work format.

-to become a more skilled, effective health care professional.

-to incorporate a holistic approach to health care service in my social work practice.

-to develop skill in facilitating a learning process for health care consumers to help them achieve wellness.

Assumptions

As well as objectives I have made some assumptions about the intervention that need to be stated. The first assumption is that the group process will be beneficial to the group participants. I expect to facilitate group processes that are both positive and beneficial for the group members. I do not expect any harm to come to group participants due to their involvement in this practicum.

The second assumption is that aging presents new challenges to women in respect to health and wellness.

The third assumption is that the social support derived from the group experience will be helpful to assist group members to deal with the challenges of aging.

Benefits to the Student

I expect to develop skill in the delivery of a feminist group work intervention which focuses on health promotion and wellness. I expect the exposure to group work methods will increase my confidence in my ability to facilitate this type

of social work intervention. I expect that the group members will teach me a great deal about health promotion and wellness by sharing their experiences. I expect to be empowered by the group support to take control of my own health which will increase my personal potential to stay well.

Terms of Reference

I will provide definitions of several of the commonly used terms used in this practicum. These definitions will provide a term of reference for the reader.

Sexism is "the tendency to construct stereotypes based on gender" (Clarke, 1990; p. 232)

Ageism is "the belief that a person's worth and abilities are determined solely by chronological age." (Brown-Doress, *et al.*, 1987; p. XXI)

Empowerment is "a process whereby persons who belong to a stigmatized social category can be assisted to develop and increase skills in the exercise of interpersonal influence and the performance of valued social roles." (Cox, 1991; p. 78)

Patriarchy is "male dominance over women" (Clarke, 1990; p.233)

Misogynist is "one who hates or distrusts women" (Wolfe, 1974; p. 448)

Paternalism is "a system under which an authority treats those under its control paternally by regulating their conduct and supplying their needs." (Wolfe, 1974; p. 448)

Part II Literature Review

Chapter 2 A Feminist Critique of Health Care

Introduction

To understand the present day health care delivery system it is important to have an understanding of the history of the development of this system. It is widely recognized and documented by feminist health care reform authors that present day health care services are inadequate to meet the health care needs of women in general and aging women in particular (Brown-Doress, 1987; DeLorey, 1984; Grambs, 1989; Lewis, 1985). Inadequacies of health care services go beyond problems of access, availability, and effectiveness. Health care service defects are rooted in the historical development of the health care - medical care delivery system *per se*. In this section I will provide an historical overview of the development of the health care - medical care delivery system as it relates to women in particular. I will focus on the literature sources that identify the factors which negatively influence the medical care system's approach to health care for women. These factors include sexism, patriarchy, the dominance of the medical model of disease treatment in health care, the medicalization of women's lives by medical professionals, and the narrow definition of health adopted by

mainstream health care providers. Aging women have special health care needs and experience greater negative impact from the underlying sources of the inadequacy of health care services for women in general. I will discuss special needs of aging women as these issues served as a guide for the development of the feminist health promotion-group work approach adopted in this practicum.

Herstory of Inadequate Health Care

The literature on the history of health care inadequacies for women is primarily from American sources. In my review I have identified parallel experiences for women from both Canada and the United States. In both Canada and the United States, women began as healers and primary providers of health care (Ehrenreich and English, 1973a; p.3). Over the centuries, women moved from positions of power and respect as healers to positions of powerlessness and disrespect as consumers. In Barbara Ehrenreich and Deidre English's pamphlet, Complaints and Disorders: The Sexual Politics of Sickness (1973a), the authors trace the history of health care service delivery from the 1300s to the 1970s. These authors traced how women began as the primary providers of health care then were slowly excluded from medical practise by the developing male dominated education institutions which began to train formal healers or male physicians. These university

trained physicians were exclusively males in the early years as women were barred from formal education. As the university trained physicians became more plentiful other measures were taken to bar women from medical practise and the label of witch was applied to female healers.

In addition to the shift from female to male healers and from informal to formally trained physicians, the medical view of women's health and illness also changed. By the 1800s, the male medical doctor viewed women as the weaker sex who were prone to illness due to their delicate physical and mental condition. Male doctors treated women of the ruling class with bedrest, tonics, and "pampering". Women were considered unfit for paid employment due to their delicate conditions. Women were told that their "subservience was biologically ordained" (Ehrenreich and English, 1973a; p. 3). The view of women's delicate condition was saved exclusively for the upper and middle classes. In general, the health care needs of poor and working class women were ignored by the university trained physician until later years.

Gynecology became a field of practice in the mid-nineteenth century and the female life cycle became medicalized. Menstruation, conception, pregnancy, lactation, and menopause became a field of medical study and women became the objects of special medical intervention (Rodin and Collins, 1991; p. 13). As the field of gynecology became more widely developed and extensively studied, the overall health care of

women became focused on reproduction. By the 1860s it was common practice for physicians to remove reproductive organs as an acceptable treatment for an extensive list of gynecological, neurological, and psychological symptoms (Rodin and Collins, 1991; p. 13). Women became primary consumers of health care services with the medicalization of the female life cycle. Rodin *et al.*, (1991) suggest that the medicalization of the female life cycle helps explain why women today are more often patients than men.

Women's emotions have also been medicalized over the past century. Women's symptoms are often diagnosed as psychosomatic when current medical knowledge is at a loss to explain their etiology. Women are frequently told that "it is all in their head," and are prescribed counselling, psychiatric treatment, and mood-altering or other psychotropic drugs (Clarke, 1990; p. 242). The medicalization of women's emotions is viewed by some authors as an extension of the nineteenth century gynecological and rest cures of social-sexual control (Clarke, 1990; p. 244). To keep women in their place and "help" them cope with their oppression they are prescribed tranquilizers and receive psychotherapy. These methods medicate women into submission and subservient roles. The medicalization of the female life cycle and of female emotions have allowed male medical professionals to become viewed as the experts on women's minds and on women's bodies.

Due to their expert status, physicians have been sanctioned as the primary providers of health care services to women.

In the literature, several other feminist authors highlight how the health care system has historically evolved as an institution of social control. Ehrenreich and English (1978) provide historical examples of how men cited women's delicate condition and their reproductive functions as rationale for women's ineligibility for entrance into universities and from employment functions in companies and businesses outside of the home. Early scholars concluded that gender and race represented different evolutionary stages according to Darwin's Theory of Evolution. Women's place in society was believed to revolve around her reproductive capacity (Ehrenreich and English, 1978; p. 127). John Ehrenreich, in his book The Cultural Crisis in Modern Medicine (1978), also provides a comprehensive historical account of the development of the health care system as an agent of social control. He states that the health care reform movement has identified countless ways in which doctors acted under the guise of the medical relationship to reinforce male domination: "...female patients...were put down, made to feel bad about their bodies, fed masses of information about "proper" female anatomy, sexuality, personality, child-rearing practices, denied control of their own reproductive functioning..." (Ehrenreich, 1978; p. 9). In the chapter, "Medicine and Social Control", Ehrenreich and Ehrenreich

(1978) concluded that the patriarchal relationship between women and the medical system has not improved over the years. They stated that women continue to receive inadequate health care services due to the endemic sexism in the medical care system.

Why Health Care Services are Inadequate for Women

Women are treated with less respect within the health care system and receive poorer medical care than men (Laskin-Siegal, 1987; p. 213). Feminist authors suggest several reasons why women receive poorer medical care than men do. Sexism and patriarchy in medicine are two reasons cited. "Sexism is the tendency to construct stereotypes based on gender" (Clarke, 1990; p. 232). The belief about women's weaker nature and biologically determined predisposition to depression and psychosomatic illnesses are two examples of common sexist attitudes held by doctors. Verbugge and Wingard (1987) in the article "Sex Differentials in Health and Mortality" identify several findings that differ for men and women on health and mortality issues. These authors conclude that doctors prescribe psychotherapeutic drugs more readily to women than to men. They cite physician sex bias as a reason for this discrepancy (Verbugge and Wingard, 1987; p. 144).

Patriarchy or "male dominance over women" is also present in the medical care delivery system (Clarke, 1990; p. 233).

"Patriarchy is also evident in the dominant positions held by men in the medical labour force and in the power of male health providers over (largely) female patients" (Clarke, 1990; p. 233). Women health care providers are identified as the workers where the bosses are men (Ehrenreich and English, 1973a; p. 3).

Medical research biases also contribute to the inadequacy of health care services for women. Women's diseases and women as research subjects are neglected in scientific research. Frequently male subjects are the sole subjects of research into diseases that affect both sexes (Macy, 1990; p. 25). When male subjects are the sole research subjects it is questionable if results can be meaningfully generalized to female populations. As well doctors and researchers can only assume the impact of the disease is the same for men and women and that treatment works equally well for both sexes (Macy, 1990; p. 25).

The medical model of health care is the dominant approach used in the current medical care system. In the medical model diagnosis and treatment of disease are the central focus. The diagnosis and treatment of disease are based on scientific technology and investigation in this model. In the medical model health is defined as the absence of disease.

Some assumptions in the medical model are that the search for causes of disease should be within the cells of the body and that disease is undesirable, abnormal, and must be

eliminated as quickly as possible (Clarke, 1990; p. 224). The medical model does not account for any social factors affecting the individual and influencing the disease process. The medical model is a scientific approach that relies on the medical profession to identify the ideal treatment for every illness and medical condition. The medical model reinforces the assumption that a person's health is best protected by medical intervention and medical cures (York, 1987; p. 2).

The critique of the medical model includes the failure of this model to explain individual differences in disease processes. Major advances have been made in medical technology but people continue to die at differential rates from the same disease. The feminist critique focuses on the narrow definition of health employed by the medical model. In the definition of disease the origin is considered to be completely within the organism or individual and the social context of people's lives is not considered. Other criticisms in the feminist literature focus on the "lack of research into a finer understanding of how health can best be maintained" and the "undue emphasis on medial therapies which frequently harm as much as they heal" (Burston, 1990; p. 25). Other models of disease better explain individual differences in health and illness but the medical model remains dominant in mainstream health care. The environmental and lifestyle models of health and illness focus on causes of disease external to the individual organism and explain disease as a

complex phenomena influenced by environmental and lifestyle factors (Clarke, 1990; p. 225). These models take into account the effects of gender, oppression, discrimination, economic, and lifestyle factors that differentially effect the health and wellness of women. These factors must be taken into account in the development of health care services to meet the broad range of women's health care needs.

The medicalization of women's lives, as discussed earlier, also contributes to the inadequacy of health care services for women in general. Women's reproductive cycle has become the focus of medical study and warranted a separate field of medical speciality. As a result, natural life processes have come to be viewed as diseases and women are socialized to seek medical intervention for these processes. "It is estimated that half the hysterectomies performed in Canada are not medically necessary" (Abramson, 1990; p. 12). As well as unnecessary surgeries, the medicalization of women's lives have also resulted in women receiving prescription drugs for nonmedical reasons more frequently than men. "Pharmaceutical companies, along with the medical profession, continue to treat menopause as a deficiency disease and in spite of ongoing controversy, actively promote hormones" (Elliott, Gottlieb, *et al.*, 1990; p. 3). Unnecessary surgeries, overmedicating, and misdiagnosis of acute processes all contribute to the inadequacy of health

care services for women due to the medicalization of the female life cycle.

Special Needs of Aging Women

Aging women not only face sexism and patriarchy as barriers to adequate medical care but they also face ageism as a major form of discrimination and prejudice. Ageism is "the belief that a person's worth and abilities are determined solely by chronological age" (Brown-Doress, *et al.*, 1987; p. xxii). Ageism, coupled with sexism, influences the medical professionals decisions about diagnosis and treatment of health complaints and influences the adequacy of health care services for aging women. "Ageism manifests itself first and foremost in the attitude that aging is a disease" (Laskin-Siegal, 1987; p. 213). The medicalization of aging results in some of the same side effects as the medicalization of the female reproductive cycle. As a result, aging women are in double jeopardy of misdiagnosis, overmedication, and for unnecessary medical - surgical intervention.

Another reason that aging women have unique reasons for the receipt of inadequate health care services relates to the dominance of the medical model of health and illness in our current medical care system. Women on average live eight years longer than men (Haley and Hauprich, 1987; p. 25). Women, as they age, experience higher morbidity rates and more

chronic illnesses than men do (Verbugge, 1985; p. 81). "The reliance on the medical model is particulary problematic because of the limited relevance of the notions of cure to the most significant diseases in modern society, namely the degenerative, chronic diseases" (Clarke, 1990; p. 227). As the medical model of disease and illness is not adequately addressing chronic illnesses the current medical care delivery system is not adequately treating these diseases. The dominance of the medical model approach to health care discourages the development of broad based services that may better address the problem of chronic illness.

Older women's health issues are unique (Lewis, 1985; p. 1). This observation has been made by several authors that write about women's health issues (Baruch, *et al.*, 1984; Brown-Doress, *et al.*, 1987; Cohen, 1984; McDaniel, 1988; Grambs, 1989). To date, this observation and account of aging women's special needs has not been considered as relevant for extensive medical study or research. Women's health care needs after menopause are not well documented nor clearly identified.

All women are undervalued in our society but aging women are devalued the most. Women's mental health needs are related to the social impact of being devalued and discriminated against (McGrath, 1992; p. 27). Aging women, therefore, have not only physical health care needs but also mental health needs that require special attention.

The current health care delivery system is failing to meet the needs of aging women. This problem will be explored further in the literature review of health promotion strategies, feminist group work, and the wellness paradigm.

Conclusion

In this chapter of the literature review I have explored the problem of inadequate health care services for women. In a review of the literature a reader can identify many issues related to the inadequacy of health care services for women. Problems of access, availability, and adequacy are three issues cites as problematic in the present service delivery system. These problems are not due to current restraint, medical knowledge, or other practical issues. The problem of inadequate health care services for women is a long standing problem that evolved in the historical development of the health care or medical care system *per se*. Historically women have moved from being central figures as healers with power in the delivery of health care to being consumers of male dominated medical care. This medical care system is not meeting the needs of women in general and aging women in particular. The origin of the inadequacy of present day services is rooted in the development of the sexist, patriarchal, paternalistic medial system that is dominant in the traditional health care delivery system. The medical

system is based on a medical model of disease and illness. Within the medical model a narrow definition of health, the medicalization of women's lives, and medical research bias are all factors that have negatively influenced the development of our present day service delivery system. The current medical system did not evolve as a benevolent service to provide health care but was developed as a system of social control to support male domination (Ehrenreich, 1978; p. 9). The system was designed to meet male supremacy needs and as a result was never intended to meet the real needs of women in respect to health care. An under-standing of the history of the development of health care services for women is crucial to an understanding of the deficits of the present day system. As the system was created as an agenda of social control mere modification of this system is not sufficient to promote changes that will allow this system to adequately meet the needs of women. The medical care system must be dramatically changed to meet the needs of women in general and aging women in particular. Consumer control versus physician control is one basic shift that must occur before services can become responsive to the individual and collective needs of women.

The health promotion approach to health care delivery offers one alternative to a medical model of a disease treatment approach. Health promotion or the lifestyle model will be discussed in Chapter Three.

Chapter 3 Health Promotion: An Alternative Approach To The Medical Model of Health Care

Introduction

Health promotion strategies are based on concepts borrowed from a Lifestyle model of disease and illness as well as from the environmental-social-structural model of disease and illness. A health promotion approach to health care includes a broad definition of health and focuses on different sources of disease than the medical model discussed in Chapter Two. Health promotion has acquired worldwide prominence in the literature as the way of the future for health care. In this chapter I will define health promotion, give a brief overview of the history of health promotion in Canada and provide a review of the literature on the effectiveness of health promotion strategies and programs. I will also provide a critique of health promotion and identify why health promotion is only a partial answer in addressing the inadequacies of the health care delivery system for women in general and aging women in particular.

Health Promotion Defined

The definition of health, in a health promotion approach, is a broad definition of health that goes beyond absence of

disease. The World Health Organization has defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (Eikenberry, 1990; p. 2). This definition of health is consistent with health promotion approaches. Health promotion has been defined in several different ways. The broadest definition of health promotion identified is "the process of fostering awareness, influencing attitudes and identifying alternatives so that individuals can make informed choices and change their behaviors to achieve an optimum level of physical and mental health and improve their physical and social environment" (Tedesco, *et al.*, 1984; p. 1).

Feminist writers define health promotion as an empowerment process that encourages health care providers to give consumers the education and information necessary to enable them to make informed decisions and become responsible for their own health care (Swaffield, 1990; p. 27). The definition of health promotion I adopted for this practicum was a combination of the two definitions cited. Health promotion was viewed as an empowerment process to foster awareness, influence attitudes, and identify alternatives for group participants to enable them to make informed choices and take control of their health care.

The World Health Organization states that health promotion strategies have five major principles. These principles are that health promotion involves the population

as a whole in the context of their everyday lives, rather than focusing on people at risk for certain diseases. Health promotion is directed towards action on the determinants or cause of health, not on individual behavioral change. Health promotion combines diverse, complimentary methods and approaches and aims particularly at effective and concrete public participation. The fifth principle is that health professionals particularly in primary health care have an important role in nurturing and enabling health promotion (DeLeeuw, 1989; p. 22). These five principles guided the development of the approach used in this practicum to deliver a feminist health promotion group work intervention to aging women.

Health promotion strategies differ from the medical model approach to disease treatment. Health promotion is based on concepts borrowed from both the lifestyle model and the environmental/social-structural model of health care delivery. In the lifestyle model of health care, disease is understood as a result of individual behaviors (Clarke, 1990; p. 225). Early health promotion programs focused on smoking, exercise, stress management, diet, sexual habits, substance use, safe driving practices, and other individual behaviors. These types of health promotion programs continue to exist but health promotion strategies also include approaches that not only look at individual behaviors as a cause of disease but also at social causes of disease. These approaches are more

consistent with the environmental-social-structural model of health and disease. In this model "disease is best understood as a result of social-structural inequalities in class, gender, race, ethnicity, and environmental conditions..." (Clarke, 1990; p. 225). The environmental-social-structural model of health and disease is more consistent with a feminist analysis as it focuses on the causes of disease that lie outside of the individual. Disease is identified as having social versus individual causes. In the environmental-social-structural model disease can not be cured by medical treatment nor by individual lifestyle changes alone. Health care services must be very broad based and focus on societal changes to cure disease in this approach.

The History of Health Promotion in Canada

Health promotion gained popularity as an alternative to traditional medical approaches in the 1970s. Marc Lalonde described detailed health promotion strategies in his 1974 document A New Perspective of the Health Care of Canadians. This report validated health promotion as a viable approach to improve the fiscally troubled Canadian health care delivery system. Jake Epp expanded on the Lalonde report in his 1986 report entitled Achieving Health for All: A Framework for Health Promotion. Health promotion and illness prevention officially entered the political and economic arena in Canada

with the publication of Achieving Health for All (Health and Welfare Canada 1987) (Fulton, M.J., 1990; p. 75).

Health care reform became a widespread, popular movement in the 1970s. Dissatisfaction with the traditional medical care system, the high costs of medicare, and the continuation of high mortality and morbidity rates, despite major advances in medical research and technology, all contributed to the widespread demands for changes in health care delivery.

A plethora of books, articles, and reports on health promotion and health education entered the Canadian literary scene in the 1980s (Labonte, R., 1990; Fulton, 1990; Green, 1986; Epp, 1986). As well health promotion strategies became popular with the general population. The emphasis on fitness, nutrition, smoking cessation, and other lifestyle changes have made these types of health promotion programs a big growth industry in private and commercial business. Despite media messages, political endorsements, and popular support, health promotion has remained a secondary approach in the health care delivery system. The medical model continues to dominate the traditional medical care delivery system. Physicians are now identifying lifestyle as a factor that does influence disease and treatment but most appear to focus on individual behavior change versus the social-structural causes of disease.

In Manitoba there has been very limited policy or program development to create a health promotion approach within the traditional health care delivery system. The plan for health

care reform in Manitoba makes reference to strategies consistent with a health promotion approach but to date their is no apparent funding commitment made for program development. To date the medical approach to health care with a disease treatment focus remains dominant in Manitoba. Despite convincing arguments in the literature on the necessity and benefits of health promotion strategies such programs have not become readily available to health care consumers within the insured health care delivery system. Health promotion programs in Manitoba are generally problem specific and available at a cost to the consumer.

Health Promotion: Effectiveness and Efficiency

"Health promotion, prevention of illness and health education form a valuable triad that presents the most challenge to health professionals, and offers the most hope to their patients or residents and the most relief to those whose increasingly difficult responsibility is to fund health services" (Warrick, 1990; p. 55). Health promotion has gained widespread, popular acceptance by a large segment of the general population. Health care consumers have made major changes in health related behaviors and lifestyle changes for the sake of their health. Consumers look at smoking, fitness, and nutrition in very different ways than they did ten to fifteen years ago. A large segment of the general population

has readily accepted the notion that lifestyle changes and healthy behaviors have a major impact on disease and illness prevention. Health care consumers have been convinced of the effectiveness of a health promotion approach to health and wellness. "The concepts of health promotion and disease prevention have become increasingly popular, timely, and politically and socially relevant topics for policy makers, educators and administrators in recent years. While these concepts are not new, many leaders in the health care field just seem to have discovered that promotion and prevention exist, let alone that they merit attention" (Gelmon, 1990; p. 41).

Indirect support for the health promotion approach stems from the failure of the traditional system to decrease mortality and morbidity rates despite major advances in medical technology. In Canada and in Manitoba, we have very high costs for sickness care as well as high morbidity and mortality rates. For these reasons a shift from disease treatment to health promotion is recommended to become more cost-effective and improve consumers health. Research support for the effectiveness of health promotion programs does exist. Studies have been done on populations with different health problems, chronic illnesses, and with different goals for particular lifestyle changes. Smoking cessation and fitness groups are the most widely studied. With aging populations research has focused on more general lifestyle habits.

The Wallingford Wellness project is a model of health promotion for the elderly. Lalonde and Fallcreek evaluated the Wallingford Wellness project in a research study. Their results supported earlier study results with younger populations in the findings that the health promotion program was effective in promoting and sustaining change regarding knowledge, attitude, and behaviors in people over age 54 (Lalonde and Fallcreek, 1985; p. 64).

In another study Fitch and Slivinkse found that health promotion strategies were most effective in maximizing effects of wellness programs for the elderly where programs emphasized perceived control by participants. This study focused on a range of lifestyle issues such as physical health, morale, level of spirituality, social resources, and others (Fitch and Slivinske, 1988; p. 67).

In the literature reviewed, many other sources cite support for the effectiveness of health promotion strategies. These strategies include health promotion policies that legislate enforcement of health related behaviors such as seat belt use, anti-drinking and driving laws, and promote anti-smoking and safe sex lifestyles.

In the health care reform literature there are numerous sources of support for health promotion on an individual level. Promotion of healthy lifestyles is accepted as the way of the future. On a societal level a focus on a healthy environment and a supportive health care delivery system is

seen as important. Effective health promotion strategies should involve all the players in the health care delivery system - policy makers - administrators - health care providers and consumers. Effective health promotion approaches offer benefits of cost reduction, disease prevention, and decreased morbidity and mortality rates.

A Critique of Health Promotion Programs

Health promotion in its broadest conception involves not only the development of personal consumer responsibility for adherence to a healthy lifestyle but also program development that focuses on the societal influence on the origins of disease. Policy makers, health care administrators, health care providers, and health care consumers should all share the responsibility to promote health. Most health promotion programs focus on the individual responsibility for the development of healthy lifestyles. As a result of this individual focus many programs have a "blaming the victim" tone. My review of the literature has led me to conclude that the environmental-social-structural model of disease provides the most comprehensive analysis of health problems. Lifestyle interventions on their own, which are the focus of many health promotion programs, fail to identify social, structural, and environmental factors that impact on disease. Health promotion strategies must address society's norms, standards

of living, sex role stereotyping, and the social context of people's lives to be completely effective (Down, 1990; p. 126). Without addressing the social origins of disease, health promotion strategies can only define part of the problem and can not be effective in creating interventions to meet the health care needs of female consumers. "In order to be effective, health promotion efforts must be directed at those social factors which cause and support behaviors requiring change" (Down, 1990; p. 126).

Health promotion strategies provide a broader perspective on health and disease than the medical model that dominates traditional health care services. In theory, health promotion focuses on lifestyle and environmental-social-structural causes of disease. In practice, most health promotion programs focus on individual behavior changes to promote healthy lifestyles. To develop effective health care programs for women, health promotion programs must address the social causes of health problems as well as promote healthy lifestyles. Without fundamental changes to the health care delivery system, itself, women will continue to receive inadequate services due to sexism, patriarchy, and other inequalities that "...engender human suffering leading to illness" (Clarke, 1990; p. 225). A feminist-health promotion group work approach adds a societal analysis of health problems and an emphasis on personal control to the health

promotion strategies discussed in this chapter. This approach will be discussed in Chapter Four.

Chapter 4 A Feminist Group Work Approach to Health Promotion

Introduction

Health promotion strategies focus on the responsibility of the individual for their own health. The responsibility for the health of themselves and the health of their family is already deeply ingrained in most women. Women have historically been socialized to be the family caregivers, the informal healers who put the health of their families first and themselves second. Women have also been socialized to take responsibility for their own health and to abdicate their right to control of their health care and their health to their physician. Most health promotion programs do not focus on the individual participants' social situation or on the impact of social oppression which are two factors that relate especially to women. As discussed in Chapter Two, in the history of health care service development, women have lost the right to control their own bodies and have been oppressed due to the social control emphasis in health care delivery. While the health promotion literature focuses on the need for individuals to become responsible for their own health, feminist writers focus on the more basic need for women to have the right to control their own bodies and their own health care. Feminist group work interventions have been documented as a powerful tool to empower women to take control

of their lives and their bodies (Butler and Wintram, 1991; p. 2). In combination, health promotion and feminist group work strategies provide intervention tools that have potential to encourage health care consumers to be empowered to address the inadequacies of the present health care delivery system for women.

In this chapter, I will review the current feminist literature on health care reform. I will provide references on why feminist reform of the existing health care delivery system is a vital part of the change package that must occur if health care services are to adequately meet the needs of aging women. I will provide an overview of the feminist critique of the medical care system and literature support for feminist reform of the health care delivery system. I will also provide a discussion of feminist group work methods and cite support for the use of this intervention approach with women on health related issues.

Health Care Reform: A Feminist Perspective

The women's health reform movement has contributed significantly to the demand for patient's rights and for demands for the reform of the health care system to more adequately address health care needs (York, 1987; p. 176).

The women's health reform movement has called for fundamental changes to make health care services more

appropriate to women's real needs and accessible to all women (Rosser, 1988; p. 117). The feminist literature on health care reform focuses on the necessity of women and health care service providers to accept that women have the right to control their own health care. The issue of patient's rights has emerged as very important in the women's movement in the 1990s (Burston, 1990; p. 25). The premise of patient's rights is that each woman has the right to health information to acquire knowledge which will enable her to choose appropriate forms of treatment and to prevent illness. In a feminist analysis of health care women's situations are viewed not merely from an individual focus but also from a collective perspective. Social-structural and environmental causes of disease are considered in a feminist perspective of health and illness. The social context of women's lives is considered as a central cause in the development of health related problems in a feminist approach.

As discussed in Chapter Two, women have moved over the past few centuries from being healers to being "patients" in the health care delivery system. Women have moved from positions of power and respect to positions of powerlessness and dependence. Men have taken control of the medical care system. In Canada the medical care system is equated with the health care system. Women are treated with less respect and receive poorer services from that system than men do (Laskin-Siegal, 1987; p. 213). "Physicians heal (or do not heal) from

a position of power; they relate in either a paternal or an authoritarian manner to their patients" (Fee, 1983; p. 20). As men have taken over control, women have lost control. As a result, women have lost the right to control their own bodies, their own health and their own health care. Men dominate upper management positions in all health care organizations and health care continues to be delivered from a male perspective. The "paternalistic nature of the doctor-patient relationship is central to maintaining an arrogant, omnipotent doctor and a passive "my doctor will fix it" patient" (Burston, 1990; p. 26).

Feminist writers are very consistent in reporting that health care reform must begin with the most basic, fundamental premise of women gaining control over their own bodies. "Taking control of our lives and of our bodies is the most basic feminist principle there is" (Brown-Doress, *et al.*, 1987; p. XIV). To take control of their bodies, women must become intimately familiar with their bodies. Feminists argue that women should understand their bodies and also know what to reasonably expect from physicians (Fee, 1983; p. 20). Feminists argue that women have earned the right to this educative process as the history of women's health care over the past years is convincing evidence paid for in "blood, pain and tears" (Burston, 1990; p. 26). "Deaths from Pelvic Inflammatory Disease and infertility caused by IUD's, the addiction to tranquilizers, the depression and immune

breakdown caused by birth control pills, recurring yeast infections, and the increasing number of unnecessary hysterectomies - all these have taught us that we must understand everything affecting our bodies and our minds" (Burston, 1990; p. 26). When women take control of their bodies they acquire knowledge. "When dealing with physicians ...knowledge is power" (Fee, 1983; p. 24).

The shift from being dependent on experts to being in control of their own bodies and their own health care is a big step for most women. "Women have long been socialized to heed the advice of "experts" especially male physicians, and to put others' needs above their own, and to take a more passive role in social interactions" (Longe, 1991; p. 113).

The literature on health reform for aging women suggests that the shift in attitude for these women to take control of their own bodies will be more difficult. The health care reform movement has not been part of the aged woman's early socialization. Older women have been socialized to respect and not question authority figures. These women have been socialized to be passive and dependent on doctors and other professionals who are deemed "expert". "Older women, both as patients and as caregivers, may defer overmuch to male decision-makers, doctors, lawyers, ethicists, or relatives" (Longe, 1991; p. 13). For aging women to take control of their own bodies, collective and individual approaches to

empowerment must start where aging women are in respect to their socialization and their reality.

For all women, taking control of their own body and their own health care is only half of the battle in acquiring the right to control their own health care. The bigger battle - the most oppressive barrier - is that the right to control their health care is most firmly denied and discouraged by the medical care-health delivery system *per se*. The oppression, paternalism, ageism, and sexism which is endemic to our medical system results in health care providers who deny that women have either the right or the capacity to be responsible for their own health care. "Clearly, women experience their oppression not only as patients but also within the delivery system itself" (Fee, 1983; p. 18). The feminist literature is highly critical of the medical care system as an agent of social control. "Radical feminists see the medical profession as yet another system which conforms to the patriarchal pattern established in the family" (Fee, 1983; p. 23).

The changes necessary to encourage women to take control of their own health care is much less formidable a task than the changes necessary to create a health care delivery system-medical care system that accepts and supports this right. In the feminist literature there are as many suggestions on what changes are necessary as their are criticisms of the health care-medical care system itself.

Feminist Health Care Models

The popularity of women's health centers grew in the 1980s. These women dominated health centers focused on a partnership approach between health care providers and health care consumers in the delivery of health care services. Construction of these alternative models of health care, set up and controlled by women, strive to help women with health problems outside the established medical care system (Fee, 1983; p. 25). In the women's health centers information sharing is encouraged between women and their health care providers. Women's health centers encourage broad treatment perspectives and alternative therapies. In a partnership approach, "the patient retains control over essential decisions concerning her own health" (Fee, 1983; p. 25). The power imbalance which is common in the traditional doctor-patient relationship is removed in feminist models. At women's health centers consumers have both the right and the responsibility to control their own health care from both the health care provider and the consumer's point of view. Feminist models of health care focus on health education, health promotion, self-help, and a holistic wellness orientation. Feminist models promote consumer control and the consumer as expert approach. Feminist models are proposed as an approach to health care for women that will be most effective and efficient (Fee, 1983; Rosser, 1988; Burston, 1990).

Feminist Group Work

Feminist group work is an intervention strategy to promote change on issues using a group work approach from a feminist perspective. The feminist perspective includes an empowerment oriented practice approach which includes consumer control, a collective analysis of individual problems, and a partnership approach between group workers and group participants. Butler and Wintram define feminist group work as "enabling women to meet and identify both their common and their diverse dissatisfactions and needs and to translate these into wants" (Butler and Wintram, 1991; p. 17).

The common theme in other definitions is women meeting together to address individual and collective issues, to provide each other with mutual support, information, and knowledge, and to empower each other to deal with issues and promote change. Butler and Wintram state that inherent in feminist group work and "integrated throughout is the belief that women have the right to seek power and control over their lives" (Butler and Wintram, 1991; p. 17). The group work approach provides women with a medium to evaluate issues and problems and to encourage change through individual and collective action (Butler and Wintram, 1991; p. 17).

Group work approaches have become a popular intervention approach in the women's health movement. Group work approaches help stretch limited resources of health care

agencies and also represent an effective approach to collective problem solving. "Self-help groups, health collectives, and health related consciousness-raising groups all demonstrated that a medical expert is not required to tell us what is going on in our bodies and that we, in fact, have special expertise from which health care professionals might learn" (Whatley, 1988; p. 131). Group interventions have an important role to play in empowering women to gain control of their bodies and their health care. A feminist group work approach can make health information available to groups of women to enable them to identify the relationship between women's roles in society, their health issues, and their access to quality health care (Whatley, 1988; p. 131).

In addition to being an effective and efficient medium to provide health information and health education, feminist group work methods are also documented in the literature as empowerment tools that validate women's experiences and encourage a collective approach to problem evaluation and action. Butler and Wintram state that their "experiences have shown us that women brought together can offer each other support, validation and strength, and a growing sense of personal awareness, in a way that is difficult to achieve otherwise" (Butler and Wintram, 1991; p. 1). Traditional medical care services have been delivered at an individual level. Health promotion programs generally focus on lifestyle issues such as smoking, nutrition, and fitness which also

focus on individual change. The group approach in a feminist group work method refocuses health care concerns from the individual to the collective level which is a necessary beginning to empowerment and collective action. Several authors focus on the critical role of groups in the empowerment process (Cox, 1991; Guiterrez, 1990; Lee and Swenson, 1986). "The self-help and social support movements lent support to the theme of mutual help as a powerful tool in maintenance of mental and physical health as well as in individual struggle for self empowerment" (Cox, 1991; p. 80).

Feminist group work is the intervention approach of choice in this practicum. My review of the literature provides support that feminist group work is an effective method of empowering women to take control of their bodies and their health care. A feminist group work approach is consistent with an empowerment oriented practice that encourages a "consciousness raising process which is important to self empowerment" (Cox, 1991; p. 80).

This type of group work approach utilizes group processes and mutual aid to encourage women to identify the political nature of their individual problems and to identify how the social context of oppression in all aspects of their lives influences their health and their wellness. A feminist group work approach can deliver an intervention that can encourage women to refocus from an individual assessment of health related issues to a collective focus on the nature and source

of health problems. This will encourage action and activism to demand more effective health care services for women. As women gain knowledge and social support they gain power to control their body, their health care, and their lives.

In this chapter I have provided literature support for inclusion of a feminist orientation in health promotion strategies. Health promotion interventions alone are not sufficient to address the inadequacies of a medical model of health care delivery for women. In the feminist critique of the medical care delivery system the shift from the power and control of the physician or professional to the power and control of the patient or consumer is of central importance. Feminist health care reform authors suggest a woman centered approach in all health care services. These woman centered approaches are consumer driven models which emphasize health education and health promotion by providing information on healthy body functioning to empower health care consumers in a self-help, consumer controlled model. Feminist group work interventions are proposed as an intervention method that encourages the empowerment of women health care consumers to enable them to take control of their bodies, their health, and their health care. Empowered women can actively participate in women centered service approaches that can improve the effectiveness and adequacy of the health care services delivery system for women.

Chapter 5 The Wellness Paradigm

Wellness is a buzzword for health programs for women in the 1990s. I have included a review of the literature on the wellness paradigm as this paradigm serves as a guide to a holistic approach to health promotion in feminist group work interventions. The broad definition of health, in the wellness paradigm, encourages attention to all components of wellness and not just to the physical component which is dominant in the medical model and in early health promotion programs. The holistic definition of health includes a social-situational component that is important in a feminist approach to health care service delivery.

In this chapter I will provide a brief overview of the definition of wellness. I will summarize key points in the definition and highlight why the broad based definition is appropriate for use in health care service delivery to aging women. In conclusion, I will provide references to wellness programs reported in the social work literature which provide support for the effectiveness of this approach.

Wellness Defined

"The wellness model extends the definition of health to encompass a process of awareness, education, and growth" (Travis, 1988; p. XV). Wellness is not a steady state nor a

specific feeling or condition which has general meaning or acceptance. Wellness is a state of being which represents a balance between the components of self which promotes physical, emotional, psychological, spiritual, and social well-being. "Wellness is a choice, a way of life, a process and an integration of body, mind, and spirit. Wellness is a loving acceptance of self" (Travis, 1988; p. XIV).

Key Elements of the Wellness Approach

The wellness paradigm goes beyond traditional health promotion strategies. Wellness is not an expert approach that dictates sets of behaviors a person must conform to (Travis, 1988; p. XV). It is not a lifestyle program that focuses on health behavior but a holistic health approach that stresses general well-being, self-awareness, and a need to address the whole person, mind, body, and spirit. The wellness approach involves the concepts of consumer control, empowerment, and self-help. In a wellness model health promotion is the central focus.

The wellness approach is a much broader approach than the traditional medical model which emphasizes disease treatment. A broad definition of health encourages the development of a broad range of health care services to meet wellness related needs. Monique Bégin stresses that to effectively redesign health care for women, the definition of health must go beyond

a "strictly medical definition" and be "expressed by the concept of well being" (Bégin, 1990; p. 5). Although the dominant medical model orientation towards the diagnosis and treatment of disease is important it only addresses surface needs and is not sufficient to address the broad range of needs that exist for the whole individual. The medical approach to health care neglects the needs of the mind and the spirit as it focuses solely on the physical needs of the diseased body.

In the wellness paradigm, and also in the health promotion and feminist reform literature, addressing the social context of people's lives is essential for the development and delivery of adequate health care programs and services. Authors from these three areas discuss the influence of social reality somewhat differently but a common theme is present in the three areas. Travis, an author who writes about the "wellness paradigm," states that "health is a result of dynamic energy exchange between the individual and everything in creation, we are interdependent elements in a living system" (Travis, 1988; p. XVIII). Borgatta, an author who writes about health promotion over the life span stresses that to be effective health promotion must take into account the historical and social context of the participant (Borgatta, *et al.*, 1990; p. 373). Catherine DeLorey, a feminist author who writes about health care reform, states that a "new system with a new perspective is needed, one that

considers all factors that relate to health. Because a person's lifestyle and past experiences are integral components of health status, it is crucial that health care include a lifestyle perspective" (DeLorey, 1984; p. 294). The authors on wellness, health promotion, and feminist health care reform are consistent in their emphasis on the need to consider the societal context of the individual consumers' lives in all health care service delivery programs. The inclusion of the social context moves the focus beyond the individual. The focus on the individual alone is a criticism of traditional health care services. The social context for women includes sexism, ageism, oppression, and misogyny which are all barriers to achieving high level wellness. Wellness programs are a step towards overcoming the medical care system's inadequate approach to the health care delivery of services for aging women.

Wellness and Aging Women

As women age health issues become more salient and more central. Women have historically been responsible for the health of themselves and their families. The double duty that women do to care for their own and the health of their family often causes strain on their own health. "Feminists have also pointed out that the multiple roles that women play affect their physical and mental well-being" (Abott, *et al.*, 1990; p.

94). Women are responsible for a great deal of the informal health care in our society and much of their caring role involves promoting the health of the families. The health care system depends on informal caregivers to care for children, the aged, the disabled, and the chronically ill. In our society the majority of both formal and informal caregivers are women. The wellness approach takes into account women's caregiving roles as a part of the social context of their lives. Aging women have a double interest in health care due to their personal interests and concerns and their increased exposure to health care services due to their caregiving roles.

Women have historically experienced greater inequities with regard to health care than men. "Many of the inequities characteristic of the female position tend to crystallize in older age" (Abu-Laban, 1980; p. 255). Mid-life women are high users of service due to the medicalization of menopause. Because menopause has been medicalized as a sign of aging, ageism influences the medical practitioner's approach to aging women earlier than it does for aging men. "In our society, women are deemed "medically old" at age forty...the prognosis regarding our mental and physical health becomes increasingly negative as we pass from forty to fifty and beyond" (Cohen, 1984; p. 53). In the wellness approach age is immaterial to well-being and physical changes in the body have much less significance than it does in a medical approach to disease

treatment. Because women receive poorer services from the existing health care delivery system they have a greater interest and a higher stake in the development of a new approach that begins to address and overcome these problems. The maintenance of "wellness" and an emphasis on self-care are important concepts in the delivery of health care services to midlife and older women. My professional experience suggests that a move away from a focus on aging, that women have been socialized to be sensitive to, towards a focus on the whole person are aspects of the wellness approach that will appeal to aging women.

Wellness is an appropriate and relevant approach to health care reform for aging women. "When we study and understand the problems of older women today, we can do much to develop interventions that will enable women to face the added years of life optimistically, serenely, and with a sense of accomplishment" (Grambs, 1989; p. 10). A wellness approach is a beginning step to gender equality in health care. Wellness approaches take into account the social reality in which women live and identify sexism, ageism, oppression, and patriarchy as relevant variables to be addressed to achieve high level wellness. The Older Women's Leagues "are particulary concerned that older women define for themselves their own special health concerns" and state that it is essential to promote the concepts of self-help and self management in the delivery of health care services (Cohen,

1984; p. 195). The wellness approach does encourage the promotion of self management and self-help to achieve a broadly defined state of well being.

Wellness Programs

Wellness programs are reported in the health and social work literature. Several programs use the term wellness program to refer to a holistic approach to health promotion which focuses interventions on the whole person. In one report, Fitch and Slivinske (1988) describe a wellness program for elderly people. In the wellness program described, emphasis was placed on preventative measures such as nutritional awareness, exercise, and stress management. The approach was most beneficial for increased wellness for group participants who had high levels of perceived control. This finding has implications for other social work interventions and supports empowerment practice methods in a feminist group work approach.

The Wallingford Wellness project is another model health promotion program for the elderly described in the social work literature. The Wallingford Wellness project expanded health promotion programs described in the literature with younger populations and used health promotion components to develop a health promotion program that focused on promoting wellness (Lalonde and Fallcreek, 1985; p. 50). The outcome effective-

ness of this program was evaluated and the results were supportive of the effectiveness of the program in promoting and sustaining change regarding knowledge, attitude, and behavior in those over age 54 (Lalonde and Fallcreek, 1985; p. 64).

These two wellness programs provide research support on the effectiveness of health promotion programs that include a broad definition of health and wellness from a group work approach.

Conclusion

In this chapter I have defined and described a wellness approach to health promotion. The wellness paradigm presents a broad perspective on health which includes a focus on physical, emotional, psychological, social, and spiritual components of overall wellness and general well-being. The wellness approach moves health promotion beyond an individualized focus of lifestyle factors to a holistic approach of health promotion for the body, mind, and spirit. The inclusion of a wellness focus in health promotion strategies delivered in a feminist group work intervention represents an eclectic approach that is applicable and appealing to aging women.

Chapter 6 Summary and Conclusions

Summary

The review of the literature, discussed in previous chapters, was undertaken to address the problem identified of the inadequacy of present day health care services to meet the health needs of aging women. The review of the literature became an incremental process to address the problem as none of the literature available appeared to address the problem directly or comprehensively. The process began with a review of the feminist and health reform literature to identify the sources of present day service inadequacies. Alternative approaches to the traditional medical model were reviewed to identify an approach that would be more effective in meeting the health care needs of aging women. None of the approaches in the alternative models independently addressed the range of health care needs aging women experience. As a result concepts were borrowed from the alternative approaches reviewed to culminate in an eclectic feminist group work-health promotion intervention which focuses on wellness. I will summarize each section of the literature review and conclude with a description of the intervention developed for this practicum.

To understand why health care services are inadequate for women today, it is important to understand how and why these

services developed historically. Feminist writers are critical of the traditional health care service delivery system. The origin of the inadequacies of present day services is rooted in the development of the sexist, paternalistic, patriarchal medical system which dominates traditional health care service delivery. The medical system is based on a medical model of disease treatment. Within the medical model the narrow definition of health limits the vision of the type and scope of services viewed as necessary to meet health care needs. Physicians are the primary providers of health care in this model and focus most of their intervention on the diagnosis and treatment of disease. The medicalization of women's lives has resulted in natural life cycle changes being labelled as diseases. Women have become the major users of health care services due to their biological differences from men and the medicalization of these differences. The bias of the medical research field which focuses primarily on male disease or on male subjects is another criticism of the traditional health care delivery system. The traditional medical care system did not evolve as a service delivery agency but did evolve as an agent of social control to support male domination. The medical care - health care delivery system developed as a system designed to meet male supremacy needs and therefore was never designed to meet the real health care needs of women in general. The traditional medical care system can not merely be modified to

adequately meet women's health care needs. Alternative models provide better explanations of the development of disease and of individualized responses to treatment of disease. The lifestyle and environmental-social-structural models focus on different sources of disease and different treatment methods to promote health. Health promotion is one approach which overcomes some of the criticisms of the medical model which dominates traditional health care.

Health promotion is an approach based on the lifestyle and environmental-social-structural model of disease and illness. The health promotion approach to health care delivery focuses on a broad definition of health and views the development of disease as due to a relationship between physical, social, and lifestyle factors. The health promotion approach explains individual differences in relation to disease processes more effectively than the medical model. The health promotion approach has a much broader vision of the type and scope of services than the medical model which focuses exclusively on individual causes of disease and individual treatment of disease.

A criticism of most health promotion programs is that in theory they focus on lifestyle and environmental, social-structural causes of disease. In practice most programs focus intervention efforts on individual lifestyle changes and as a result fail to address the societal context of people's lives. A feminist group work approach to health promotion encourages

a societal analysis of individual health problems and encourages consumer control which are two concepts missing in most health promotion approaches.

In a feminist group work approach health issues are addressed within the socio-political framework in which they occur. Women meet to discuss issues that have both individual and collective meaning for them. In a feminist group work approach to health promotion, women are encouraged to assume control over their bodies, to acquire knowledge and to take action to promote their health. Feminist group work methods encourage the empowerment of group members to enable them to work towards individual and collective action. As women gain control of their bodies and are empowered to actively deal with issues relating to their health care they can obtain strength to demand change. Collective demands for change will encourage health care service providers to become responsive to individual and collective needs of women consumers. The empowerment of women is a beginning step to overcome oppression in the receipt of health care.

The wellness paradigm represents a holistic definition of health. In this paradigm the physical, social, emotional, psychological, and spiritual components of health are all considered as factors that influence general well-being. An overview of the wellness paradigm was included in the discussion of the review of the literature as it provides a frame of reference for a feminist health promotion group work

approach. Wellness is a concept that moves health beyond individual and lifestyle components to a health framework that encompasses all aspects of the self and stresses the need for balance to achieve high level wellness. In the wellness paradigm, the social context of people's lives is considered critical to the understanding of wellness.

Conclusion

The traditional health care delivery system is inadequate to meet the needs of aging women consumers. A feminist health promotion group work approach is proposed as a social work intervention that can empower aging women to take control of their health care and become active participants in achieving wellness. This approach is not going to address the inadequacies of the traditional health care delivery system. However, it will encourage the women group participants to identify the political nature of service inadequacies. It will also encourage the women to identify the relationship between patriarchy and health care service delivery to move problem analysis from an individual to a collective level. Increased awareness and a critical evaluation of women's collective situation will encourage the empowerment of group participants to take control of their health care and demand services that will be adequate to assist them to stay well.

Part III The Practicum Report

Chapter 7 Growing Older - Staying Well

Introduction

In this section I will describe the group intervention delivered to two groups of women. The groups were called Growing Older - Staying Well. The intervention strategies used represented an eclectic approach to group work. Concepts and strategies were borrowed from health promotion strategies, self-help groups, the "wellness paradigm" and from feminist group work methods. The intervention evolved as an eclectic approach as none of the approaches listed appeared to be able to meet the needs of aging women on their own.

As the literature review in the previous section reveals, the current health care delivery system is failing to meet the needs of women in general and aging women in particular. Sexism and ageism are two reasons for this failure. The medical model of health care practise and the neglect of the special needs of aging women are two other reasons cited. Feminist group work is discussed in the literature as one of the most effective ways of offering women support, validation, and the strength to be empowered to deal with a range of health-related issues (Butler and Wintram, 1990; p. 1). The review of the current literature on feminist health care

reform, health promotion, self-help and empowerment, feminist group work, and the wellness paradigm all guided the development of the practicum intervention.

In this section, the intervention will be described in detail. An overview of the planning process, group recruitment, group selection, and intake processes are discussed. I will describe the characteristics of the participants from both Group One and Group Two. To provide a full impression of the group process, I have included session notes for both groups. At the end of this section, I have identified common themes discussed by group members and compared the group process for the two groups. The description of the intervention in section three is purely for descriptive purposes. The evaluation measures are discussed in section IV.

The Planning Process

Planning for the practicum included the submission of a proposal to the Women's Health Clinic. This proposal was submitted to the staff of the clinic in June 1992. The proposal followed discussion sessions with Joe Kuypers (advisor) and Sheila Rainonen (clinic contact-liaison person and committee member).

The proposal was accepted by the Women's Health Clinic in July 1992. The Women's Health Clinic agreed to provide me

with meeting space, advertising and recruitment support, equipment, resources, and supplies. The practicum committee was selected in August 1992. The committee included Professor Joe Kuypers (advisor), Professor Kim Clare (Winnipeg Education Center), and Sheila Rainonen, MSW and feminist counsellor at the Women's Health Clinic. In September the recruitment poster was mailed out along with a covering letter to all agencies on the Women's Health Clinic mailing list. By late September, twenty women had responded and expressed an interest in group attendance. By October 7, 1992, the intake process was complete and the potential group members were selected.

The group start date for session one was scheduled for October 22, 1992. I initially planned to run two groups simultaneously. The potential group member response was sufficient to facilitate an evening group but insufficient to warrant facilitating an afternoon group. It was decided to hold a second evening group in January 1993. The decision to facilitate two groups was strongly encouraged by the practicum advisor Joe Kuypers. By facilitating the two groups, my learning potential would be increased and the opportunity to develop greater skill in group facilitation, a main objective of the practicum, could be achieved.

Throughout the course of both Group One and Group Two, I consulted with the practicum advisor and committee members for

the purposes of ongoing planning and modification of the intervention.

The Setting

The setting of the practicum was the Women's Health Clinic, a non-profit community clinic designed to provide an alternate health care service to the women of Manitoba. The clinic was founded in 1981. The Women's Health Clinic is a feminist, community-based health centre promoting the health and well-being of all women by facilitating empowerment, choice, and action (Women's Health Clinic - General Manual, 2).

The Women's Health Clinic (W.H.C.) evolved from a grassroots movement of volunteers who were concerned about the overall quality of health care for women in our society. The W.H.C. is governed by a board of directors, and is comprised of members who are interested in women's health care issues. A large portion of the funding for the W.H.C. is provided by the Manitoba Health - Insured Services Branch. Other funding sources include Federal and Provincial governments' job creation and training program grants, the United Way, Secretary of State, The Winnipeg Foundation, and donations from individuals throughout Manitoba. The clinic staff includes an Executive Director, Coordinators for the three volunteer programs, a resource coordinator, staff physicians,

nurse-practitioners, client-service workers, support staff, a dietician, health-educators, and social workers. A large number of volunteers and students complete the clinic staff.

There are three general service areas operating at the Women's Health Clinic. They are health care, counselling, and health promotion. The W.H.C. provides client service to women individually, in groups, and by telephone and written contact. The W.H.C. also provides resource information on health care related services, programs, conferences, and groups.

The W.H.C.'s primary target groups include: teenaged women, women with concerns about fertility regulation, menstruation, and menopause; women preoccupied with weight; and women who have difficulty accessing the medical system. Women are primarily self-referred but occasionally are referred by other physicians, social workers, or other health care providers. Most women are referred due to specific problems such as problems with menopause, menstruation, weight preoccupation, post partum stress, and unplanned pregnancy. The clinic strives to provide respectful, compassionate, and non-judgemental services. The services are based on a holistic, multi-faceted approach to health and the treatment of disease and dysfunction. The clinic attempts to promote healthier lifestyles, health maintenance, and advocacy for community solutions to health and social problems. The W.H.C. is designed to be a model of feminist philosophy in the delivery of health related services. The W.H.C. is committed

to providing support for the type of care each woman chooses, according to her lifestyle and beliefs.

The primary service the clinic provides to aging women is the Menopause Information and support groups. There is a small number of aging women who utilize the clinic's medical services program. The 45+ age group of women is generally underrepresented in the clinic client population. However, the W.H.C. was selected to host the practicum due to the feminist philosophy, the holistic view of health, the feminist orientation, and the political and practical fit with the nature of the practicum. The clinic clientele are all women and the W.H.C. has the Menopause Information and support groups that attract the target population to the clinic. The clinic's focus on wellness and their belief in the value of the social work process made the W.H.C. a suitable choice to host the practicum. The clinic's commitment to the philosophy and profession of social work and the presence of a staff person with an MSW who was interested in the practicum also contributed to the selection of the W.H.C. as the setting of choice. The nature and focus of the practicum made selection of the Women's Health Clinic as the most viable setting in the City of Winnipeg for the practicum Growing Older - Staying Well.

The Group Selection Process

Group members were recruited via an information poster (Appendix A and B) that was mailed out by the Women's Health Clinic. The mail-outs were to the agency mailing list which included sister agencies, health care facilities, health service agencies, and medical clinics. As well, all women who had attended a menopause information session at the W.H.C. in the previous six months received a copy of the poster. A cover letter was sent to all the agencies as an invitation to display the poster and to provide a brief introduction to the nature and purpose of the practicum (Appendix C and D). The poster included a telephone number for potential group members to call to get more information.

The plan was to recruit women for two groups. The groups were to run simultaneously, on Tuesday afternoons from 1:30 to 3:30 p.m. and on Thursday evenings from 6:30 to 8:30 p.m. I planned to recruit between ten and twelve women for each group. The minimal requirement for group membership was eight women per group.

Approximately one hundred posters were sent out in September 1992. The mail-outs were repeated in December 1992 to the same agencies and to all women who had attended the Menopause Information and support groups from September to December 1992.

The Intake Interview

The intake interview consisted of telephone contact with each woman recruited. In the initial telephone contact, I explained the nature of the practicum and the purpose of the group. I asked each respondent about their specific interests in health and why they were interested in group attendance.

The two prerequisites for group membership included that the woman be over forty years of age and have a general interest in health that would allow her to take part in a variety of health promotion topics related to wellness. Questions asked in the initial telephone contact included: time available to attend (evening or afternoon), age, source of information on the group, topics of interest, and past group experience.

Twenty women responded to the posters. Five women were interested and available for the afternoon sessions, fifteen were available for the evening sessions. Fourteen of the women had learned about the group through the personal mail-out to women who had attended the Menopause Information and support sessions at the W.H.C., one woman read the poster at the Re-Fit Center, one saw the poster at Great West Life Fitness Center, one woman saw the poster at the Grace Hospital, two women saw the poster on the W.H.C. bulletin board, and the twentieth woman saw the poster at her family physician's office. The women's ages ranged from forty-one to

sixty-eight. Eighteen of the women expressed a general interest in health and wellness. Two of the women were mainly interested in menopause and were referred to the Menopause Information and support sessions at the W.H.C. Fourteen out of the twenty women who responded had previous experience in groups at the Women's Health Clinic, two women had prior group experience at the YWCA, and four of the women had not had previous group experience.

Following the intake interviews, twelve women were selected to attend the Thursday evening sessions. Those women not selected were not available in the evening or were referred elsewhere. The afternoon session did not attract the minimum number of eight women set as a guideline requirement to facilitate a group. The afternoon session was cancelled and the five women recruited for this group were kept on a waiting list for the January 1993 sessions. Twelve women were scheduled to attend the sessions for Group One beginning October 22, 1992, from 6:30 to 8:30 p.m. at 419 Graham Avenue. As a result of cancelling the afternoon group, I decided to recruit women for a second group that would be held in January 1993.

In the second recruitment process the same process and procedures were followed. In addition to the respondents from the second recruitment process, I also had eight names on a waiting list. The women on the waiting list had expressed an

interest in Group One but were either not available Thursday evenings or had registered after Group One had begun.

In total, including the waiting list, twenty-five women responded to the second recruitment process for Group Two. From these twenty-five women, ten were available for Wednesday evenings and met the intake requirements for attendance in Group Two. The fifteen women not selected to participate, were excluded for several different reasons. Three of the women were only available for afternoon sessions as they reported that due to safety concerns they do not go out at night. Three women were not available Wednesday evenings and all had initially signed up for the Thursday sessions for Group One. Five of the fifteen women who responded were going to be on holiday for more than two sessions between January and March and were excluded in favour of those able to make a commitment to attend most of the sessions. Two of the women recruited withdrew their request to attend due to too many other commitments. One women was primarily interested in menopause so was referred to the W.H.C. for the Menopause Information and support sessions. The fifteenth woman screened out in the intake interview had a change of employment hours and could not attend at 6:30 p.m. Following the commencement of Group Two other women called to express interest in attendance in a similar group. The waiting list has been forwarded to the W.H.C. for future reference.

The intake interview included the same questions for Group Two as it included for Group One. The ten women selected ranged in age from forty to sixty-six. Two of the women received posters in the personal mail-out to women who had attended the Menopause Information and support sessions. Four of the women had heard about the group from friends. Two of the women had learned of the group form their family physician's office and two women had called the W.H.C. about upcoming programs. All of the women expressed interest in a variety of health related topics. Two of the women selected for the group had previous group experience, both at the W.H.C. The woman were also asked for a commitment to be available to attend the eight sessions. The ten women selected were scheduled to begin Group Two January 20, 1993 from 6:30 to 8:30 p.m. at the W.H.C., 419 Graham Avenue.

Chapter 8 The Group and The Group Process

Introduction

The intervention was delivered in a group format to two groups of women. Health promotion strategies were facilitated from a feminist approach. The intervention goal was to empower the women in the group to take control of their own health care. The group participants' goal was to learn ways to achieve wellness and to stay well as they age. A feminist group work approach is based on a feminist theoretical framework. This framework includes a political and personal analysis of women's social situation as it affects their lives, their health, and their wellness. A group facilitation role was assumed to minimize the power differential between facilitator and participant. A holistic approach to health and wellness was adopted.

For the purpose of clarity I will describe the intervention for Group One in detail then provide comparisons for Group Two. Each group of women met for two hours once a week for eight weeks. Group One met on Thursdays from October 22 to December 10, 1992. Group Two met on Wednesdays from January 22 to March 10, 1993.

The groups planned for this practicum were established for a specific purpose. They were both closed groups for women over forty. A closed group format was selected due to

personal preference and in response to the preferences stated by the potential group members in the Intake interview. All of the women in the group had a general interest in their health and a desire to explore a variety of health-related topics in a group setting. All of the women were asked for a commitment to attend all eight sessions.

The purposes of the group sessions were for group members to learn ways to promote health and stay well. The grounding assumption was that the challenge of aging and the biases women face in a patriarchal society may confront health and well-being. The group sessions were used to explore health related issues, share interests and concerns, discuss resources, and share effective personal strategies from each group member's experience.

The groups will be described with respect to demographic information. Session notes for both groups will be provided. An overview of the group structure will be included. Common themes for Groups One and Two are summarized at the end of the session notes. A comparison of group process and the dynamics that occurred for Groups One and Two is included at the end of the section.

The Group Members

The practicum provided the opportunity to facilitate eight sessions for two groups of women. The groups were both

entitled Growing Older - Staying Well. Group One consisted of twelve women, all of whom were self referred. The ages of the women in Group One ranged from forty to sixty-seven. Eight of the twelve women attended the first session. These eight women completed the next seven sessions. Their ages ranged from forty to fifty-seven. All eight were white women. Sexual orientation was not identified. Seven of the eight women in attendance worked at paid employment outside of the home. The eighth woman was seeking paid employment outside the home. In Group One three women were married, two women were in common-law relationships, two women were divorced, and one woman was separated from her spouse. Seven out of the eight women were mothers. The four women who were selected for Group One but who did not attend any of the eight sessions reported the following reasons for their non-attendance. One of the women was unable to attend due to a family illness that required her to provide caregiving on a daily basis. One woman reported a change in paid employment hours preventing attendance. A third woman forgot about the group after she signed up and a fourth woman attended on the wrong date and was unable to reach me to clarify the date and time before two sessions had passed. Three of the four women who were unable to attend Group One asked to be contacted about Group Two.

Group One had eight sessions between October 22 and December 10, 1992. The eight women members held a ninth session on January 14, 1993 as a final wrap-up. The eight

women in Group One all had previous contact with the W.H.C. as they had all attended the Menopause Information session. Four of the eight women had also attended the menopause support group. Five of the eight women also had previous involvement in issue specific self-help groups (YWCA Self Esteem, Tough Love, Parents Without Partners) and community organizations. The eight women each attended an average of seven sessions. All eight women had a general interest in health and none were in acute distress or crises at the onset of session one. Two of the women did become acutely ill during the group sessions. One woman in the group had an exacerbation of a chronic, degenerative illness. The second woman developed a very serious cardiac condition.

The second group consisted of ten women who signed up and were selected to attend by January 6, 1993. One of the group members brought a friend to the first session on January 20, 1993 and the total number of women in attendance at session one was eleven. The ages of the women in Group Two ranged from forty to sixty-six. All of the women were white. Sexual orientation was not identified. Five of the women worked in paid employment full-time outside of the home. Two of the women were unemployed and seeking employment. One woman remained at home in a homemaker role by choice and one woman worked part-time for paid employment. Two of the women were retired from paid employment. Five of the women were married, one woman was in a common-law relationship, one woman was

separated from her spouse, and four women were single. Five of the women were mothers, one woman was a step-mother to grown step-children.

The eleven women in Group Two attended an average of 5 sessions. Three women attended all eight sessions, two women attended seven sessions, one woman attended six sessions, two women attended four sessions, one woman attended three sessions, and two women attended two sessions. The main reasons cited for non-attendance included vacation, family death, inability to attend alone, lack of child care, and changes in paid employment commitments. The average number of women in attendance for each session was seven.

The Structure of Group Sessions

The practicum objectives guided me in the selection of group session structure. As I sought to develop innovative ways of facilitating group processes, I did not predetermine topics to be discussed nor set agendas prior to session one for each group. My goal of learning to facilitate versus direct group processes guided the planning for each session. The women in each group selected the topics according to their interests, they set the agendas and they guided the intervention methods. A model of group work, developed and practised by staff at the W.H.C. was adopted. This model included the use of an opening round, a closing round, and a

combination of small and large group discussions and pair exercises. I intended to use role plays but the majority of women in each group preferred not to take part in this exercise.

The opening round for each session was used to encourage the women to focus on the topic for the evening. In the opening round the women were encouraged to share interests, concerns, goals for the session, and any other personal information they wanted the other women to know. The group members always had the option to pass and a shell was used to signify when they were finished their turn. The closing round was structured in the same way but had a different purpose. In the closing round the women were encouraged to share their feelings, comments, concerns, and criticisms about the session. The closing round served as an evaluation tool and provided me with weekly consumer feedback about how to facilitate group processes to meet the needs of the individual women. The closing round also became a method for group members to wrap-up each session and provide each other with feedback, support, and encouragement. In the closing round the women were encouraged to share issues they felt required more discussion, to request resource material on issues of interest not covered in the session, to suggest agenda items for the next sessions' topic, and to share their feelings about the group process. In addition to the opening and closing rounds, each session had a main topic for discussion

and a scheduled break for herbal tea. The sessions ran from 6:30 to 8:30 p.m. with a fifteen to twenty minute tea break. I remained behind at the end of each session. I invited the women to share individual concerns, suggestions, or complaints at that time. I also made myself available to individual group members by telephone evenings and weekends.

The process and content themes for each session were recorded in a weekly journal. The journal was a personal log in which I recorded the session agenda, the group processes, and my observations. The journal was used as an evaluative tool for the committee evaluation and for my self-evaluation.

The structure of each group session varied according to the topic and the group agenda. Detailed agendas were placed on a flip chart for each session for Group One. Agendas for sessions three to eight for Group Two were less structured and more spontaneous. Each session will be described so the reader can receive a full impression of the group process and the content themes.

Session Notes - Group One

Session One

Session one was attended by eight women. The first session was extremely important in beginning the process of joining group members and the facilitator together. Each group member had met the facilitator by telephone during the

recruitment and intake process. Introductions were the first order of business. I introduced myself as the facilitator and provided some personal history, information on the purpose of the practicum, my expectations of the group members, and my relationship to the W.H.C.

The women were asked to interview the woman to their left and introduce her to the group. One of the women refused to take part in this exercise and suggested each of the women introduce themselves. Each woman did introduce herself and gave a very brief overview of her goals for the group and her interest in health and aging.

I provided the group with information about refreshments, donations, parking, bathrooms, and proposed an agenda for the evening. Herbal tea and decaffeinated coffee were served at each break. The primary goal for session one was to select and priorize the topics of interest. The topics selected would serve as the topic for discussion for the next seven sessions.

The first task of the group was to decide on group agreements that would serve as group rules. The purpose of the group agreements were to set down behavior expectations to encourage the development of a supportive group environment. As the facilitator, I had two expectations about group behavior which I shared. The first expectation was that all of the women in the group would take responsibility to participate and share their interests, concerns, and

experiences to enable the group sessions to meet their individual needs. The second expectation was that the group members would follow the Group Agreements selected to enable the creation and maintenance of a supportive atmosphere for sessions. I encouraged the women to share their interests and concerns to establish individual and group goals. I reminded the women that the group ownership belonged to the members and not to the facilitator.

The women in the group agreed to eight group agreements. These agreements were listed on a flip chart and were to be displayed at each session. These group "rules" were to serve as a guide for behavior for each of the next seven sessions. The Group Agreements included: To respect each other, To share time, To maintain confidentiality, To participate, To share our own issues and experiences, To respect each other's opinions, To not interrupt each other, and To practise self-care.

The next task for session one was to select the topics for the next seven sessions. The women were very quiet and reserved. I provided them with copies of the recruitment poster that listed some topic suggestions as a starting point. The group was encouraged to select their own topics. The common theme expressed was that several of the women had decided to participate in the group because the topics listed had appealed to their interest. The topics selected by the women included: Dealing with Anger, Wellness, Stress

Management, Assertiveness, Dealing with Illness, Self-esteem, Transitions, and Financial Wellness. Each topic was put on the flip chart and the group completed a brainstorming exercise to identify specific issues of interest for each topic. After the topics were selected, it became apparent that seven sessions would not be sufficient to cover all of the areas of interest. The next task was to priorize the topics in order of importance to ensure that the topics covered would be those topics of greatest interest to the group majority. The group members also decided that two hours would not provide sufficient time to cover some topics, therefore, session agendas would be determined from week to week as topics were covered to the group's satisfaction. The group priorized the topics, in order of importance as, Wellness, Stress Management, Dealing with Anger, Assertiveness, Dealing with Illness, Self-Esteem, Transitions, and Finances. Wellness was selected as the topic for discussion for sessions two and three.

After these exercises and a break, the time for session one was almost up. We ended the session with a closing round. The women were encouraged to share how the session had gone for them, how they felt about the first session and how the group process fit with their expectations. The women each shared their feelings about the group process. All of the women expressed an interest in the topics selected and their intention to continue their attendance. The women were very

positive about the work done, the agendas created, and the comfortable atmosphere of the group.

On the whole, the women were very polite, respectful, and somewhat reserved during the session. My anxiety level as facilitator was evident in my voice and I acknowledged this in my closing round. The women were very supportive of this acknowledgment. The women were also supportive of each other and all made consistent attempts to address each other by name and to support points of agreement made in discussion. The women were also very political about their analysis of issues that were of interest and concern. Group members identified discrimination, sex-role stereotyping, and misogyny as factors related to women's problems with anger and society's problem with angry women. The group members appeared to have quickly developed a common identity as women in this session. The session was overall very positive and formed a supportive tone for future sessions.

Session Two

Session two was attended by all eight women. One member had previously stated she would not be present but had rescheduled her parent-teacher interviews to allow her to be present. In the opening round the group expressed a common theme. The women were all tired and have all had a very stressful week. I reviewed the agenda for the evening then asked the women to break into small groups. The exercise the

women did in the small groups was to define personal wellness, define the elements of wellness, and discuss the components of wellness as they affected them personally. After twenty-five minutes the group reconvened to discuss the three issues in the large group. Each group defined wellness as a balance between physical-social-sexual-psychological, emotional, and spiritual components of wellness. One women defined wellness as a balanced feeling that enabled her to lose the need for a sense of control. This was an interesting reversal of several of the women's perceptions of balance being a sense of control. An interesting discussion of control issues followed.

Following a break for tea, the discussion moved to why wellness is different for men than for women. The group approached this discussion with a feminist analysis about how societal discrimination and oppression affects every aspect of women's lives. Common themes were expressed about discrimination from doctors, employees (with regard to wellness and women's multiple roles), sex-role stereotypes, work load, biases in medical research, diagnosis, and treatment of illness. A particularly emotional discussion followed on societal pressure for women to have the perfect body and how that message counteracts messages about wellness with respect to nutrition, exercise, and unnecessary surgery. Differences in socialization of boys and girls and how that counteracts the activity-exercise aspects of wellness were

also discussed. Overall the discussions during the session were lively and noisy. Some group members expressed feelings of anger and hopelessness about the extent of oppression and discrimination and the atrocities women face from the medical system. One woman expressed extreme sadness about how women are treated by society at large and the medical profession in particular.

The group expressed a consensus about feeling challenged due to an increased awareness of how women's situations influence wellness. As the facilitator I attempted to help the women reframe the anger and sadness from a reaction of despair and hopelessness to one of challenge for action. As the discussion wrapped up I shared information about the resource center at the clinic and the availability of the resource coordinator. I handed out pamphlets obtained from the clinic on osteoporosis, mammography, hormone replacement therapy, calcium therapy, and menopause. I also made reference to the resource book "Ourselves Growing Older".

In the closing round the group members were quite verbal about their feelings about the process and content of session two. The process comments were very positive from each woman. Comments on content were quite emotional and reflected feelings of anger, sadness, and challenge about women's struggle for wellness. Three women remained behind after the group concluded. Two of the women expressed their disappointment about having to miss the third session. Both of these

women shared their history of sexual discrimination. One woman shared her concern about her daughter's disinterest in women's issues. We talked about ages and stages of feminist awareness and how it is an individual process for all women. The other woman talked about the sexism she grew up with in her family and how her mother was treated for trying to counteract the male domination. Both women appeared to leave on a challenged note and stated they would return for session four. The third woman who stayed behind reviewed resource material and shared some personal difficulties with me. I encouraged her to return next session.

At the conclusion of session two some very interesting dynamics became apparent. The group identity became very clear and a supportive atmosphere was noticeably present. Several women brought resource information to share with each other based on last week's discussion. An informal lending library was developed within the group. The tone of the session was one of mutuality, encouragement, and support. The women were very respectful towards each other and openly caring. All of the women were very talkative and interacted freely with each other. The use of the flip chart appeared to discourage free discussion, therefore, the use of the flip chart was then limited to agenda use only.

Session Three

Five out of the eight group members attended session three. There was a lengthy opening round as the members appeared freer in disclosing with each other about happenings in their personal lives. The topic for the session was Wellness Goals. The women paired up to set their personal goals for wellness. The group reconvened after thirty minutes. The rest of the evening was spent discussing goals for wellness, goal attainment strategies, and barriers to goal attainment. In the closing round the women shared very positive feelings about the process of session three. A common theme in the closing round was the feeling that the women present had really got to know each other and had got to the "heart" of the issue. The women expressed how supportive the atmosphere had become and how comfortable they felt sharing with each other.

Overall, the tone of session three was very positive. The group identity I felt was evolving in session one and two was verbally acknowledged by all women present. The sharing of feelings moved to a very personal and intimate level and the women were extremely supportive and encouraging to each other. The flip chart was used only for the agenda. The decreased use of the flip chart served to deflect focus from myself as a reference point and served to encourage the women to share with each other.

Session Four

This session was attended by five women. One group member had a work commitment, one woman was ill, and the third member absent did not give notice. The opening round was quite lengthy. The women present at session three shared the session with those who had been absent. The women talked about how positive the process and content of session three had been for them. The next task suggested was for the group to review the topics selected for discussion and to provide feedback on what they would like the content of the next four sessions to be. The group reviewed the topics, identified subtopics, and repriorized the sequence of importance of the topics. The women agreed that they would be ready to move from wellness to stress management in session five.

The discussion in session four was focused on barriers to wellness. The women broke into small groups to review their goals related to wellness and to share the individual barriers they face to achieving those goals. The group reconvened quite naturally after about twenty minutes. Each woman shared her personal barriers to achieving her goals. As each woman shared her particular concerns the other women listened attentively and offered support, empathy, and suggestions on how the barriers could be overcome. As the women brought up issues other women shared their experiences with similar problems and shared what had worked for them. One previously quiet member was much more vocal this evening and the rest of

the group were particularly attentive and encouraging to her.

The tone of session four was again one of mutual support and caring. The closing round was again very positive about the process and content of the session. One woman thanked the other women for some new insights she had gained about her childhood experiences and how these experiences influenced her adult life. One woman thanked the other women for their encouragement on a particular problem with her partner and reported how this encouragement made her feel empowered to be more assertive with him. All of the women expressed how the session had encouraged positive, hopeful feelings about overcoming barriers and a sense of optimism about goal attainment and the pursuit of wellness.

Session Five

Session five was attended by all eight women. The group convened late as each woman expressed concern to the woman who was ill for session four and wanted to hear about her particular problem as they arrived. The illness was quite serious and all of the women expressed concern, encouragement, and support for her. The opening round was quite lengthy as well as the women wanted to share their week in detail.

The agenda for session five was stress management. I shared some definitions related to stress such as eustress, distress, and stressors. The women broke into pairs, with women they did not know well, to identify their stressors.

The women appeared to really enjoy the exercise as the tone was boisterous, loud, and they laughed a great deal. The group reconvened to talk about what stressors could be managed, what stressors could be minimized, and which stressors were beyond our control. Each woman in the group shared their personal struggles and received empathy, support, and suggestions from the other women. A lengthy discussion about self-care followed and the group contracted with each other to practise one form of self-care over the week.

The discussion moved from self-care to social change. The societal sources of stress for women were discussed on a very political level. The conclusion from the discussion was that women need to achieve a balance between managing personal stress and working towards change on collective sources of stress that all women experience. The discussion moved from a personal analysis of stress management to a collective focus on stress being endemic to women's lives. The women identified collective barriers to wellness that most women face due to their gender related roles and oppression.

The bond between the group members was very apparent in session five. Overall, the tone of the session was very caring, supportive, and respectful. All of the women participated actively and openly. Several of the group members set goals to join other women's groups to allow them to work towards collective action on issues once this group has terminated.

Session Six

Session six was attended by six of the women. The agenda for session six was dealing with anger. In the opening round the women were asked to identify two positive qualities about themselves. All six of the women identified personality traits such as being honest, responsible, hard working, loyal, dedicated, and having a sense of humor. None of the women identified any qualities related to physical appearance.

Following the opening round the group planned the agenda for the next two sessions and then moved into dealing with anger. The group discussion about anger focused on feeling angry as well as women's experience of men's anger in the forms of physical, verbal, and emotional abuse. The women talked at length about the Montreal massacre and how that event made each one of them feel. Each group member expressed recall of having a deep feeling of personal threat, loss, and extreme sadness. The other common experience discussed was how all of the women experienced people close to them (their male partners, friends, employers) questioning why they took these women's deaths so personally when these women were strangers and two provinces away. The women expressed how the Montreal massacre had increased their identification with other women and increased their collective view on being a woman.

Following the group discussion the women broke into pairs to define their anger as to Who-What-Where-When-Why. The

women really got involved in this exercise and continued past the time suggested until the break at 7:30. Following the break the group reconvened to discuss their anger exercise findings. Two of the women expressed a newly found observation that they were angry at men when they were treated as less than equal because of their gender. A lively discussion about sexism and oppression followed. Each woman shared experiences of sexist treatment from employers, partners, family, and society at large. The women concluded that anger was a positive emotion when it alerted us to wrong and challenged us to work towards change. They also concluded that anger is a very negative emotion when it is turned inward as depression and self blame.

The tone of session six was again very supportive, encouraging, and caring. The discussions began as a personal assessment of anger and moved to collective analysis. The group talked at length about how they could channel personal anger into collective action. Although some of the women expressed feelings of being overwhelmed at the task of forging change in such a sexist society, other women offered encouragements with a historical review of women's situation and the changes that have occurred for women over the past fifty to one hundred years. The meeting concluded with a discussion of where the women could pursue involvement in feminist organizations working towards change on specific issues of interest and concern to them.

The closing round for session six was very positive. All six women present talked about the "new insight" they had gained into their feelings of anger and how they deal with anger. The women stated that they felt they had learned new ways of turning anger out instead of in which they all felt would contribute to their increased wellness. The group remained for 20-35 minutes after closure reviewing resource material, talking informally, and sharing resource information about women's groups in the city.

Session Seven

Eight women attended session seven. The topic for the evening was Assertiveness. The opening round was very lengthy as the women had all become very interested and involved in each others "happenings of the week". The women shared their experiences in detail.

To open the discussion I provided the women with several definitions of assertiveness and aggressiveness. These definitions were selected from current literature on assertiveness. The group broke into pairs to identify common situations where they were aggressive - passive and assertive. The pair discussions were lively. The group rejoined to continue the discussion.

Two common themes emerged. Some of the women identified that they were assertive with family, partners, and close friends. They felt they were most assertive, when they wanted

to be assertive, when the power balance was equal. These same women identified that they acted either aggressively or passively with employers, co-workers, and in situations where the power relationship was one of imbalance and where there was an element of dependency for services, wages, and career advancement. The second common theme was that the women were generally passive or aggressive in behavior in all relationships. The women who identified this pattern of communication reported that most relationships in their lives involved a power imbalance. These women also stated they were most assertive with other women in relationships founded on common interests, concerns, and friendship.

The discussion moved from a personal assessment of assertiveness to a broader analysis of how assertive women are treated by society at large. The women identified that there is a "proper" communication style expected in certain situations for women which is generally a passive, accepting style. The women stated they were sometimes punished by others for being assertive in situations where a power imbalance existed. Examples included sexual harassment by employers, emotional abuse by male partners, and verbal abuse from male coworkers. The women shared experiences and common problem situations and offered each other suggestions and encouragement to deal with these problems.

Following the topic discussion, the session ended with a planning session for the final session. The group members

decided to meet away form the clinic at a local restaurant. The final session was planned as an informal wrap-up Christmas party. Two of the women were not able to attend the final session so the group set a date in January as a final wrap-up.

I asked the women to identify issues, topics, and concerns that they would like more information on. Two of the women requested references for cholesterol studies done with female subjects. I agreed to consult the resource coordinator at W.H.C. for more information. One woman requested information about volunteering in a group that focused on affirmative action and employment equity. I agreed to contact some sources in government to obtain some leads.

The closing round was quite lengthy. Several of the women used the round to review all seven sessions and to talk about what they had learned, what goals they had set, and about how the insight they had achieved would empower them to pursue wellness. The closing round was very positive and felt very much like an ending. The women provided me with feedback about the group process that was very affirming about my facilitation skills. The session ended forty-five minutes late. I gave each woman an evaluation form and asked them to return it in person at session eight or by mail.

Session Eight

The group met at a local restaurant and were all dressed in festive attire. Five women attended session eight. One

absent member had been admitted to hospital and two women were out of town on business. The agenda for session eight was open and informal. The group discussion mainly focused on the group experience, the challenges of aging, and the insights gained from the group. The women present also shared more personal information, holiday plans, and family situations. All of the women also talked about how close they felt to each other and how positive the sharing in the group had been for them. The general conclusion of the women was that the group experience had been a very positive, affirming, and empowering experience. The women made plans to continue meeting on a monthly basis. The purpose of the monthly meeting was to continue the supportive relationship established and provide a self-help medium for continuing the pursuit of wellness.

In conclusion, the agenda of the final session concentrated on satisfactory termination with reference to each member's impression and reactions towards the overall group process. The informal discussion focused on what each woman had gained from the sessions. Some negative emotions aroused by termination were raised. The women individually and collectively discussed how they would gain support and work towards collective action outside the group setting.

Session Notes - Group Two

Session One

The first session for Group Two was attended by eleven women. The session was scheduled for a different meeting room than was used for Group One and this meeting room proved to be too small for twelve people. Despite the overcrowding and constant interruption of late comers, I proceeded with introductions. I began introductions by welcoming the women to the group. I introduced myself as the facilitator, provided a brief personal history, and explained the purpose of the practicum and my relationship to the W.H.C. I also reviewed the proposed group process and structure for the group sessions. The eleven women who attended each introduced themself to the group and talked about their reasons for joining the group. Due to the large size of the group it was decided to each wear a name tag to help address each other on a personal level. After the group had introduced themselves I provided information about refreshments, donations, bathrooms, clinic layout, and parking. We took an early break after the housekeeping items were discussed so I could try to locate a larger meeting space.

Following the break we moved to a larger room and proceeded with the rest of the agenda. The group agreed to the following group rules: to respect each other, to share time, to participate, to maintain confidentiality, to advise

others when we will not attend, to respect each other's opinions, to practice self-care, and to not interrupt each other. The women all agreed to an opening and closing round for each session. Following a brief discussion of group process suggestions the women moved on to topic selection. Nine topics were identified as topics of interest. Each topic was briefly discussed and then collapsed and regrouped into seven main topics for discussion. The women in Group Two stated a majority preference to take one topic each week. The women felt that seven sessions would allow for an introduction to each topic. The majority of group members stated a preference to schedule sessions this way instead of leaving out some of the topics selected. The topics selected were then rank ordered to set a topic schedule. The session topic schedule included: stress management, self-care, relationships, dealing with anger, assertiveness, dealing with illness, and transitions. The topics were broken down into issues in a group brainstorming session. The issues identified as pertinent to each topic were to guide the agenda for each session.

In the closing round the general feedback was that the group members were optimistic about the future sessions. The women all expressed positive feelings about the topics selected, about how the group had worked together, and they expressed a general interest in the content for the next seven sessions. In the closing round several women expressed

personal agendas for the group sessions. Some of the women expressed very task-oriented goals to learn specific information about staying well. Other women expressed more affective goals such as sharing interests, feelings, and experiences with other women. At the conclusion of the session two women asked for agendas for the next seven sessions. They stated if they had agendas they could prepare for each session.

The women were invited to bring resource information to share with the rest of the group. Overall, the tone of the session was very positive. The women were quite relaxed and talkative for an introductory session. The women in Group Two all reported very limited experience in groups. Two of the group members had attended the Menopause Information session at the W.H.C. The rest of the nine members had no prior experience in groups.

Session Two

This session was attended by seven women. Two women called with regrets, one woman had a change of employment hours and the fourth women absent was unable to arrange child care. The opening round was quite lengthy.

In the opening round each woman was quite verbal about recent experiences that were stressful and problematic. The women also had quite clear goals for the session. We began the session with an exercise called the body stress check

list. This exercise was designed to identify a person's current level of stress. Some of the women expressed surprise and concern about their score while others reported that it reflected what they already knew. This exercise worked well to focus the group on the topic. The women broke into pairs following definitions of stress - eustress, distress, and stressors. In the pair exercise the women identified their stressors. After the women regrouped a lively discussion followed. The women identified stressors as both personal and organizational. They moved the discussion from a personal analysis of stress to a societal analysis of stress for all women. The session ended with a relaxation exercise. The women were encouraged to select relaxation activities that worked best to relieve their stress outside the group and report back on these next session. The closing round was very positive. The overall tone of the session was positive, respectful, and encouraging. The women were somewhat reserved in stating opinions or suggestions to the other group members. The women listened attentively to each other and did affirm what each woman was saying.

Session Three

This session was attended by seven women. The women who did not attend all called to advise they would be absent. The agenda for session three was self-care. The opening round was quite brief. Four of the women in attendance had not attended

session two and these women were quite reserved. I began the discussion on self-care with an overview of the components of self. The group quickly focused in on the importance of achieving balance of the different components of self for wellness to be achieved. The group broke into pairs to discuss how they personally practice self-care. Following the break the group reconvened to discuss the barriers that exist, both personally and socially, to the practice of self-care. This discussion was very lively and there was a lot of cross-talking. The women frequently interrupted each other and there were two and three discussions going on at once. Group agreements were posted on the board but were generally ignored. Overall, each woman present seemed to proceed with their personal agenda. Some of the group members knew each other prior to the group and these women carried on their own discussions within the group.

The closing round was very positive. Despite my observation, the women were very positive about the session and about the atmosphere of sharing that developed. Two of the women expressed how affirming it was to hear other women express the same concerns they had and to know they were not alone. The women briefly inquired as to the agenda for the next session. I reminded the women of their ownership of the session content and asked that they come prepared to discuss their issues and concerns regarding relationships. The overall tone of the session was very positive despite

behaviors from all women present that did not follow the initial group agreements. The personal agendas of the group members present appeared to take precedence over the group agenda.

Session Four

Session four was attended by seven women. Three of the absent members from last session returned. The four women absent for session four all called to advise they would be absent. Two of the women absent were out of town on vacation, one woman would not attend without her friend who was on vacation, and the fourth woman had a critically ill family member.

The topic for session four was relationships. As there were so many ways to approach this topic I purposely came without an agenda to enable the group to set their own agenda. The opening round was quite lengthy. The women reported to each other the ways they had practised self-care over the previous week and the plans they had made to practise self-care regularly.

Following the opening round the discussion topic was relationships. Each woman shared experiences with both positive and negative relationships in their lives. The discussion was very lively. The women listened attentively to each other and all shared a great deal of very personal information about their own relationships. The group identity

began to emerge this session. The women were very supportive, respectful, and encouraging to each other. In the discussion two of the women emerged as leaders and drew out the quieter women whose messages were not quite clear. The women suggested different approaches to each other on problem relationships and validated each others' feelings. As the facilitator I withdrew from active leadership and observed the group process. The women remained on a very personal level of analysis on the topic of personal relationships. The women had a very political discussion on work relationships and sexual discrimination. In this discussion the women moved the analysis of problems beyond a personal to a collective level of analysis.

The closing round was generally positive for session four. One woman suggested the topic be continued next session as she felt she has more issues to discuss with the group. The other group members present expressed that they preferred to move on to the topic of dealing with anger. The majority of the group members present reiterated their initial preference of using the group sessions to provide introduction to the topics of interest decided on in session one. As the majority of women preferred, the topic of session five was set on dealing with anger. The agenda for session five was discussed briefly.

Overall, session four was quite positive. The comments in the closing round reflected the women's comfort in the

group environment created. The women moved the discussion beyond a personal analysis of the topic and focused on the collective female situation. The women actively participated in the group and group cohesion was apparent. The women encouraged and supported each other during disclosure and a tone of caring and respect was present.

Session Five

This session was attended by seven women. The same four women who were absent from session four were absent again for the same reasons. The opening round was quite lengthy as the women wanted to share many details about their week with the group. Following the opening round and the topic introduction I suggested a pair exercise on anger. The exercise suggested was for each of the women to identify the who-what-where-when-why of their anger. One of the women in the group (J.) responded that she could not do the exercise as anger was a wasted emotion and that she never allowed herself to get angry. J. stated very certainly that women just needed to learn that anger was a waste of time and get on with their lives. The other women in the group visibly sat back in their chairs and withdrew. J. went on to discuss her lack of anger but then qualified the statement that stupidity made her angry. The group remained very quiet. As the group members were visibly not prepared to continue with the exercises I suggested that I open the discussion with my personal

difficulties in dealing with anger. At this point I used self disclosure to reframe the discussion on anger. I acknowledged that what J. had said may be valid for her but stated that it was not valid for me. I shared some personal experiences in which I got angry and I would have liked to have dealt with my anger reaction differently. I also shared how sexism and oppresion angered me. The other group members began to engage in the group process after my self disclosure. After about thirty minutes the discussion became quite lively and the group members, including J., became actively engaged in the discussion.

There were two common themes that emerged in the discussion. Three of the women talked about their anger, about society's treatment of women, and the discrimination women face because of their gender. Three of the women focused on anger on a personal level with respect to their own experiences. J. continued to deny that anger had any impact on her personal life. J. frequently interrupted the other women in this session and took an evaluative approach to their comments. She frequently made suggestions on how they could deal with problems differently and why they experienced the problems they raised. In several instances J. told the other women that they got into the situations discussed because of their "victim-like behavior".

Despite the tension present and the development of conflict between J. and some other group members, the women

verbalized positive feelings about the group process for session five. In the closing round I did observe that two of the women who had participated actively on previous sessions were quiet and reserved. Both of these women visibly sat back in their chairs when J. responded to their stories. A group identity was not present for session five and each of the women present appeared to concentrate on their personal agendas.

Session Six

Session six was attended by seven women. One absent member from last week returned, three of the previously absent remained away for the same reasons and a fourth woman was unable to arrange child care.

The opening round was again fairly lengthy. The women had developed a pattern of sharing their week in great detail with each other. I began the session with an overview of assertiveness. I reviewed the most recent literature available and provided definitions to distinguish assertiveness, aggressiveness, and nonassertiveness. We remained in the large group to begin the discussion. The opening discussion focused on where the women have the greatest problem being assertive or communicating in a way that promotes equality in all relationships. The common theme was that most of the women had problems being assertive at their workplaces. The majority of the women talked about

personal experiences in which they were treated as much less than equal and had responded in a nonassertive manner then became very angry at themselves for their passivity. Although the majority of women expressed common experiences, J. focused on S.'s particular experience and on her response to a reportedly very sexist supervisor. J. told S. that only a victim-like stance allowed this treatment. With her finger pointing at S., J. told her how she "should" behave in such situations. I inter-vened at this point and asked the group what they thought about "allowing others to be aggressive" towards us. Two of the other women talked about their experience as civilians working in the military. These women minimized the personal responsibility of a victim stance for receipt of aggressive communication from others and focused on typical male behavior in their workplace. At this point the discussion moved beyond a report on personal experiences to a collective analysis of sexism that women face due to power imbalances based on patriarchy. J. continued to interject that sexism and discrimination were only problems if we allowed them to be but generally the other women carried on the discussion despite this analysis. The final part of the session was spent talking about the agenda for session seven for the topic Dealing with Illness.

The closing round was somewhat reserved but the women were generally positive about their feelings about the group process. Some of the women appeared quite tense from their

nonverbal communication. Overall the tone of session six was one of disorganization and chaos. The atmosphere was tense, conflictual, and judgemental. The group did not listen attentively nor supportively to each other as they had in the past sessions. The women frequently interrupted each other and there was a great deal of cross-talk while others were speaking. Frequently two or three discussions were going on at once and the conversations often strayed off topic. At one point the women divided on an issue and were arguing the pros and cons of unions with raised voices. Two of the women remained behind when the group session ended. S. and her friend expressed their concern about the group process. S. reported feeling attacked by J. Her friend and I offered her encouragement to return and I assured her I would take steps to discourage a repeat performance.

Session Seven

This session was attended by six women. S. did not attend due to her paid employment commitments. Three of the women who were absent for the past three sessions had called to withdraw from the group. One of the women had left on a trip for six weeks and her friend would not attend without her. The third member's sister had died and she did not feel emotionally able to return. The fifth woman absent for session six could not arrange child care.

The opening round was very brief and the women appeared quite reserved. Following the opening round I asked the group to review the group agreements. I expressed concern about the group processes that had occurred in sessions five and six. I reminded the group of the importance of practising self-care versus the care of others. I summarized the principles of self-care discussed in session three. I reminded the women that evaluating others' experiences and trying to solve each others's problems was not consistent with practising self-care. I encouraged the women to respect each other by listening and providing encouragement and support to each other rather than instruction and direction. I also encouraged the group to respect each other's differences without judgement or blame. I focused the discussion on affirmation and empowerment. All of the women had cited goals of sharing interests, concerns, and issues with each other to obtain affirmation and be empowered to take control of our lives and pursue wellness. The introduction to session seven was the most directive role I had assumed with this group. Some of the women asked for clarification on points made but the group was generally quiet with a few women nodding their heads occasionally.

After the review of the group agreements I invited discussion on the topic dealing with illness. I began the discussion by asking the women how they deal with illness in their personal lives. Each of the women shared their methods

in an individual go around. The discussion then moved on to issues of obtaining satisfactory medical care, the sexism endemic in most doctor-patient relationships, and alternative and nontraditional therapies. Several of the women reported on their personal experience and satisfaction with alternative therapies. These included fasting, rolfing, massage, herbalism, reflexology, health food and nutritional management of health problems, yoga, Tai Chi, meditation, visualization, exercise, and self-help groups. The discussion was very interesting and lively. The women were all attentive to each other and more respectful in their listening skills. There was much less interruption and less cross-talk. All of the women participated actively. The discussion moved beyond a personal level to a collective level. The women began to identify collective experiences women have with the medical care system. The women talked about ageism and how that has influenced health care for women.

The closing round for session seven was very positive. The group appeared relaxed, comfortable, and to be enjoying the process. The women shared very personal information about their health. The comments in the closing round reflected the positive tone of the session. The group was actively involved in the discussion and went thirty minutes overtime. Overall the session went well and the group followed the group agreements. The women were open, respectful, encouraging, and supportive to each other. The criticism and judgement

witnessed in session six was not present. The group concluded and I gave out the final evaluation.

Session Eight

Session eight was attended by seven women. The one member absent was again unable to arrange child care. The topic for the evening was transitions. Following the opening round the discussion was opened to the group. The women chose to discuss this topic by focusing on life events, i.e., child bearing, child rearing, childlessness, menopause, marriage, singlehood, losses of family - parent - siblings - partners, and losses associated with aging. The group talked about how they deal with losses now, how they dealt with losses in the past, and how they think they will deal with losses in the future. The discussion continued in a very informal, unstructured way on a variety of issues until 8:15 p.m. I reviewed the group agendas, group process, and summarized the eight sessions. The women returned the group evaluation forms. The closing round was quite lengthy and the women all expressed very positive feelings about the group experience. Some of the women shared new insights they had gained from the group and reported on new behaviors they had learned. Overall the members stated that they had a new approach to achieving wellness and felt optimistic about their progress. Following the closing round the group made plans to meet for a follow-up session in May. A group list of names and phone numbers was

shared. The women remained after the agenda was completed to talk informally and say their goodbyes.

Common Themes About Wellness

Group One and Group Two reported several common themes related to wellness.

1. Women's multiple roles serve as barriers to wellness.

The women in Group One and Group Two reported that the multiple roles women hold serve as barriers to wellness. Caregiving, employment responsibilities, and responsibilities for management of household issues are all very time consuming and leave little time for self-care.

2. Barriers to achieving wellness are different for men than they are for women.

Women face sexism, ageism, discrimination, and oppression in their personal lives and these create barriers to achieving wellness.

3. Relationships are a primary concern for women.

The women reported that relationships were of central importance in their lives. The group members all agreed that developing supportive relationships in all aspects of their lives was a prerequisite to wellness. The women stated that the presence of supportive relationships enabled them to cope with transitions, illness, loss, and change that accompanies aging.

4. Self-care is central to wellness.

The common conclusion was that as women they must take responsibility for their own self-care and incorporate self-care practises into their daily lives to achieve wellness.

5. Social support in a group process is empowering.

The women in Groups One and Two both expressed how empowering the group process was for them and how they felt social support increased their potential for achieving wellness.

6. Oppression exists in the personal lives of women collectively.

The women in both Groups One and Two identified how oppression in the workplace, the family, and health care delivery system serves as a barrier to achieving wellness. The women stated how the group helped them to identify the affects of oppression in every aspect of their lives and how they were encouraged to pursue collective action from this new awareness.

7. Wellness is a process that will change with aging.

The women in Groups One and Two all reported a new awareness of wellness as a process rather than a program or a static state of being. The women acknowledged that the personal meaning of wellness would change for them over time and was mainly a balanced approach to living.

Summary of Group Processes

The group processes for Groups One and Two were very different. At the onset of both groups the group members expressed common interests in topics and set similar goals for the group. The groups developed very differently over the course of the eight sessions.

Group One developed a clear group identity by session three. The group identity was consistent through the next five sessions. The women of Group One came to the group with an acute awareness of their common identity as women. This was a result of past group experience at the W.H.C. The absenteeism rate for Group One was very low. The eight women who started the group in October finished the group in December. Friendships developed in the group and these friendships carried on after the group terminated. The tone of every session was very positive and the women were very supportive, encouraging, and respectful to each other. The group consistently focused their discussions on the collective meaning of the topics discussed. The women were very political in their analysis of topics. All of the women in Group One reported feeling empowered by the group process. All of the eight women returned their consumer feedback questionnaires. The eight consumer feedback surveys were extremely positive about all aspects of the group.

Group Two did not develop a cohesive nor consistent group identity. The sessions differed in tone according to personal agendas. The absenteeism rate for Group Two was higher than for Group One. Eleven women began the group in January and eight women finished the group in March. Two of the eight women who attended the group until March missed fifty percent of the sessions. The tone of the group sessions varied from week to week. Tension and conflict were present in three sessions. Other sessions had a very supportive atmosphere and the women were encouraging and respectful to each other. The group did not move beyond a personal level of analysis on the overall topic of wellness. The women remained quite individually focused in their goals. There were no active plans to pursue involvement in other groups for the purpose of collective action. Seven out of the eight women returned their consumer feedback surveys and the feedback was mixed.

The main difference between Group One and Group Two was their past involvement in groups and their collective identity as women. Group One members had all attended the W.H.C. Menopause Information session and all came to session one with a common collective identity as women. The women in Group One all had a mutual identification which encouraged the growth of trust and reciprocity. The group dealt with conflicting opinions in a manner of appreciation for each other's differences instead of as a personal criticism of their opinion.

As the facilitator, I found that Group One was easier to facilitate and less stressful. I learned a great deal from both groups of women. I feel my experience with these women has increased my knowledge about group facilitation and about wellness. The group experiences with both Groups One and Two were very empowering for me.

I feel a second difference between Group One and Group Two was the amount of structure I provided to the group. In Group One, my own apprehension resulted in a facilitation style of providing written agendas for each session. I feel I provided more structure for Group One than for Group Two. According to Butler and Wintram "a balance between group structure, planning, and spontaneity is necessary to set boundaries within which safety, warmth, and compassion can develop" (Butler and Wintram, 1991; p. 187). In Group One I feel I achieved a greater balance between structure, planning, and spontaneity and this may have encouraged the more positive atmosphere, that developed for group processes in Group One. From the group experience, I did gain first hand knowledge of the importance of a clear understanding of group process theory in practice.

Part IV Evaluation

Chapter 9 Evaluation Methods

The evaluation methods were selected to evaluate if the objectives for the practicum were met. As the practicum was not research oriented, evaluative methods were not research measures. The practicum was evaluated by four major methods. These included consumer evaluations, committee evaluation of group journals, ongoing consultation and feedback with the advisor and on-site committee member, and self evaluations. I planned to audiotape at least one session from each group but the physical limitations of the meeting space did not allow for clear taping. I had also hoped to have the on-site committee member, Sheila Rainonen, co-facilitate a group, but the closed nature of the group did not allow this to be done without major interruption.

The consumer evaluation methods included the use of closing rounds at the end of each session. The purpose of the closing round was for the women to provide feedback to the facilitator about strengths and weaknesses of the facilitation methods and to state what they liked, disliked, or would like changed in the next session. The consumer feedback questionnaires (Appendix G and I) were given to group members to complete after the seventh session. The committee members reviewed the session notes in respect to closing rounds and

the consumer feedback questionnaires. The self evaluation also occurred after each session. I itemized what I felt I had done well, what could have been done differently, and how I could have used more effective facilitation methods. The four areas of evaluation will now be discussed separately.

Consumer Evaluation

Closing Rounds

Group One and Group Two were structured with an opening round - agenda for the topic of the session - closing round. The closing round format for each session was used to provide the women participants with an opportunity to provide feedback for each session. The group members were encouraged to provide feedback on the group process, what they liked about the session, what they did not like about the session, what they would like to see done differently, and how they could benefit most from each session. Overall the closing rounds were consistently positive. In Group One the women focused the closing rounds on the group process and did make some suggestions for change of seating arrangement, use of more large group discussion, and decreased use of the flip chart. In Group Two the closing round was mainly focused on personal feelings about the group content with only session six being focused on the group process. In session six one of the women stated that the pace of the sessions was too hurried. The

group majority decision was to continue with one topic per session even if the discussion was left unfinished for some topics. The closing round was most effective in both Group One and Group Two to wrap up the session and decide as a group on how to proceed with the next topic of interest.

Consumer Feedback Questionnaire

The consumer feedback questionnaire was developed in conjunction with the practicum advisors. The questionnaire was designed to measure the group member's satisfaction with the group process, their assessment of the facilitators' strengths and weaknesses, and to report on the overall feelings and comments about the group experience. The group members were asked to share their feelings and reactions about the group. They were also asked to provide feedback about what should be changed to make the group more enjoyable and more effective. The questionnaires are reproduced in Appendix G for Group One and Appendix I for Group Two.

In Group One, eight women returned the questionnaires. A different consumer feedback questionnaire was used for Group Two as some questions on the first questionnaire were unclear or redundant. Seven women returned the questionnaire for Group Two. I have summarized the consumer feedback questionnaires in Tables One and Two in Appendices H and J.

Summary of the Consumer Feedback Questionnaire Results

The results of the consumer feedback questionnaires suggest that the women in Groups One and Two received emotional support, had sufficient opportunity to participate, and received information they felt would contribute to their ability to stay well. Nine out of the fifteen women surveyed reported that the group met their expectations, five stated the group experience partially met their expectations, and one woman stated the group failed to meet her expectations. The consistent theme from the fifteen respondents was that the most beneficial aspect of the group was having the opportunity to share their interests, their concerns, and their experiences on health related topics with other women in a supportive environment. Thirteen of the fifteen respondents recommended the group be continued and the fifteen respondents all stated they would recommend the group to their friends. Ten of the women reported that eight sessions were a satisfactory number of sessions while five women suggested an eight week group was too short. One of the respondents suggested that ten to twelve sessions would be a more satisfactory number. Eleven of the women respondents reported that they learned more about women's issues from the group experience, one respondent was unsure, and two women reported they did not learn more about women's issues in the group. Seven women rated the group experience as extremely positive,

five women rated it as above average, one respondent rated the group experience as average, one woman rated the group experience as below average, and the fifteenth respondent did not rate the group experience.

Committee Evaluation

The practicum was evaluated by the practicum advisor and by the two committee members. Prior to session one for Group One it was decided that the advisor, Joe Kuypers, would have consultation with the student following sessions one, four, and eight for Group One. Sheila Rainonen agreed to a weekly consultation to review on-site arrangements, resource requirements, and to share group process information. Kim Clare agreed to be available to me for consultation on as needed basis. The advisor and the committee met at the conclusion of Group One to review the group journal and the consumer feedback questionnaires.

The first consultation for Group One occurred October 26, 1992. Sheila Rainonen provided me with several practical suggestions on facilitation methods. Sheila also suggested that I contact the W.H.C. Resource Coordinator to obtain pamphlets, resource material, and reference material available at the clinic. The first session was a very positive experience and few concerns were noted. In the consultation both Joe Kuypers and Sheila Rainonen mainly offered me

encouragement and listened to my account of the session experience. On November 3, 1992 I met with Sheila Rainonen in person to review some practical concerns regarding equipment and to share the group process from the first two sessions. Sheila gave some suggestions about how to refocus the group from using the facilitator as a reference point and encouragement to use less structured agendas. The consultation session was very effective to provide me with direction for future sessions and to clarify impressions about the group process occurring. To that date the group experience was very positive according to verbal reports from the members and from their attendance. Sheila offered encouragement and support for me to continue the process.

The second consultation with the practicum advisor, Joe Kuypers, occurred November 17, 1992. This consultation occurred by telephone. The purpose of this session was to review the group session notes for the first four sessions. The advisors offered a few practical suggestions about the group exercises. As the first four sessions had also been very positive from both my viewpoint and according to the feedback from the women in the closing rounds, the advisor mainly offered encouragement to continue the process begun.

The committee met to evaluate the consumer feedback questionnaires and session journal on January 8, 1993. Each committee member received the group consumer feedback questionnaires and the session notes. The committee suggested

some changes for Group Two. The consumer feedback questionnaires were discussed and some modifications were planned for the second group. The committee members all provided the student with positive feedback on the effective facilitation of Group One and commented on the enthusiasm exhibited about the whole group experience. The committee offered encouragement, praise, and support to continue the group work in Group Two.

Group Two was evaluated in the same way. I contacted Sheila Rainonen and Joe Kuypers following session one to report initial impressions, attendance, and group composition. The evaluation plan for Group Two was less structured than for Group One and left open on an as needed basis. As several problems with group dynamics arose in Group Two consultation with all committee members was more frequent. I continued the weekly consultation with Sheila Rainonen, bi-weekly consultation with Joe Kuypers, and consulted twice with Kim Clare on group process concerns. At each session Sheila Rainonen offered suggestions and encouragement. Joe Kuypers offered specific facilitation suggestions on how to deal with group conflict and encouraged me to prepare carefully for dealing with the concerns that arose within the group. Kim Clare offered suggestions about facilitating from a feminist approach and encouraged me to facilitate versus direct group processes. The committee met individually with me in April, 1993 to review the Group Two experience. Group differences

were discussed and the overall practicum experience was reviewed.

Self Evaluation

A self evaluation process was used to evaluate my facilitation methods and group work skills at the end of each individual session. Following each session I completed session notes. I recorded the content and the process for each session. At the conclusion of the notes I summarized my impressions of what I had done well, what could be improved, and how I could have facilitated the session differently. My self evaluation guided modifications I made and served as an agenda for discussion with the committee members. The self evaluation process encouraged me to remain focused on my facilitation skills and to use the practicum objectives as a guide for all of my activity with the group.

The self evaluation allowed me to conclude that I had met most of the objectives of the practicum previously stated in Chapter One. My personal objectives were all met. I was able to increase my theoretical knowledge about health promotion and about feminist group work methods by reviewing the literature on these topics. From my review of the literature I was also able to gain more insight into the source of the inadequacies in the traditional health care system for aging women. This insight strengthened my commitment to encouraging

and supporting the provision of alternative types of services. I was able to facilitate two groups to nineteen women in sixteen sessions in the practicum intervention. This enabled me to increase my practice skills in group work with women and provided the opportunity to integrate health promotion and a feminist group work approach. The results of the closing rounds, my journal recording, and the general comments in the consumer feedback questionnaire all allowed me to conclude that I was successful in facilitating increased consciousness and that the group members were empowered by the group process.

My practice objectives for the practicum were partially met. I was able to develop a new and different approach to meet some of the health related needs for the women in the two groups. I was unable to evaluate the usefulness of a feminist group work-health promotion approach as I did not use research measures. The anecdotal reports from the group members did suggest the approach was useful to them. The practicum experience did enable me to become a more skilled and a more effective health care professional. The group experiences encouraged me to incorporate a holistic approach in my paid employment as a health care professional. I learned ways to facilitate health education and health promotion processes to encourage health care consumers to achieve wellness.

Summary of the Evaluation Methods

The evaluation methods selected allowed me to assess the efficacy of the intervention to meet the practicum objectives. By facilitating two groups I was able to increase my practice skills in group facilitation. The consumer feedback, committee consultation, and self evaluation measures encouraged me to modify methods on an ongoing basis and be responsive to the needs and wants of the group members. By facilitating two groups, my practise experience was lengthened and I was able to relax and become more attentive to the spontaneous interests of the group members present for the individual sessions. As my need to structure the group decreased I was able to become more attentive to the immediate interests of the group rather than the subtopics they had selected for each topic in session one. This was evidenced by my discontinuation of use of detailed agendas for Group Two by session three.

The results of the consumer feedback questionnaires provided support for the two assumptions which grounded the practicum. All of the women participants in both Group One and Group Two reported that they received personal benefits from the group experience. The second assumption was also supported. The women reported increased optimism and feelings of empowerment to meet the challenges presented by aging. The women also reported an increased awareness of the value of

social support and the positive relationship that exists between social support and coping.

As the practicum was external to my paid employment I was not constrained by agency policies, procedures, nor accepted methods of practise. This encouraged me to develop more innovative practise methods and be responsive only to the group members' needs on health related issues. The practicum provided me with the opportunity to work with nineteen women on health issues of both personal and professional interest. The practicum provided me with the opportunity to increase my personal and practise objectives and become a more skilled health care worker. The skills I developed will assist me in both my professional work as a social worker in a health care program and in my personal life as a volunteer community organizer.

Limitations

There were a number of limitations related to the evaluation methods selected and some aspects of the practicum itself that require identification. The practicum was not designed as a research practicum. Research measures were not used and therefore the efficacy of the intervention for the group members remains only anecdotal. This does not allow for any findings to be discussed in research terms and does not allow for any generalizations to be made about the group

intervention. From the evaluation methods selected I could not conclude that a feminist health promotion approach was any more effective for the group than any other group work approach would have been. The lack of pre-test and post-test measures to identify wellness behaviors does not allow me to suggest any relationship between health promotion interventions and wellness.

The short term nature of the group intervention did not allow consumers to identify any patterns or consistent behavior changes in response to the group experience. The women in the two groups were only able to assess their current feeling of motivation to work towards achieving wellness rather than assess any individual behavior changes that might have occurred as a result of attendance in the group.

The limitation of the consumer feedback questionnaire also became apparent after it was used. This instrument did not address empowerment and should have been more directly tied to the practicum objectives to provide better evaluation of the achievement of the objectives from the consumers' point of view.

Recommendations

My group work experience in delivering the intervention based on a feminist health promotion approach to wellness led me to the following recommendations.

I would recommend that a feminist health promotion group be made available to other women. The response rate to the groups in my practicum suggests sufficient interest on the subject of wellness and that an identified need is felt for such a group by women in Winnipeg. The group members identified that there are very few groups in Winnipeg that address the general health care interests of women after menopause. The women in the group all reported that they felt a similar group should be continued.

I would recommend that the group be made available both afternoons and evenings to recruit women from a wider range of ages and with different demographic characteristics. I would also recommend a group be held at a site away from downtown to provide greater access to women who live in other areas of the city and for women who perceive a downtown location as unsafe.

I would recommend that the group be created as a pilot project to provide an opportunity to enable the evaluation of the effectiveness of such a group. The practicum evaluation I completed did not include research measures and this would be recommended in the evaluation methods selected for future groups. The objectives for future groups would need to be

research based objectives to assess the efficacy of the intervention rather than focus on facilitator skill development.

There are several specific recommendations related to group management issues I would like to make.

I would recommend that the sessions be facilitated from a social support, self-help approach rather than information sessions on specific topics. This approach is consistent with consumer driven models discussed in the literature as the most effective method to empower behavior change and increase coping skills. This approach was also very positively evaluated by the women in the groups for this practicum.

I would also recommend that the groups be facilitated as closed groups as this was one characteristic of the group that the women recruited stated was important to them.

I would suggest that the number of group sessions be kept flexible depending on specific group needs. I feel that more sessions may increase the likelihood of the group continuing after termination as a self-help group.

I would also recommend that efforts be made to assist individual group members with specific needs such as child care or transportation to allow for consistent attendance.

My final and most important recommendation is that service providers develop programs within their agency to meet the special needs of aging women. The practicum experience has provided support for the assumption that aging women have

special needs that are not being met in the current health care delivery system. These women require opportunity to obtain social support and increase the chances of achieving wellness and staying well as they age.

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APPENDIX A

GROUP ONE RECRUITMENT POSTER

women's health clinic

GROWING OLDER

STAYING WELL

SHARING AND LEARNING WAYS TO STAY HEALTHY

WHAT: A HEALTH SHARING GROUP FOR WOMEN OVER 40. TO EXPLORE A VARIETY OF HEALTH RELATED ISSUES: DEFINING HEALTH, ALTERNATIVE HEALTH CARE, HEALTHY LIFE STYLE, PROMOTING WELLNESS, ASSERTIVENESS, SELF-ESTEEM, DEALING WITH ANGER, AND THE POLITICS OF WELLNESS.

WHERE: WOMEN'S HEALTH CLINIC
2ND FLOOR - 419 GRAHAM AVENUE

WHEN: OCTOBER, 1992
ONCE A WEEK FOR 2 HOURS
TUESDAY 1:30 TO 3:30 PM
OR
THURSDAY 6:30 TO 8:30 PM

EACH GROUP WILL RUN FOR 8 WEEKS
SESSIONS WILL BE FREE OF CHARGE

TO REGISTER PLEASE CALL SHERRY OR LEAVE YOUR MESSAGE AT

APPENDIX B

GROUP TWO RECRUITMENT POSTER

women's health clinic

GROWING OLDER

STAYING WELL

SHARING AND LEARNING WAYS TO STAY HEALTHY

WHAT: A HEALTH SHARING GROUP FOR WOMEN OVER 40. TO EXPLORE A VARIETY OF HEALTH RELATED ISSUES: DEFINING HEALTH, ALTERNATIVE HEALTH CARE, HEALTHY LIFE STYLE, PROMOTING WELLNESS, ASSERTIVENESS, SELF-ESTEEM, DEALING WITH ANGER, AND THE POLITICS OF WELLNESS.

WHERE: WOMEN'S HEALTH CLINIC
2ND FLOOR - 419 GRAHAM AVENUE

WHEN: JANUARY, 1993
ONCE A WEEK FOR 2 HOURS
WEDNESDAY 6:30 TO 8:30 PM

EACH GROUP WILL RUN FOR 8 WEEKS
SESSIONS WILL BE FREE OF CHARGE

TO REGISTER PLEASE CALL SHERRY OR LEAVE YOUR MESSAGE AT

APPENDIX C

AGENCY LETTER - GROUP ONE

September, 1992

Dear Friend,

I am writing to invite you to display my poster in your office.

I am a masters students in the Faculty of Social Work at the University of Manitoba. I will start my practicum in September, 1992. My practicum is to facilitate a health promotion group for women over 40. In this group, I will facilitate sessions with a goal of empowering the women in the group to take control of their own health care.

Potential group topics will include: Defining Personal Health, Promoting Wellness, Self Esteem, Alternative Health Care, Assertiveness, Dealing with Anger, The Politics of Illness, and Aging Well. I will conduct intake interviews with all potential group members to ascertain that group members will have interests that are general enough to enable them to take part in the group on a variety of health-promotion topics.

My practicum will be greatly assisted by the Women's Health Clinic. The groups will meet at the Women's Health Clinic. Sheila Rainonen will provide consultation and serve on the committee for my practicum.

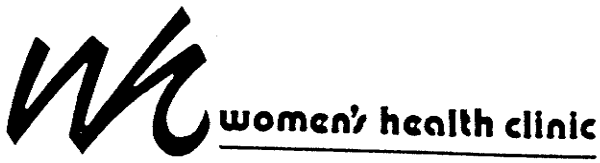
Please feel free to contact me at 896-1295 if you have questions, referrals, or would like more information.

Yours sincerely,

Sherry Mooney

APPENDIX D

AGENCY LETTER - GROUP TWO



December, 1992

Dear Friend,

I am writing to invite you to display my poster in your office.

I am a masters students in the Faculty of Social Work at the University of Manitoba. I will start my practicum in September, 1992. My practicum is to facilitate a health promotion group for women over 40. In this group, I will facilitate sessions with a goal of empowering the women in the group to take control of their own health care.

Potential group topics will include: Defining Personal Health, Promoting Wellness, Self Esteem, Alternative Health Care, Assertiveness, Dealing with Anger, The Politics of Illness, and Aging Well. I will conduct intake interviews with all potential group members to ascertain that group members will have interests that are general enough to enable them to take part in the group on a variety of health-promotion topics.

My practicum will be greatly assisted by the Women's Health Clinic. The groups will meet at the Women's Health Clinic. Sheila Rainonen will provide consultation and serve on the committee for my practicum.

Please feel free to contact me at if you have questions, referrals, or would like more information.

Yours sincerely,

Sherry Mooney

APPENDIX E

GROUP TOPICS - GROUP ONE

Group Number 1

October - December, 1992

GROWING OLDER - STAYING WELL

GROUP AGENDAS

1)	INTRODUCTION - TOPIC SELECTION	OCTOBER 22, 1992
2)	WELLNESS	OCTOBER 29, 1992
3)	WELLNESS REVISITED	NOVEMBER 5, 1992
4)	BARRIERS TO WELLNESS	NOVEMBER 12, 1992
5)	STRESS MANAGEMENT	NOVEMBER 19, 1992
6)	DEALING WITH ANGER	NOVEMBER 25, 1992
7)	ASSERTIVENESS	DECEMBER 3, 1992
8)	TRANSITIONS - WRAP-UP	DECEMBER 10, 1992

APPENDIX F

GROUP TOPICS - GROUP TWO

Group Number 2

January - March, 1993

GROWING OLDER - STAYING WELL

GROUP AGENDAS

1)	INTRODUCTION - TOPIC SELECTION	JANUARY 20, 1993
2)	STRESS MANAGEMENT	JANUARY 27, 1993
3)	SELF CARE	FEBRUARY 3, 1993
4)	RELATIONSHIPS	FEBRUARY 10, 1993
5)	DEALING WITH ANGER	FEBRUARY 17, 1993
6)	ASSERTIVENESS	FEBRUARY 24, 1993
7)	DEALING WITH ILLNESS	MARCH 3, 1993
8)	TRANSITIONS	MARCH 10, 1993

APPENDIX G

CONSUMER FEEDBACK QUESTIONNAIRE - GROUP ONE

GROWING OLDER - STAYING WELL

FINAL EVALUATION

The following evaluation form allows you to share your feelings and reactions about the group Growing Older - Staying Well. Your response will help me to evaluate myself as your facilitator and to plan for other potential groups. Your name is not required. Your honest feedback is requested. This evaluation will be shared with my practicum advisor Joe Kuypers and my committee members Sheila Rainonen and Kim Clare. Thank you for your feedback.

1. Do you feel you received emotional support from the group?

1	2	3	4	5
Poor		Average		Excellent

2. Was there enough opportunity for participation?

1	2	3	4	5
Poor		Average		Excellent

3. Did the group sessions provide you with helpful information about staying well?

Yes No Partly

4. Did the group sessions provide you with information about where you can go to get the information you need and want to stay well?

Yes No Partly

5. How did you feel about the physical facilities (i.e., room, location)?

1	2	3	4	5
Poor		Average		Excellent

6. What were your goals and expectations on beginning the group?

_____

_____

_____

7. What did you find most helpful about the group?

_____

_____

_____

8. What did you find least helpful about the group?

_____

_____

_____

9. Did the group sessions meet your goals and expectations?

_____

_____

_____

10. What was most useful in the group sessions?
(Rank order from 1 - 10: 1 = least useful, 10 = most useful

Sharing with other women

Information from the facilitator

Pair exercises/discussions

Small group discussions

Group discussions

Handouts

Resource material

Breaks

11. What did you find most enjoyable in the group sessions?
(1 = least enjoyable, 10 = most enjoyable)

Sharing with other women

Resource material

Handouts

Group discussions

Pair exercises/discussions

Brainstorming/Flip Charting

Breaks

Small group discussions

12. Would you recommend this group be continued?

Yes Maybe No

13. Were eight sessions

Too long Just Right Too short

14. Would you recommend this group to your friends?

Yes Maybe No

15. What were the strengths of the facilitator?

_____

_____

16. What were the weaknesses of the facilitator?

_____

_____

17. Do you feel you have learned more about women's issues?

Yes Maybe No

18. What would you keep the same about the group?

_____

_____

19. What would you change about the group?

_____

_____

20. Overall how would you rate your group experience?

1	2	3	4	5
Extremely Negative		Average		Extremely Positive

21. Do you feel you stand a better chance of staying well?

Yes Maybe No

22. General Comments?

_____

_____

_____

_____

_____

Thank you all so much.

Sherry

APPENDIX H

RESULTS OF CONSUMER FEEDBACK QUESTIONNAIRE - GROUP ONE

	Emotional Support	Opportunity for Participation	Info needed to stay well	Info for Resources	Group Setting	Goals and Expectations on beginning Group	Most Helpful about group
1	Excellent	Excellent	Yes	Yes	Above Average	Discuss health related issues, share current concerns and interests, strengthen my commitment to healthy lifestyle	Sharing of info-supportive atmosphere
2	Excellent	Excellent	Yes	Yes	Average	Get information re building self-esteem and anger	Sharing things that upset me in a supportive non-threatening atmosphere
3	Above Average	Excellent	Yes	Yes	Above Average	Meet other women same age, get info re staying well - feeling better	Support, ideas about dealing with stress, pair discussions
4	Excellent	Excellent	Partly	Yes	Above Average	Cover Health related issues	Discuss issues with other women and resource material
5	Excellent	Excellent	Yes	Yes	Excellent	Info about physical changes and aging, i.e., HRT and high cholesterol	Sharing experiences and coping skills with other women my age
6	Average	Excellent	Partly	Partly	Above Average	Learned everything I could to help feel better	Sharing feelings and ideas
7	Excellent	Above Average	Yes	Yes	Average	Get ideas for creating balance in my life	Sharing experiences
8	Excellent	Excellent	Yes	Yes	Above Average	Learn more about myself (aging), achieve a better understanding of how to take care of myself	Group participation, sharing knowledge and experience resource information

Table 1: Consumer Feedback Questionnaire - Group 1

	Least Helpful About Group	Goals and Expectation Met	Most Useful in Sessions	Most Enjoyable in Sessions
1		Yes	-Sharing with other women, group discussions, info from facilitator, small group discussions, hand-outs, pair exercises, resource material, breaks	-Sharing with other women, group discussions, small group discussions, pair exercises, brainstorming, hand-outs, resource material, breaks
2	Some topics did not relate to me, but were informative	Yes	-Sharing with other women, info from facilitator, group discussions, small group discussions, resource material, pair exercises, hand-outs, breaks	-Sharing with other women, group discussions, small group discussions, brainstorming, pair exercises, breaks, resource material, hand-outs
3	First night when trying to decide topic schedule	Very Good - all women related well, info more than adequate	-Sharing with other women, pair exercises, resource material, small group discussions, group discussions, breaks, info from facilitator, hand-outs	-Sharing with other women
4		For the most part	-Sharing with other women, pair exercises, resource material, small group discussions, group discussions, breaks, info from facilitator, hand-outs	-Sharing with other women, group discussions, small group discussions, brainstorming, pair exercises, breaks, resource material, hand-outs
5		More tools to search for specific answers	-Sharing with other women, hand-outs, resource material, info from facilitator, small group discussion, pair exercise, break	-Sharing with other women, hand-outs, group discussions, small group discussions, resource material, pair exercise, brain-storming, breaks
6	Hand-outs	Partly	-Sharing with other women, info from facilitator, group discussions, small group discussions, pair exercises, hand-outs, resource material, breaks	-Sharing with other women, group discussions, brainstorming, small group discussions, pair exercise, breaks, resource materials, hand-outs
7	Not applicable	Yes	-Sharing with other women, group discussions, pair exercise, info from facilitator, small group discussions, hand-outs, resource material, breaks	-Sharing with other women, group discussions, brainstorming, pair exercise, small group discussions, hand-outs, resource material, breaks
8	Everything was helpful for me	Yes	-Sharing with other women, info from facilitator, pair discussions, small group discussions, group discussions, breaks, hand-outs, resource material	-Sharing with other women, group discussions, brainstorming, pair exercise, small group discussions, hand-outs, resource material, breaks

Table 1: Consumer Feedback Questionnaire - Group 1

	Recommend Continue	Group Length	Recommend to Friends	Strengths of Facilitator	Weakness of Facilitator	Learned about womens issues
1	Yes	Too short	Yes	Flexible, willing to follow group objectives, to listen, to provide resource material, knowledgable and pleasant	N/A	No
2	Yes	Just right	Yes	Very understanding, maintain control, gentle friendly manner, allowed group to set agenda, provided informative resources and hand-outs	I can't think of any	Yes
3	Yes	Just right	Yes	Kept us on course-got us going, gave us strength. Enthusiastic	Cannot think of any	Yes
4	Yes	Just right	Yes	Open, warm, set relaxed tone, very flexible, went with wishes of group, shared personal info, good resource info, kept group moving	None apparent	Yes
5	Yes	Too short	Yes	Flexible, able to draw others out, well-prepared, good knowledge of resources, knowledgable	Can't think of any	Yes
6	Yes	Too short	Yes	Good listener, knowledgable, caring	?	Yes
7	Yes	Just right	Yes	Excellent facilitator, kept group on track on our agenda not hers	More about her experiences	Yes
8	Yes	Too Short	Yes	Fun, cheerful, sense of humor, informative, encouraged participation, kept us on track, resource info available	Can't think of any	Yes

Table 1: Consumer Feedback Questionnaire - Group 1

	Keep Same about Group	Change about Group	Rate Group Experience	Better Chance of Staying well?	General Comments
1	Size, format, length of sessions	Go 10 weeks, more large group discussions	Extremely positive	Maybe	Maybe depends on me - my choices and follow through on commitments to positive changes. Was good beginning.
2	Large group discussions, small group discussions	Leave out pair exercises and role plays	Extremely positive	Yes	Learned a lot about myself and about womens issues. Saddened by the way society treats women, lots of work to be done.
3	Agenda		Extremely positive	Yes	Good group and leader. Enjoyed sharing our thoughts. Good to know others have same concerns and problems.
4	Group size and everything in question 10 and 11	Use games to mix up seating order	Extremely positive	Maybe	I am very glad you ran these sessions - very positive and enlightening experience.
5	Size and location	More small group discussions	Extremely positive	Yes	Another positive experience in my life. Look forward to keeping in touch with group.
6	Size and group discussions	Nothing	Average	Maybe	The group was helpful but wish it lasted longer.
7	Size	Try to keep ages more homogeneous	Above average	Yes	Very enjoyable, received valuable information, very good facilitator.
8	Everything	More resource material	Extremely positive	Yes	I enjoyed the group, excellent facilitator, learned a lot.

Table 1: Consumer Feedback Questionnaire - Group 1

APPENDIX I

CONSUMER FEEDBACK QUESTIONNAIRE - GROUP TWO

GROWING OLDER - STAYING WELL

FINAL EVALUATION

The following evaluation form allows you to share your feelings and reactions about the group Growing Older - Staying Well. Your response will help me to evaluate myself as your facilitator and to plan for other potential groups. Your name is not required. Your honest feedback is requested. This evaluation will be shared with my practicum advisor Joe Kuypers and my committee members Sheila Rainonen and Kim Clare. Thank you for your feedback.

1. Do you feel you received emotional support from the group?

1	2	3	4	5
Poor		Average		Excellent

2. Was there enough opportunity for participation?

1	2	3	4	5
Poor		Average		Excellent

3. Did the group sessions provide you with helpful information about staying well?

Yes No Partly

4. Did the group sessions provide you with information about where you can go to get the information you need and want to stay well?

Yes No Partly

5. How did you feel about the physical facilities (i.e., room, location)?

1	2	3	4	5
Poor		Average		Excellent

6. What were your goals and expectations on beginning the group?

_____

_____

_____

7. What did you find most helpful about the group?

_____

_____

_____

8. What did you find least helpful about the group?

_____

_____

_____

9. Did the group sessions meet your goals and expectations?

_____

_____

_____

10. On a scale of 1 to 10 rate the following activities of the sessions: 1 = least useful, 10 = most useful

Sharing with other women

Information from the facilitator

Pair exercises/discussions

Small group discussions

Group discussions

Handouts

Resource material

Breaks

11. Would you recommend this group be continued?

Yes Maybe No

12. Were eight sessions

Too long Just Right Too short

13. Would you recommend this group to your friends?

Yes Maybe No

14. What were the strengths of the facilitator?

_____

_____

15. What were the weaknesses of the facilitator?

_____

_____

16. Do you feel you have learned more about women's issues?

Yes Maybe No

17. What would you keep the same about the group?

_____

_____

18. What would you change about the group?

_____

_____

19. Overall how would you rate your group experience?

1	2	3	4	5
Extremely Negative		Average		Extremely Positive

20. Do you feel you stand a better chance of staying well?

Yes Maybe No

21. General Comments?

_____

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Thank you all so much.

Sherry

APPENDIX J

RESULTS OF CONSUMER FEEDBACK QUESTIONNAIRE - GROUP TWO

	Emotional Support	Opportunity for Participation	Info needed to stay well	Info for Resources	Group Setting	Goals and Expectations on beginning Group	Most Helpful about group
1	Average	Above Average	Yes	Yes	Above Average	Share knowledge and experiences	Willingness of group members to participate
2	Above Average	Above Average	Yes	Yes	Average	Information on staying well	Ability to discuss problems, listen to others, share and support
3	Below Average	Above Average	Yes	Yes	Above Average	Anticipated the group would discuss aging related problems and their possible resolutions	Sharing sources of additional information and the resource material
4	Average	Below Average	Partly	Partly	Excellent	In-depth examination and learning re stress management, relationships, dealing with anger, transitions and areas difficult to cope with	Hearing other womens experiences and sharing my own, good for morale to be with other women
5	Average	Excellent	Yes	Yes	Average	I wanted answers	Talking to others
6	Above Average	Above Average	Yes	Yes	Average	Finding what kind of help exists for women, knowing how other women stand up for their rights	I found most women had the same fears, stressors and problems. Where and how to conquer them. Everyone cared about one another
7	Average	Excellent	Partly	Yes	Above Average	Sharing information on womens health concerns	Opportunity to discuss concerns

Table 2: Consumer Feedback Questionnaire - Group 2

	Least Helpful About Group	Goals and Expectations Met	Most Useful In Sessions	Recommend Continue	Group Length	Recommend To Friends
1		For most part	Sharing with other women, group discussions, resource material, hand-outs, info from facilitator, breaks, pair exercises	Maybe	Just right	Yes
2	More info on finding medical help	Yes, I benefitted from the sessions	Sharing with other women, info from facilitator, pair exercises, hand-outs, resource material, small group discussion, group discussions, breaks	Yes	Just right	Yes
3	Some participants believed it was group therapy sessions	Yes in area of info and resources, confirming knowledge we all deal with same problems	Resource material, hand-outs, info from facilitator, group discussions, small discussions, breaks, sharing with other women	No	Just right	Yes
4	Sessions too short to get into topics	Not as well as I would have liked	Hand-outs, resource material, group discussions, info from facilitator, sharing with other women, small group discussions, pair exercises, breaks	Yes	Too short	Yes
5	There are no set answers	I had no goals	Sharing with other women, group discussions, pair exercises, hand-outs, resource material, breaks, info from facilitator, small group discussions	Yes	Just right	Yes
6	More talk about relationships	Yes	Info from facilitator, group discussions, hand-outs, resource material, sharing with other women, pair exercises, small group discussions, breaks	Yes	Just right	Yes
7	Some negative reactions, not enough feedback from other women	Not really	Info from facilitator, group discussions, hand-outs, sharing with other women, resource material, breaks	Yes	Just right	Yes

Table 2: Consumer Feedback Questionnaire - Group 2

	Strengths of facilitator	Weaknesses of facilitator	Learned about Womens issues	Keep the same About Group	Change about Group	Rate Group Experience	Better Chance of staying well
1	Sensitive to everyones needs	Allow people to go on tangents	Yes	Number of participants	Use other resources	Above average	Yes
2	Remembered names and info, got people involved, friendly	Better time regulation	Yes	Size of group and informal discussions	Shorten open and closing rounds, facilitator take more active role in time management	Above average	Yes
3	Drawing group into discussions, excellent resource material	Preferred stronger input from facilitator	Yes	Size and diversity of group	More focus on aging related issues and options	Above average	Yes
4	Friendly, approachable, good resource material, provided valuable info, insured all had chance to speak	Covered complex issue in too short a time frame	Yes	The issues, group size, location and time	Work on some issues in-depth		Maybe
5	Guided, did not criticize		No	Just as it is	Need more concrete answers	Above average	Maybe
6	Confidant, organized, knew material	Could have added humor	Yes	Length and basic topics		Extremely positive	Yes
7	Understanding of womens concerns re health issues	Allow group to be structured by minority	Maybe	Opportunity for all to participate	Encouraged those unwilling to participate	Below average	Maybe

Table 2: Consumer Feedback Questionnaire - Group 2

	General Comments
1	All in all an enriching and empowering experience.
2	I feel I have benefitted a great deal from our discussions. The general friendly atmosphere, which I feel was set by the facilitator, led to active participation by all.
3	We had some very stimulating discussions which I personally enjoyed. I would have preferred the session be more topical, i.e., growing older -staying well and less personal problem oriented. Stronger input and guidance from facilitator.
4	I found it bothersome to see women come to a session or two and not return. I am grateful that I had the opportunity to be part of this group.
5	I enjoyed hearing other peoples situations and trying to relate it to my own.
6	Enjoyed it very much.
7	

Table 2: Consumer Feedback Questionnaire - Group 2