

**Childhood Sexual Abuse and Sexuality: A Group Approach for Women Sexually  
Abused as Children**

**by**

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**CHILDHOOD SEXUAL ABUSE AND SEXUALITY:  
A GROUP APPROACH FOR WOMEN SEXUALLY ABUSED AS CHILDREN**

**BY**

**LINDA HAYES**

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University  
of Manitoba in partial fulfillment of the requirements of the degree  
of  
MASTER OF SOCIAL WORK**

**Linda Hayes      1997 (c)**

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### **Abstract**

Childhood sexual abuse has a profound effect on the way in which women and men view their sexuality. Often, women in my practice identify issues related to sexuality. The confusion they experience regarding relationships, intimacy and sex cause a great deal of turmoil and pain in their lives. The sexual victimization that they have suffered and survived has left its mark. It is about the essence of their very being, about who they are as women, about how they project their womanhood onto the world and how they distort and become ashamed of their femaleness. It is with this in mind and through feedback from women who are survivors, that I decided to offer a twelve week closed group to women, that focused on the effects childhood sexual abuse has on sexuality.

This report explores the effects that childhood sexual abuse has on women's sexuality. The purpose of the report is to describe the group process and evaluate the effectiveness of this model in helping survivors understand the impact that sexual abuse has on their attitudes and beliefs about sexuality. Women in the group explored issues related to sexual and non-sexual relationships and intimacy. Through the group process and results from questionnaires I was able to identify some themes and make some observations. However, I do not expect that the results of this study are conclusive or final nor can I predict how other women in future groups will respond to a group of this nature.

**DEDICATION**

This report is dedicated to the eight women who graciously gave of themselves. They are truly “Brave Hearts”.

**TABLE OF CONTENTS**

	<b>Page</b>
ABSTRACT	ii
DEDICATION	iii
LIST OF FIGURES	vi
LIST OF TABLES	vii
ACKNOWLEDGMENTS	viii
<b>1. Introduction</b>	1
Objectives	2
Conclusion	4
<b>2. Literature Review</b>	6
Women & Sexuality	6
Definitions of Sexual Abuse and Long Term Effects	10
Effects on Sexuality	19
Treatment Recommendations	36
Conclusion	38
<b>3. Intervention Model</b>	41
Introduction	41
Why a Group???	42
The Setting	46
Supervision	47
The Client Group	48
Screening Interviews	50
Structure and Format	58
Sessional Structure	59
The Program: Content and Process - Session One - Twelve	62
Conclusion	92

	<b>Page</b>
<b>4. Outcomes</b>	96
Introduction	96
Method	97
Results	104
Advantages and Limitations	123
Threats to Internal and External Validity	125
Additional Problems	127
Conclusion	129
<b>5. Conclusion</b>	131
Overview of Findings	131
Recommendations	141
Conclusion	144
<b>References</b>	146
<b>Appendices</b>	151
A. Letter of Introduction	153
B. Contract for Service and Audio/Visual Authorization	156
C. Group Guidelines	158
D. Topic List	162
E. Weekly Group Report	164
F. Family of Origin Questions	167
G. Index of Self-Esteem	171
H. Generalized Contentment Scale	174
I. Miller Social Intimacy Scale	177
J. Negative Attitudes Towards Masturbation	180
K. Group Evaluation Form	183

**LIST OF FIGURES**

	<b>Page</b>
Figure 1 - Index of Self-Esteem	107
Figure 2 - Generalized Contentment Scale	110
Figure 3 - Miller Social Intimacy Scale	113
Figure 4 - Negative Attitudes Towards Masturbation Inventory	115

**LIST OF TABLES**

	<b>Page</b>
Table 1 - Index of Self-Esteem	106
Table 2 - Generalized Contentment Scale	109
Table 3 - Miller's Social Intimacy Scale	112
Table 4 - Negative Attitudes Towards Masturbation Inventory	114
Tables 5-15 - Group Evaluation	117

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## **CHAPTER ONE**

### **Introduction**

We often talk about sex. We hear the word on television and in conversations. We read about sex in magazines and books. However, it would seem that although we use the word we do not give much thought to what we mean when we do use it. Do we mean sex, as in gender, or do we mean the sexual responses and reactions that we have for someone to whom we are attracted; or, do we mean "love"? When we speak of our sexuality, are we talking about our bodies, our emotions or what it is that makes us who and what we are? As I thought and read about sex and sexuality, I realized that we are talking about all of these things. It is about who we are as male or female, how we come to know our bodies, our emotions and our actions and it is about intimacy and relationships.

Women with whom I work in counselling situations, often raise issues related to sexuality, either in individual sessions or in groups. The topic is discussed sometimes through giggles and laughs and sometimes through tears and anger. I began thinking more about sexuality and its meaning, as I began working with female adult survivors of childhood sexual abuse. ( The term "survivor" will be used throughout to refer to women who have experienced childhood sexual abuse.). Most survivors, at some time or the other during the counselling process discuss problems they experience with sexuality. Many women express confusion about their sexuality. Most claim that they do not enjoy sex, even if it feels good, and instead experience guilt and shame about their sexuality. Some wonder why they are having problems with intimacy and trust. Some women express concern because they engage in risky sexual behaviour in spite of their fears of contacting

STDs or HIV. They may decide to abstain from sex for a period of time or have many sexual partners. Some question whether they are straight, lesbian or bisexual. The majority talk about hating their bodies and themselves. On the outside - everything is in place, is "perfect" (unless of course "you screw up" in order to prove badness), but on the inside many say that there is a void, a sense of numbness and confusion.

I have become aware that the women who shared their stories with me are in a great deal of pain and inner turmoil about who they are. The sexual victimization that they have suffered and survived has left a mark only they know and feel. It is about the essence of their very being, about whom they are as women, about how they project their womanhood onto the world and about how their femaleness has been distorted and shamed. They have worked hard to cover up their pain and shame and have become weary doing it. It is with this in mind and through feed back from survivors, that I decided to focus on sexuality and the effects that childhood sexual abuse has had on their sexuality. Additionally, I will be concentrating on the effects sexual abuse has specifically on adult female survivors' sexuality. I am aware that males also experience the life long effects of sexual abuse, but the focus of this paper remains with women.

### **Objectives**

When I decided that I would like to offer a group on sexuality for survivors I discovered that there were very few resources to draw upon. Most of the information that I read discussed different techniques and exercises that could be used either individually or in a group format (Dolan, 1991; Covington, 1991; Maltz, 1991 and Westerlund, 1992). I had offered groups in the past that were more general in nature. These groups focused on

the long term effects that sexual abuse has on trust and boundaries, for example; and offered group members an opportunity to share their stories and explore their anger and pain. However, I was not able to find examples of groups that focused specifically on issues related to sexuality. In spite of this, as I read through the literature I began to formulate ideas about a group; about what I hoped to learn and what I hoped would be accomplished in a group setting.

An important goal was to discover whether group intervention would help survivors identify their meanings of sexuality and discover how the abuse affected their attitudes about sex, intimacy and relationships. It would be an opportunity to explore the triggers in the environment and in their relationships that interfered with their ability to fully enjoy sex and experience intimacy. I hoped that they would be able to share their experiences and learn how to intervene when they were “triggered” and experiencing a flashback.

As well, survivors generally do not consider their own feelings, needs or wants. They often ignore the messages their bodies or “inner voices” are giving them and have a great deal of difficulty saying no to any requests from others, whether they are sexual or not. I hoped that this group would provide a format for survivors to begin to listen to their body messages and to act upon them.

I also identified additional goals. If this group was successful I would like to offer it again in the future. Additionally, because I was video-taping each session, I hoped to be clearer about my own facilitation style and enhance and improve upon it.

Ultimately, this group was for the women. Although the focus was on sexuality, I also hoped to facilitate a format open enough that women could explore their experiences and

gain insight into their problems. I am interested in their experiences, what they feel they need to change, and how they can bring about changes given their own special circumstances. In my experience with groups, women bring problems they are experiencing to the group in order to receive support and suggestions from others in the group. I hoped that they would continue to do this.

### **Conclusion**

The purpose of this report is to describe the group process and evaluate the effectiveness of this model in changing survivors' understanding of sexuality and attitudes they hold towards their sexuality. In Chapter Two the literature will be reviewed. I discuss the effects childhood sexual abuse has on survivors and then describe the effects the abuse has on sexuality. This section is divided into three sub-sections. First, I explore the influence the family of origin has on a survivor's attitudes and beliefs about her sexuality. Secondly, body perception is discussed and the effects sexual abuse has on a survivor's ability to know her body; to know the messages it gives her, the ability to care for herself, and to own her body. Lastly, I explore the effects the abuse has on a survivor's sexual responsiveness.

Chapter Three examines the intervention utilized. The rationale for using a group format is discussed. I explore the feminist perspective that is at the foundation of my work. This chapter describes the setting, who was involved, how the selection was made and why and other aspects of the program including supervision, group topics and structure.

The fourth chapter explores the outcome of the group. I also discuss the type of evaluation tools used and the findings. I will discuss the advantages and limitations of the tools that I chose. Although I provide graphs and statistics, the majority of the results are more descriptive in nature and can only describe what occurred for this particular group.

Finally, the last chapter explores my learning goals and whether I accomplished what I had hoped. I discuss my working style and my limitations and strengths. I examine what appeared to work well in the group and what didn't work and suggest changes. Finally, I put forward recommendations regarding whether or not this type of group should be offered in the future.

## **CHAPTER TWO**

### **Literature Review**

#### **Women and Sexuality**

Women in therapy often express concerns about their sexuality. At one time I thought that this would be one of the last issues that would arise during the counselling process and would likely be the most difficult to address. However, I discovered that this is not the case. Women at various stages of healing and at different times in the counselling process will bring up the topic. Wendy Maltz (1991) shares similar experiences in her book, The Sexual Healing Journey: A Guide for Survivors of Sexual Abuse. She found that healing is not linear and women present concerns regarding their sexuality at different stages in the healing process (p. xvii).

The trauma that survivors experienced as children has a profound effect on how they relate to others on a daily basis and how they feel about themselves as persons. I also discovered that as I read about sexual abuse there was an occasional reference to sexuality and the relationship women have with their bodies. Unfortunately, there has not been a great deal written specifically on this topic. I have found some useful information from the addictions field, in which a great deal of work has been done on co-dependency and the problems created for both men and women who grow up in a dysfunctional family (Covington, 1991 and Woititz, 1989). In addition, Hutchinson, (1985), describes a series of visualizations to help women accept their bodies.

As I read through the literature, the majority of authors discussed the problems that women generally face regarding sexuality (Bass and Davis, 1988; Briere, 1992; Covington, 1991; Dolan, 1991 and Maltz, 1991). From the very moment we are identified as either male or female, society places certain expectations upon us. Stephanie Covington (1991) discusses, in her book, Awakening Your Sexuality: A Guide for Recovering Women, the messages we learn as we grow up; messages based on our gender. These messages affect our self-image and how we act in the world. As females we are taught to please men at our own expense. This message incorrectly recognizes straight relationships as the only legitimate kind of relationship between two people. This message also negates our friendships with women and sets us up to compete with other women for the attention and love (sex?) of a man. We are to be passive but at the same time good in bed. As Covington (1991) states to make the point; “What a man really wants is a whore in the bedroom and a virgin at the breakfast table” (p. 10). This mixed message is terribly confusing but it is ever present in our daily lives, in the media and in our conversations. A woman’s sexuality is good if it benefits someone else but bad if she is too knowledgeable and seeks to please herself. Even if we pretend or try to be “whores” in the bedroom, we better pretend in the light of day that we know nothing about our sexuality and project an innocent and virginal image.

In addition to these conflicting messages and beliefs, many of the writings and religious teachings use the word “he” to describe both men and women. The omission of “she” in writing and language eliminates 50% of the population and renders us invisible. Once again our experiences and voices are silenced. We are considered evil and require a

strong hand to tame our naturally wild natures. Women must pay for the sins of Eve but we never are able to atone for our inherent evil. We are referred to as sluts and whores or called frigid and cold. In spite of the sexual revolution of the late 60's we have been tormented with guilt and shame about our sexuality and have been told directly and not so directly that our needs do not count (Covington, 1991, pp. 10-11).

Society views women's sexuality as something that is disconnected from the rest of their being, as if it is some "thing" that is foreign and outside them. Covington (1991); Maltz (1991) and Woititz (1989) regard sexuality in a more holistic way. This view does not separate a woman's body into parts, such as "breasts, legs, and vaginas", but takes into consideration the whole woman. Sexuality is a part of our emotional, physical, psychological, and spiritual selves. Sexuality is about many things. It is about the meaning of being male or female. It is about sex, love and intimacy and our right to be involved in healthy friendships and sexual relationships. It also means having the choice to refuse sex (Maltz, 1991, p. xvii). When describing her experience with women in recovery, Stephanie Covington (1991) writes; "The message implicit in these women's experiences is that sexuality is much more than sexual behaviour. It's an identification, an activity, a drive, a biological process, an orientation, an outlook. Its content is physical, emotional, psychological, and spiritual. Sexuality is a lifelong process of discovery, a totality of who we are and how we are in the world" (p. 26). This broader definition of sexuality encompasses woman as a total person and embraces the very core of her being.

If women generally feel a great deal of confusion about their sexuality and are blocked from experiencing it, what is the impact that sexual abuse has on a woman's sense

of herself as a sexual being and a woman? Many books have been written since the 70's and 80's when feminists began to listen to and believe the stories that women had to tell them about their lives and experiences. The overwhelming aspect of these stories that feminists became aware of, was the number of women who came forward to talk about their childhood sexual abuse. Covington (1991) relates that approximately 38% of women in the US have been abused sexually before they are 18 years old (p. 41). John Briere (1992) quotes the numbers to be 20-30% for females and 10-15% for males where there is sexual contact " ... ranging from fondling to intercourse ...." ( p. 4). In Canada it is estimated that 1 in 3 females have experienced some form of unwanted sexual contact before 18 years of age and that 1 in 6 males have experienced the same (Samson, 1991, p.2 ). Many researchers and therapists believe the incident to be much higher. Covington (1991) discusses one finding that states 100% of alcoholic women were assaulted sexually before they began using alcohol (p. 41). This is relevant because as will be discussed later, alcohol is often used as a way to cope with painful memories of sexual abuse and to avoid the feelings associated with the memories.

An issue that concerns some survivors is sexual orientation, which I will discuss in more detail later. Some women who have been sexually abused by either males or females will question their sexual orientation and wonder if they are lesbian (Westerlund, 1992; Maltz, 1991 and Bass and Davis, 1988). Some women may experiment with their sexual orientation and others are clear about it (Westerlund, 1992). However, it appears that sexual orientation seems to be irrelevant when comparing sexual orientation of women and the overall effects that sexual abuse has on relationships. Regardless of sexual orientation,

women's relationships are affected by the trauma they experienced in their childhood. However, a lesbian may be placed in double jeopardy. She will be experiencing not only the effects of sexual abuse but will also be subjected to the negative attitudes that society holds towards her as a lesbian. She may even incorporate these attitudes into her own values and beliefs. However, I believe that lesbian and gay relationships are legitimate. As a way to acknowledge this, I use the term partner to refer to the other person in a survivor's life.

### **Definitions of Sexual Abuse and Long Term Effects**

Janet Woititz (1989) describes sexual abuse as “. . . any experience or attitude imposed on an individual that gets in the way of the development of healthy sexual responses or behaviours (p. 1).” As can be seen, this definition encompasses much more than sexual contact. It is now recognized that for behaviour to be deemed sexually abusive, it does not have to be direct sexual contact between an older person and a child (Maltz, 1991 and Woititz, 1989). As well, an offender does not have to be necessarily related by blood for abuse to be considered incest. Any one holding a position of authority and also of trust within a family can be included when discussing incest and its effects (Dolan, 1991; Maltz, 1991 and Westerlund, 1992). This includes abuse by siblings where they have greater authority and power over their brothers and/or sisters. Attitudes as well as behaviours can also have a profound effect on a person. Force or coercion is used to get something from someone. In the case of sexual abuse, an older person, usually an adult, is in a position of power over a child. The child does not have the power to protest or may not know they even have that option. The child is manipulated, coerced, or

threatened to engage in sexual acts or to feel humiliated and embarrassed by certain behaviours. Wendy Maltz (1991) in describing sexual abuse writes, "Sexual feelings and behaviour are used to degrade, humiliate, control, hurt, or otherwise use another person. Coercion or betrayal often play into sexual abuse"(p. 31).

John Briere (1992) has broadened his focus to include all forms of abuse that can be traumatizing to a child. He recognizes that sexual abuse is a more severe form of abuse but believes that the symptoms seen in sexual abuse survivors are present in survivors who have experienced other forms of abuse (physical, emotional, psychological). Herman (1992) also focuses on trauma and its effects on men and women. This is important to mention because clients who have experienced physical abuse, neglect, or who have witnessed abuse can and do present with similar problems even though they have not been sexually abused. As well, sexual abuse goes hand in hand with other forms of abuse and definitely is emotionally abusive. For my own purposes I am focusing on sexual abuse, but it seems that further research into childhood trauma and effects needs to be done.

Maltz (1991) and Woititz (1989) each discuss a continuum of sexual abuse, from covert to more overt forms. Covert or indirect forms of sexual abuse are much more subtle but can be just as traumatizing to the child. The child is affected on an emotional level. Some examples of indirect sexual abuse that are taken from both the readings and my own practice are; not allowing a child or adolescent privacy in the bathroom, making inappropriate sexual remarks to a child or adolescent, becoming upset or jealous if the child goes out on a date or following them while they are out, a parent or care giver calling a child or adolescent derogatory names such as "slut", "boy toy", or "she dog", or

explicitly talking to a child about the parents' or adults' sex life (Maltz, 1991 and Woititz, 1989). There are many other examples that can subtly affect a child's development, attitudes and beliefs about who they are. This can result in a life time of guilt and shame.

Examples of overt or direct forms of sexual abuse are; inappropriate nudity, fondling, kissing inappropriately on the lips, oral sex, masturbating self in front of the child or using the child to masturbate the adult or masturbating the child, intercourse, sodomy, and other forms of penetration (Maltz, 1991 and Woititz, 1989).

Sexual abuse leaves in its wake long term problems for the survivor. Damage has been done to the child that affects every aspect of her life. All books on sexual abuse discuss the long term effects that sexual abuse has on a child. Every survivor copes differently with their abuse. Most have problems trusting others, including themselves. Others have problems with intimacy and relationships. Some women misuse alcohol and drugs to cope. Briere (1992), Herman (1992) and Dolan (1991) discuss post traumatic stress syndrome and forms of dissociation and dissociating behaviours that develop in the survivor. This symptom is not new and is discussed by Herman (1992) in her book Trauma and Recovery . Freud identified post-traumatic stress in the 1800's but at the time the term hysteria was used. Symptoms of post-traumatic stress were noticed in female patients who were institutionalized. As Freud began working with these women he found that they had been victims of childhood sexual abuse. Although he made this connection he recanted shortly afterward (Herman, 1992). Once again women were disbelieved and left to doubt their own experiences and sanity. Post-traumatic stress syndrome or hysteria was identified again but this time in the men who fought in WW I and II as well as the

Korean and Viet Nam Wars (Herman, 1992). However, it was not until the Viet Nam War and the effects the war had on returning vets that the impact of this disorder was understood (Dolan, 1991 and Herman, 1992). The symptoms associated with post traumatic stress, as seen in veterans, were also described in survivors and were present years after experiencing the original trauma (Dolan, 1991 and Herman, 1992). Therapists then began to examine the relationship between post traumatic stress and childhood sexual abuse.

Post-traumatic stress occurs when a survivor experiences stress in her life that acts as a trigger or reminds her of the original trauma she experienced in her abuse. She will often feel that she is back in the past, re-experiencing the abuse all over again. She may engage in various dissociative behaviours. Briere (1992) describes dissociating “ ... as a defensive disruption in the normally occurring connections among feelings, thoughts, behavior, and memories, consciously or unconsciously invoked in order to reduce psychological distress ....” (p. 36). Survivors may react by numbing or not feeling, or they may "space out" or feel as if they are somewhere else for a period of time. Women have learned in childhood to disconnect their feelings from their thoughts and behaviour. They may become fragmented into many parts in an attempt to cope with the abuse and with the memories.

Survivors often experience frightening nightmares, intrusive thoughts and flashbacks that seem to come out of nowhere and leave the survivor feeling afraid and panic stricken. Often survivors discuss their hypervigilance. They always feel that something bad is going

to happen and thus they must remain on the alert. Because they may experience intrusive thoughts, it becomes difficult to concentrate, which can cause problems at work or in school (Dolan, 1991). Survivors also experience depression and anxiety ( Briere, 1992 and Dolan, 1991). Dissociative Identity Disorder (formerly referred to as Multiple Personality Disorder) is a more extreme but creative form of dissociation that some survivors develop in response to their victimization. The woman develops other personalities that are very different from one another. Switching personalities may be followed by a headache (Dolan, 1991, p. 115). Often the person will have lost time and may develop elaborate plans to keep track of herself. The common problem that arises for survivors when they are dissociated, whether or not they have developed multiple personalities, is that they are not in the present. They are in the past, re-experiencing the trauma and fear and they are desperately trying to forget the experience. As a result, some survivors have difficulty attending to their present situation, to the “here and now”.

Dissociation also affects memory. Many survivors have some memories about certain events but have blank periods in their lives. Others remember clearly what has happened. For many, memories that have been dissociated are sometimes triggered by an event that resembles the original trauma. For instance, some women I have worked with, found that their child's victimization has triggered their own memories. At times when a survivor's child reaches the same age the survivor was at the onset of her own abuse, she may begin to remember. For many women it seems that once they begin talking about the abuse that is in their memory, other memories are triggered.

I would like to mention the controversy amongst therapists regarding the retrieval of dissociated memory. Some therapists, for example, Yvonne Dolan (1991), for one, uses hypnosis to help a survivor access memories. Dolan (1991) describes ways a practitioner can access memory through the use of Eriksonian hypnotic techniques. Other therapists believe, as I do, that, it is best to work with the memory that is present (Briere, 1991 and Sleeth and Barnsley, 1989). The belief held is that a survivor will remember only when she is ready to deal with the memories. There is danger in flooding the survivor with memories and feelings that are too overwhelming for her. An additional concern for therapists is the backlash arising from the efforts of the False Memory Society. Group members have accused therapists of wrongfully suggesting to survivors that they have been sexually abused and therefore, causing problems that are non-existent. Unfortunately, this places therapists in a very vulnerable position and they must be careful about the techniques they use.

At a conference I attended, called "Incest and Dissociation: Healing the Split". the speaker, Christine Courtois, addressed this issue. She is the Clinical Director for Abuse Recovery and Empowerment at the Psychiatric Institute of Washington, D.C. and has worked with survivors for many years. She has also written books and articles in journals and travels the conference circuit discussing her work. At the conference she suggested taping sessions if a therapist is using hypnosis or any other kind of guided visualizations. These emerging issues and controversies have many treatment implications for those of us working with adult survivors. However, fear must not control us. We need to be guided by our ethics and women's decisions about what they believe is most helpful.

Sleeth and Barnsley (1989), in their book, Recollecting Our Lives: Women's Experience of Childhood Sexual Abuse, describe the long term consequences of the abuse. Because a survivor is being violated by a person she has trusted, she will become confused about her identity. The survivor bases this distorted sense of self on the offender's perceptions and rationalizations about the abuse. He is only concerned about meeting his own needs and therefore will distort the child's reality about what is occurring. He can, therefore, convince himself and the child that the abuse is not wrong. This allows him to continue the abuse (Sleeth and Barnsley, 1989). Children do not understand what is happening to them. They do not have anything with which to compare this experience. Often, if she is abused under the guise of love, she will become confused about what is normal. In addition, we are all taught to obey our elders and as children we do not have any other choice. If a child refuses the adult she may learn that she will be hurt physically or threatened with violence. As well, she may be told that if she tells, she will break up the family or she may be blamed for seducing the adult and enjoying the contact. In reality, her boundaries have been violated and she will experience confusion about setting limits for herself, physically, emotionally and sexually. She may express confusion about sex, love and intimacy. Eventually she will blame herself and feel that there is something wrong with her. Even if the abuse is not violent, secrecy blankets the event. If it is not wrong, why is it a "secret", she may wonder.

In order to survive she develops "survival skills" (Sleeth and Barnsley, 1989, pp. 134-173). Some dissociative symptoms, such as numbing and spacing out, have been mentioned earlier in this chapter. However, she may have learned other methods to cope

and keep the secret. She may intellectualize because it is too painful to deal with feelings. Often women I see in my practice are very good at analyzing but when asked about how they feel they do not know. The body can be a source of pain and shame so it is easier to "split" the mind from the body than to deal with the pain (Sleeth and Barnsley, 1989, p. 135). As children they may learn to excel at school and always be the good little girl. Some children fluctuate between failing and excelling, leaving teachers and others wondering about their abilities, perhaps even blaming them. Other children act out or are just too exhausted to concentrate and be present. Other survivors hide and become passive. Many will hide their bodies by wearing baggy clothing or layering. Others may withdraw into books, religions, relationships, or physically withdraw from any social interactions. Alcohol and drugs can also be used to numb unpleasant memories and feelings. Often, survivors, while they are drinking, become even more vulnerable and are open to abuse by others who may take advantage of them. Some may fight and use alcohol to dispel the anger and rage that they feel. Others may use it because it makes it easier to be sexual while intoxicated or high. In the end it is only temporary relief and they feel guilty and worse about themselves when they do use alcohol or drugs. Sometimes drinking or drugging can be followed by suicidal thoughts and actions.

Another skill I have noticed about survivors is their great capacity to laugh and use humour in spite of their pain. In the groups I have facilitated there is always laughter and joking. Although humour can be a positive coping skill, it is sometimes used as a way to cover up the hurt and fear associated with painful memories. Humour is a way for a survivor to feel in control and safe (Sleeth and Barnsley, 1989, p. 143). It can also hide a

survivor's true feelings because she appears in control, at ease and to be doing well. No one will question her or know about her secret.

Survivors also learn how to become helpers and rescuers as a way to avoid their own feelings and to feel worthwhile. At the same time they also become resentful because they are unable to say no to requests. They may act out sexually or in other ways, using drugs and alcohol or sex as a way of reducing the tension they feel. Some run away, especially as adolescents, or fantasize and lie as a way to protect themselves from the reality of their abuse. Others become suicidal for different reasons and some self-mutilate. Some women do want to die, but for others a suicidal attempt or self-mutilating behaviour may be a way to reduce tension. Sometimes self-mutilation is a way to feel other kinds of pain rather than that associated with the abuse or it is a way to know they can feel. At times they may experience an "adrenaline rush or emotional high" that lets them know they are alive (Briere, 1992; Dolan, 1991 and Sleeth and Barnsley, 1989). Again the behaviour can be one way the survivor feels in control of uncontrollable feelings and situations.

Most women that I see have experienced suicidal thoughts but believe that they would not act upon them for various reasons. A minority view suicide as an option and as a way out. For some it has become a pattern, a way to reduce tension and draw attention to the pain they are feeling. The women, for the most part, want to end the pain but they do not necessarily want to end their lives. In whatever way the women have learned to cope and survive the trauma, it has provided them with a sense of control over some aspect of their lives even when the behaviour is self-destructive.

### **Effects On Sexuality**

The intent of this practicum report is to explore the effects sexual abuse has on sexuality. However, in order to discuss this issue I felt that it was also important to understand the wide range of effects and the complex coping mechanisms that women develop during childhood in order to survive. Part of the healing process involves identifying ways in which women have coped with the abuse. Some women in my practice talk about “leaving their bodies” when they are triggered by something that reminds them of the abuse. During the original experience of abuse they learned to view themselves from a corner of the room. They become disconnected from their bodies. I often notice women staring into space with a “far away look” in their eyes. I will gently call them back to the present and invite them to talk about what happened. Some women inform me that they are often unaware of “drifting off”. This frightens them because they are uncertain of the amount of time that has slipped by. Some women I have worked with also use alcohol and drugs to cope with their pain. A woman uses these mechanisms automatically in her everyday contacts with others and it has an impact on her sense of self. These mechanisms have also served her well, and have made unbearable situations livable. That being done, I would now like to focus on sexuality and the impact the abuse has on women who have experienced sexual abuse as a child.

Sexual abuse is about using someone sexually. The effect this has on a child's growing identity and sexuality is far reaching. It is “harm done that robs a person of any or all of his or her sexual rights. When these rights are infringed on in the course of sexual abuse, the

victim's sexuality suffers harm" (Maltz, 1991, p. 35). The areas that are affected and described by Maltz (1991) are:

- the way in which a survivor feels about being female, about her body, genitals and other parts that are female.
- how her body operates.
- what she thinks about sex and expressing sexual feelings.
- how she feels about sexual pleasure and intimacy.

In order to understand the impact sexual abuse has on sexuality, I have organized the paper into three areas. The first area to be explored is the survivor's family of origin and the messages she learned about being female, about roles and about sex, intimacy and love. Next I would like to explore survivors' attitudes learned about their bodies, what it looks like and how it works. Lastly, I would like to explore issues related to sex and intimacy, including sexual orientation, and the effect abuse has on sexual relationships.

### **Family of Origin**

When Sleeth and Barnsley (1989) conducted their research on childhood sexual abuse they asked survivors about their families and what it was like to grow up in their homes. Not everyone is raised by their family of origin. The place where a woman grew up, regardless of whom the caretakers were, can still be considered family. The offender may be a stepfather, lover of a parent or a foster parent. In any case, it is the nature of the relationship that seems to be important and has an impact on the survivor.

Sexual abuse can happen in any family regardless of race, religion, or economic background. In some families, the offender, if it is the father or father figure, may appear as though he is an upstanding citizen who holds down a responsible job and is a loving husband and father. In most cases the atmosphere is one of control and domination (Sleeth and Barnsley, 1987). A survivor's mother may also be physically abused and controlled in other ways, rendering her powerless and unable to protect her children. The confusion in most homes is enormous. Self esteem is undermined and the child is confused. The child becomes uncertain about the expectations caregivers hold of them. I find similar accounts told to me in my own practice. Women often discuss the way in which they and other family members lived in fear of physical abuse and were controlled by someone who had authority over them. In addition, where an older sibling or other relative is the abuser, the same kind of confusion and lack of support from parents may be present. The child does not feel that she can approach her family. The fact that a child does not feel free to tell someone in her family about what is happening may indicate a low level of interaction and trust in a family.

This is not to say all families are unsupportive. Within in my own work, I find that some women do receive a great deal of encouragement and support following disclosure of abuse. Sometimes the love and support comes from a mother or another adult with whom a survivor feels close (Sleeth and Barnsley, 1989). Siblings could also be supportive of each other. In some cases, older siblings may try to protect younger ones from the abuse or they may develop elaborate plans as a way to protect each other from an abusive parent or other person. However, they are still only children who have very little, if any,

power. Sleeth and Barnsley (1989) found that in most cases any positive relationships were discouraged and undermined by the abuser.

Many women were not allowed to have friends or be involved in extra activities at school. Often women were afraid to bring other children home for fear that the offender may try to abuse them. A lot of energy goes into keeping the secret and trying to be safe. In other instances the survivor may have sought refuge in school so that she could stay away from home as much as possible. In any case, it appears that survivors grow up very isolated and alone. Generally they did not receive the protection they required to feel safe and develop trust. Family relations were conflictual and were physically, emotionally and spiritually abusive as well.

Survivors often question their mother's or other non-offending caretaker's knowledge of the abuse (Dolan, 1991; Forward and Craig, 1978; and Bass and Davis, 1988). In some cases there are instances where the child is set up covertly by the non-offending parent. The parent is aware that the abuse is occurring but does nothing to stop it. This is the case when a child discloses, but is not believed. Another possibility is that the non-offending parent, knowing the child is being abused, places her in vulnerable situations and leaves her alone with the offender. Susan Forward and Craig Buck (1978) discuss the non-offending parent's collusion with the abuse on some level, whether it is conscious or unconscious (p. 45). Because women are usually the ones who are responsible for the care of their children they are therefore, the easiest and perhaps the safest to target when abuse has taken place. Although I have concerns that mothers are unduly blamed and held responsible for the abuse, women in therapy, do express a great deal of anger at their

mothers for not protecting them. They need to be able to identify their anger and be given permission to resolve their feelings towards their mothers. However, in my experience it appears that women also are angry at their parents when the offender is a relative or friend of the family. They feel betrayed because of the lack of support and protection they felt from them. There are also examples in the literature where some mothers also participate overtly in the survivor's victimization (Forward and Craig, 1978 and Dolan, 1992). In my own practice a very few women disclosed that their mothers were aware of the abuse but did little to stop it or would leave them alone with the offender. I have not worked with any women, to date, who had been sexually abused by a woman.

Sleeth and Barnsley (1989) also found that in homes where children are being abused, traditional sex roles are adhered to. They found that generally, girls were expected to do all the work in the home including the boys' jobs, but boys were not expected to do the girls' jobs. In my own practice women have discussed being responsible for all the house work and being "little parents" to younger siblings and to their own parents. They try to win approval and will do anything to please and receive some sort of attention from parents. However, they are rarely appreciated and are almost certainly expected to be responsible for duties that are way beyond their years. There is very little value placed on what the survivor did even when it was expected of them (Sleeth and Barnsley, 1989, pp. 46-47). Many learn to try harder in order to please others but there is often no reward for them at the end. Some survivors in my practice point out that they become obsessive about cleanliness in the home and spend hours cleaning and scrubbing. Again this may be a result of trying to receive some recognition and to prove that they are "OK" as people. It

may be a way to hide how they feel inside and it is certainly another thing that is controllable to them. As well, some survivors have difficulty relaxing because when they try to relax they begin to think about the abuse. By keeping busy they can stop themselves from experiencing the pain and it becomes a way to cope with unpleasant memories and feelings. However, it also takes its toll and causes a great deal of conflict and unhappiness. They are expected to, and expect to, conform to others' wishes. As in their family of origin, they feel their efforts are never truly appreciated.

Survivors are often taught the importance of displaying traditional feminine characteristics (Sleeth and Barnsley, 1989). The traits that are encouraged are the ones which leave women feeling powerless and voiceless. Little girls are encouraged to be polite, quiet, dependent, nurturing, and passive. These very characteristics are the ones that offenders prey upon and encourage in order to victimize children (Sleeth and Barnsley, 1989, p. 47). Wendy Maltz (1991) discusses the way in which an offender grooms a girl to accept sexual abuse and eventually intercourse. They may start by bathing them and spending time in the bathroom or bedroom. They then begin to prepare the child to engage in touching and other forms of fondling. Although some may stop here, some will eventually engage in intercourse with them. For some survivors the abuse will begin under the guise of love and the offender may tell her that the abuse is a way that people express affection towards each other (Maltz, 1991 and Sleeth and Barnsley, 1989). However, as women have told me, there is an underlying sense that they dare not refuse. Often the abuse becomes violent or there is a threat of violence if they do protest. The

ultimate outcome, regardless of the tactics the offender uses, is that independence and autonomy are not encouraged, ensuring the survivor's silence and compliance.

In families we also learn about affection and love and the way in which we can express these emotions. Sleeth and Barnsley (1989) found that for the most part survivors did not receive a lot of affection or tenderness in their families. Besides the emotional distance, families that are abusive do not display any affection for one another openly. However, on the other hand, in my practice some women mention that their families often displayed inappropriate affection towards one another. Inappropriate nudity, touching, kissing or sexual intercourse between parents in front of children, at times occurs causing a great deal of confusion and reinforcing the belief that all relationships are sexual. Survivors may grow up thinking that this kind of behaviour is normal. Although these examples may seem as if they are on opposite ends of the continuum, the common components are that boundaries are violated and the survivor is in a double bind. In the first instance the abuse is hidden, no one touches any one openly. In the second instance the abuse is overt, everyone is aware that it is happening but no one is acknowledging it.

A survivor learns that their needs do not count. They are not able to distinguish between a positive display of affection and abusive behaviour. Their boundaries become confused because on the one hand the kind of touch and affection displayed is inappropriate and abusive but on the other hand they may not know any other kind of touch or expression of love. The child and later adult may not know the difference between abusive and non-abusive touch. They may grow up believing that any kind of

touch between two people is sexual in nature and abusive (Sleeth and Barnsley, 1989 and Maltz, 1991).

It is not surprising then that women experience a great deal of confusion regarding relationships and their role in them. Because survivors have learned to be passive and care for others' needs, they will have a great deal of difficulty putting their own needs first (Bass and Davis, 1988 and Engel, 1989). In fact the thought of putting one's self first can be very frightening to even consider. They may believe that women do not have any power and that their role is to do what is expected of them above all else. Many may find themselves in adult relationships where the domination and abuse they grew up with continues. They may also find it difficult to express any kind of emotion towards a partner or show any affection because of the connection to the abuse. As well, they may experience overwhelming feelings and flashbacks with a partner that may lead to avoidance of any kind of touch or sexual contact (Maltz, 1991).

Another issue with which women may have difficulty, is expressing affection and love towards their own children. Many survivors in my practice have made a concentrated effort to hug and kiss their children. They do not want to repeat the same patterns that they learned in their childhood. However, in spite of this, many survivors are fearful that they will repeat the abuse and have difficulty touching their children or bathing them after their children reach a particular age (Bass and Davis, 1988). In some instances the fear can become so overwhelming for the survivor that they may avoid all physical contact with their own children. Children need to be touched and to learn about appropriate expressions of affection. When parents avoid this aspect of the relationship, their children

may seek out affection elsewhere and become vulnerable to abuse. The survivor, in her role as mother, unintentionally may be placing her own children at risk for future abuse (Sleeth and Barnsley, 1989).

### **Body Perception**

The second issue for survivors is the effect sexual abuse has on their perception of their bodies. The abuse is something that is done to the body. It is the body that we live in and it is the body that has betrayed the survivor. Many survivors hate their bodies and blame themselves for the abuse (Bass and Davis, 1988). Survivors that I have worked with felt that perhaps they were too cute or not cute enough or they were bad or stupid. Maybe they liked it, especially if their bodies reacted to touch. They believe that it is wrong to feel any joy or to enjoy bodily sensations (Sleeth and Barnsley, 1989). If they do feel any pleasure, it is associated with the abuse, resulting in feelings of guilt and shame. Ultimately they believe that it was something about them that caused the abuse.

Survivors learn to cope with the abuse by developing the survival skills that have been discussed previously. Many survivors talk about "splitting". They were not present during the abuse, mentally and emotionally, and could not feel anything. Some talk about leaving their bodies and viewing the abuse from the corner of a room. Splitting is a form of dissociation and in some fashion has been used as a way to create a boundary between themselves and the abuser (Sleeth and Barnsley, 1989, p.133). When the situation is stressful the survivor can "leave" emotionally and does not have to experience the fear and confusion. This coping mechanism is carried into adulthood when a situation becomes stressful or scary (Bass and Davis, 1988). Some survivors in my practice talk about the

embarrassment they feel when they "leave" because they do not know what is going on or what is being said.

An issue related to the body and dissociation is the difficulty a survivor may have identifying and knowing what she is feeling. Sleeth and Barnsley (1989) write, "For the survivor, the result is loss of partial or full use of her emotional or intellectual ability to distinguish or recognize her own feelings and thoughts. She loses the ability to know herself and to feel good about herself until she can recollect the lost pieces of her life (p. 134)." The survivor needs to talk about her experiences so that they become real to her and she then can begin to feel anger, sadness and hurt, as well as happiness and joy .

As mentioned above, the survivor may lose the ability to feel sensations in her body (Bass and Davis, 1988; Dolan, 1991; Engel, 1989 and Sleeth and Barnsley, 1989 ). Because she has learned to split herself off from her body it becomes difficult for her to know what she is feeling and she may not be able to respond appropriately to her environment. As women, we speak of our ability to sense or know. We call this intuition. It is our inner voice that talks to us, that sometimes tries to guide us in our everyday encounters. However, when a child's sense of reality is denied, as it is with survivors, as an adult she loses the ability to trust in her "gut feelings" (Dolan, 1991). She may become other directed and have difficulty knowing and believing in herself. She may even find herself in vulnerable positions and unable to react to signals that tell her she is in danger. On the other hand she may not be able to enjoy herself fully because she is unable to trust in herself while she is interacting with others. When this occurs women lose their voice and are silenced. Helping survivors to develop a positive relationship with their bodies by

learning to listen to the messages their bodies are telling them will assist them to identify their feelings and to know what they want and need. This can lead to an end to dissociation (Dolan, 1991; Engel, 1989 and Sleeth and Barnsley, 1989).

When we do not listen to our bodies we most likely will not take care of them. By ignoring the body's signals we will become physically exhausted and ill (Bass and Davis, 1988). Because survivors have been trained to ignore their own needs it is very difficult for them to take care of themselves. They have trouble sleeping, may not exercise or may become addicted to alcohol, drugs or food. Self-mutilation is a way of hurting the body as well, as is starving or vomiting. In order to care for the body, survivors need to know how to feel and then to act on what they feel is right for themselves. This is difficult. Survivors may feel they do not deserve to care for themselves or have their needs met. They need to take tiny steps that lead to self-care. Most survivors that I have worked with have come to a point in their lives where they are beginning to work on self-care and part of this is learning to identify and express feelings. Because women, generally, have been taught to care for everyone else, and especially so for survivors, lessons in self-care are an on-going challenge for all women.

Because survivors loathe their bodies they may not be aware of how their bodies function or in particular what their genitals look like (Covington, 1991 and Westerlund, 1992). In her research on sexuality in survivors, Elaine Westerlund (1991) discovered that 74 percent of the women reported "Negative and/or distorted body perception.... (p. 52)". Women hated their bodies and felt that they did not own them. They felt they had no control over their bodies and were disgusted with the way their bodies responded sexually.

As well, survivors may have difficulty looking at their bodies because of the shame (Maltz, 1991). They do not know their bodies, what they look like or the differences between women's bodies. They also may not know what their genitals look like and are unaware of the variation between women, because they may feel they are damaged in some way as a result of the abuse (Maltz, 1991 and Westerlund, 1991).

Westerlund (1991) also discovered that many survivors experience a lot of difficulty regarding reproduction and pregnancy. Their concerns revolved around parenting issues and fears related to either repeating the abuse or being over protective. Some survivors also felt that their bodies were out of their control once they became pregnant. This feeling of a loss of control was also reported by women during the birthing process (Westerlund, 1991).

As mentioned, women may not have been taught about their bodies and how they function. As we grow and enter puberty, our bodies change and this can be frightening. Sleeth and Barnsley (1989) found that information about the body, about menstruation and pregnancy, was not talked about in their homes. As a result a survivor learns that the body is something to be ashamed of and feared. As well, adding to this are the negative images that women live with regarding their bodies. Covington (1991) discusses the repulsion that women feel towards their bodies. The words used to describe a woman's genitals are degrading and a source of shame.

Recently it has become popular in the media for a grown woman to resemble a starving waif. These images are of women who have no bosoms or hips, and may resemble

young boys or little girls. Given the difficulty survivors have with their own bodies, these images could only contribute to further self-loathing and fear of the body.

### **Sexual Responsiveness**

The third issue, that ties into body function, is how the body responds sexually to touch. This is a source of pain and disgust for many survivors because as children their bodies may have responded to sexual stimulation (Maltz, 1991; Sleeth and Barnsley, 1989 and Westerlund, 1992). The offender may have used the survivor's response as a way to justify the abuse and blame her for it. She, therefore, feels a great deal of shame about any sexual response she may have with a partner or by herself. As well, some may not even be aware of the stages of sexual arousal or they may not believe that it is normal for a body to react to sexual stimulation (Covington, 1991; Maltz, 1992 and Westerlund, 1992). Relationships can be sexualized and therefore, women may not be able to identify the process involved in developing a relationship with a sexual partner. In my work with prostitutes a young woman could tell anyone how to make a man "come" in 10 seconds flat, but she was unable to describe what an orgasm was in relation to her own bodily responses. Because survivors were children when they were abused, they did not have the words or the knowledge to know what was happening to them (Sleeth and Barnsley, 1989). Often, survivors in my practice, consider themselves to be virgins because any sexual contact they had was not viewed as a choice and they did not feel that they had fully experienced sexual pleasure.

**a. Sexual Orientation**

In her study of women who were sexually abused as children, Elaine Westerlund (1992) asked her interviewees questions regarding sexual preference and lifestyle. She found that the survivors were confused over their sexual orientation. She reports that heterosexual women were under-represented in her study (p.36). However, she states that her findings do not support nor contradict the belief that sexual abuse causes women to chose a lesbian orientation (p.72). However, she did find that those women who were celibate or undecided about sexual orientation, perceived that the sexual abuse did influence their orientation (p.72). Wendy Maltz (1991) suggests that sexual abuse does not cause a survivor to be lesbian, heterosexual or bisexual but it can affect the way in which she defines her orientation. What she states is that "Some survivors adopt the sexual orientation role they had in the abuse (Maltz, 1991, p.126)." A survivor may assume that she is a lesbian or not, depending on the sex of the abuser. If the abuser was male she may believe she is heterosexual or if the abuser was a female, then she may believe she is a lesbian. If she is comfortable with this role then it may not be a problem for her. The survivor may label herself as either one or the other even if it is contrary to the way she really feels inside. That is, she may feel inside that she is a lesbian but denies this because of her experience of sexual abuse. Maltz (1991) states, "But if a survivor identified with a different sexual orientation before the abuse, or had not yet identified an orientation, this influence can be disturbing and confusing, and even lead to years of unhappiness" (p. 126). As well Maltz (1991) suggests that a survivor may identify with a certain sexual orientation because of the sexual arousal that may be associated with the abuse. As Maltz

(1991) suggests; "Sexual abuse can teach us arousal patterns that affect how we define our sexual orientation" (p. 127). If a woman is not responding sexually to a male partner she may believe she is a lesbian. Therefore, sexual orientation may be a reaction to the abuse causing a survivor to believe that she is of one sexual orientation over another.

Westerlund (1992) suggests that women have not had the opportunity to express themselves on issues related to sexual preference.

In my own practice, women often discuss their confusion about sexual orientation but all the survivors I have worked with to date, have been heterosexual, as far as I am aware. This could be that women are fearful of admitting any sexual attraction to other women because of the social stigma that lesbians face. As well, in a small town it is very difficult to be anonymous and it may be that women try to hide the fact that they are lesbians. It would appear that much more research needs to be directed into exploring the question of sexual abuse and sexual orientation. However, it would appear that sexual abuse does not seem to be a determining factor regarding a survivor's sexual orientation.

**b. Intimacy**

Many survivors are confused about intimacy and sex, often thinking they are the same. As a result women experience difficulty in their relationships with partners (Bass and Davis, 1988; Briere, 1992; Dolan, 1991; Jehu 1987; Maltz, 1991; Sleeth and Barnsley, 1989 and Westerlund, 1992). Because they have been hurt in family relationships, by someone they trusted, they may experience great difficulty trusting any partner. Many women discuss the fear they experience when a relationship becomes too close. They expect that the partner will abuse them and the survivor may try to sabotage a

relationship. Some women feel more in control if they are involved in "one night stands", partly because there are no expectations placed on the relationship (Briere, 1992; Maltz, 1991 and Westerlund, 1992). At the same time that they are pushing away a partner, they will express anger at themselves because they long for intimacy and love. As well, Briere (1992) suggests that engaging in compulsive sexual activities is a way for the survivor to reduce tension and soothe herself (p.159). Overall, Westerlund (1992) found that survivors as adults tended to be more inhibited in their sexual relationships and generally avoided sexual contact with a partner.

c. Sex

The literature indicates that survivors experience a great deal of problems with their sexual functioning. Because survivors have learned that their needs do not matter they may feel that they can not refuse sexual advances (Maltz, 1991; Engel, 1989 and Sleeth and Barnsley, 1989). They may not find sex very pleasurable. Many survivors report that they experience flashbacks during sexual contact. Often something the partner has done will remind the survivor of her abuse and will trigger a reaction from her. During these flashbacks the partner does, in essence, become the abuser. Many survivors feel they are unable to stop their partners or to say no in spite of the fear they experience. Survivors may also split from the experience so that they do not have to feel anything. Survivors that I have worked with say that they often "do it" to please their partner and can hardly wait for sex to be over. They express anger at themselves and their partners because they want to enjoy sex with their partner and they are impatient with themselves for being blocked in their sexual responses.

Some survivors develop such extreme physical reactions to sexual contact that they are unable to engage in any kind of sexual activity or even be examined internally by a doctor. As well, a survivor may experience painful intercourse. The first condition has been identified as vaginismus, an actual contraction of the muscles of the vaginal wall that make intercourse or any internal exam extremely painful and impossible (Maltz, 1991 and Masters, Johnson and Kolodny, 1982 ). The second condition is known as dyspareunia, a burning or cramping that can flare up during intercourse (Maltz, 1991). Although Masters, Johnson and Kolodny (1982 ) mention sexual abuse as a contributing factor to sexual problems in women, they do not focus on it to any great extent. Jehu (1987), Maltz (1991) and Westerlund (1992) discuss these conditions in more detail and focus on the sexual abuse as a causative factor. They assist women therapeutically to overcome these conditions through various exercises involving progressive touch and suggest that women use vaginal dilators for such conditions as vaginismus. In addition, Maltz (1991) found in her own work, that survivors did not respond well to traditional sex therapy because they need to focus on the effect sexual abuse has on their sexuality, something traditional sex therapy has not done.

Besides the physical problems affecting sexual activity, survivors may not feel any desire for sex and if they do it is associated with shame and guilt ( Maltz, 1991 and Westerlund, 1992). They may experience disturbing sexual fantasies that are related to their abuse and therefore have difficulty continuing with sex. They may also become compulsive about sex and rely on their fantasies of abuse in order to be aroused. In addition Maltz (1991) and Westerlund (1992) found that many survivors can not

experience orgasm ,or they may reach orgasm very quickly, but it appears to be out of their control. Survivors have come to think of sex as something that is uncontrollable and done to them. As a result of their sexual victimization they have developed what Wendy Maltz (1991) terms a “Sexual Abuse Mind-Set” (p.86). Sex is bad, dangerous, shameful and either should be avoided or done in secret. Their belief becomes so ingrained that it is difficult to view sex as healthy and pleasurable. Our society's attitudes towards women contribute as well to this mind-set.

Maltz (1991) describes five components of healthy sexuality. They are; "consent, equality, respect, trust, and safety, or CERTS" (p. 88). If these conditions are not present in a survivor's relationship then the negative attitudes and mind-set will continue and be reinforced. It is important for survivors to befriend themselves and learn to change their old responses. It is also important that they begin to challenge their unhealthy beliefs and nurture healthier lifestyles and choices. This is difficult for survivors if they are in relationships that are abusive and disrespectful of their rights. However, in time, survivors can make changes and with the support of others who respect their choices, they can heal and live fulfilling lives.

### **Treatment Recommendations**

Westerlund (1991) offers treatment recommendations specifically regarding the treatment of sexuality issues. She has developed an aerobic training group for survivors called I.R.Obics. This is specifically geared for survivors and takes into account their special needs and concerns about their bodies. Besides working with the body she proposes that treatment should incorporate an educational and cognitive/behavioural

component. Understanding the root of their problems and then identifying and changing negative thoughts and beliefs can help a survivor lessen feelings of anger, guilt, and shame. She suggests methods to deal with displaced anger and guilt and recommends corrective cognitive techniques that can interrupt flashbacks a survivor experiences during sexual contact with a partner.

Maltz (1991) also uses a cognitive approach when working with survivors. Clients are taught how to interrupt negative thoughts or the sexual abuse mind-set mentioned earlier by identifying and changing automatic reactions. It is important for survivors to recognize their reactions and then identify the triggers. Often these triggers resemble the original trauma or remind the survivor of their victimization. A response or set of responses is set in motion that can have a devastating effect on the survivor. Specifically, Maltz (1991) is speaking of how these automatic reactions affect sexual relationships. She offers a four step approach to handle automatic reactions that survivors can learn to use when they are being triggered and experiencing flashbacks. These four steps are, “stop and become aware, calm yourself, affirm your present reality and choose a new response” (Maltz, 1991, p. 161).

These steps are similar to the grounding exercises that other therapists suggest and have written about (Bass and Davis, 1988 and Dolan, 1991). Grounding helps a survivor to be present. She can learn to gently bring herself back to the here and now. Yvonne Dolan (1991) suggests the use of a visualization for comfort and safety which can help the survivor imagine a place that is safe and relaxing when she is reacting automatically to triggers or experiencing flashbacks (p.102-103). She also suggests that survivors consider

body work, such as massage or aerobics, to help them along with their healing. Writing a letter to body parts and drawing the body are some suggestions she makes to facilitate healing. Regarding issues related to sex she suggests solution-focused techniques that draw upon experiences that survivors had that were pleasurable or sensual. She encourages them to explore the situations they occurred under, what it felt like and then do more of them. By doing this a survivor can sensitize herself and then experiment with different kinds of touch as she notices that she is feeling good about herself and her partner (p. 166).

Jehu (1987), Maltz (1991) and Westerlund (1991) suggest exercises that will slowly assist a woman to experience pleasure. Survivors can be taught deep relaxation techniques to help them be aware of their bodies. Maltz (1991) offers a wide range of techniques that can help a survivor re-learn touch. Some of the exercises are done alone and others are with a partner but do not involve sexual intercourse. Survivors are also encouraged to experiment with masturbation in order to learn about their bodies and how they respond sexually. Maltz (1991) suggests survivors take a vacation from sex for up to three months. It is essential for a woman involved in a sexual relationship, to have the support of her partner if the therapy is going to have an effect. Providing the partner is supportive and abuse is not present in the relationship, it would be important for the partner to seek out counselling individually or in groups. This can help the partner understand the issues facing the survivor and how she/he can be supportive. At the same time the partner needs to take care of her/himself and work through her/his own feelings about the abuse. In addition, couple therapy would be necessary to work through their problems and learn to

communicate. Group therapy for couples might be effective as well and help to break isolation and share ideas and concerns.

It is extremely important that survivors work at a pace that is comfortable to them. Flexibility in treatment approach and timing is important as a survivor works through her experiences. Briere (1992) discusses the importance of using diverse therapeutic techniques in addressing the complex issues that arise in treatment. In my exploration of the literature, the main point presented is that therapists and counsellors must respect the survivor, provide a safe environment in which to do the work and empower her to feel in control, competent and self-reliant.

### **Conclusion**

Survivors of childhood sexual abuse have had to cope with overwhelming experiences and pain as children. Throughout this chapter I have attempted to explain the long term effects that sexual abuse has on survivors and the treatment options that seem to be helpful. As children they had to learn to cope with the reality of their lives. The messages they learned as children have taught them to ignore their own needs. They had to develop survival skills that kept them alive and helped them to get through the day. These skills, such as loss of memory, splitting, acting out and using humour, assisted them to survive. However, as adults, these coping mechanisms no longer serve a useful purpose and prevent survivors from fully experiencing themselves as whole human beings.

Sexual abuse affects a survivor's sexuality. She has learned that her gender, her body, and her being are not important. Her family of origin shaped her attitudes about love, affection and sex and how they are expressed. She learned about being female and the

value placed on her gender. She discovered that her body was the enemy and could betray her. She also learned to ignore her body and the messages it sends her. She may not have learned about how her body functions sexually. Relationships with partners and children are often tense and uncomfortable because they find it difficult to be close and express feelings. Survivors fear that the abuse will re-occur with their partners or that they will become abusive with their own children. They may be confused about their sexual orientation, intimacy, and sexual contact. Sex and intimacy are often considered to be one and the same, making it difficult to separate the two. Sexual responses cause shame and trigger automatic reactions that prevent survivors from experiencing sexual pleasure. Ultimately, the experience of sexual abuse has cut off a survivor's ability to know and care for herself and to make healthy choices.

However, in spite of the horrendous nature of their experiences, survivors have proven how resilient and hopeful the human spirit is. Although they can never change or forget the abuse, they can lead full and happy lives. Through therapy and self-help, survivors do overcome the debilitating effects of their victimization. I am always amazed at the depth of their understanding and the great amount of determination and strength they possess. They deserve the best and they deserve to experience themselves as full and loving human beings. Survivors of childhood sexual abuse no longer have to be victims or merely survive. They can and do go beyond survival and "live".

## **CHAPTER THREE**

### **Intervention Model**

**The Road Not Taken...  
...But Frequently Traveled**

**My life has been a map of roads,  
Mountains, valleys and underpasses  
Cluttered with cars, vans, trucks and  
pedestrians.**

**The road that in all my journeys I  
have been able to avoid,  
Is the route that would have made  
all my travels clearer and I wouldn't have been so lost.**

**Many times I speed, but I  
have never been caught.  
And more times than not,  
I don't wear a seatbelt, even now.**

**The day I had the accident,  
The one I could not avoid, control or steer clear of,  
I was thrown from my safe car,  
to the road.**

**Alone, feeling guilty about not protecting myself,  
not putting on the brakes, and wondering why the other driver had no control.**

**But that was yesterday,  
today, I see the accident differently.  
I was still thrown from my car,  
to the road.**

**But it wasn't a road at all-  
it was the route I needed to be on,  
The one I'm driving on today -  
The road called "Healing Street.**

**Tracy Lee Pierce (April 13, 1995; with permission)**

### **Introduction**

I chose to place this poem in this chapter because it is about the journey survivors take on their road to healing. This is the point of intervention when a survivor decides that it is time for her to address the effects of her abuse, understand what has happened and make changes in her life. As counsellors and therapists we are placed in a position of trust and are given the privilege of bearing witness to their stories. Women initially come to us individually seeking help and answers to their problems. At some point we may suggest

that a woman enter a group. When women decide to participate in a group they are also sharing their stories with others, forever breaking the silence and isolation that binds them in a circle of shame. In a group, women's experiences are normalized as they realize that they share similar concerns and challenges and are not alone.

I had experience facilitating groups and was aware of the powerful impact they can have on members. As I became more aware of the issues related to the effects sexual abuse has on sexuality I decided that I would offer a time-limited group on the topic. Women expressed interest in participating when I discussed the group with them. This chapter will focus on the program that was offered and the process that took place. I will discuss why I chose a group, the setting, the client group and then I will discuss each session. In the discussion on the client group, I will focus particularly on the screening process. I will consider issues facing small communities and the effects this has on the screening process. In addition, because I knew a majority of the women from my work with them individually and/or in prior groups, I will explore some of my thoughts and questions regarding the selection of group members.

### **Why A Group???**

As mentioned above, groups can be very powerful and are often a recommended form of intervention (Corey & Corey, 1992; McEvoy, 1990; Walker, 1987; Johnson, 1987 and Sprei, 1987). A group setting can provide the safety and support that women need in order to work through the reality and pain of their trauma. Walker (1987) states; "Groups provide a unique opportunity for participants to assess themselves, validate their experiences and perceptions, attempt personal, behavioural, and attitudinal changes,

express feelings, and receive feedback” (p.3). As women have told me, in a group they no longer have to be on guard. They know that they are being heard and understood when they speak of their experiences. One group member described the group experience as a “sisterhood” that evolves when women share a common experience and bond.

As I read the literature I found material that explored issues of trust, boundaries, self-care, grief and anger. Various activities and exercises were offered as a way to explore these issues, such as writing a letter to the abuser or using art to represent anger or grief. I was aware of the kinds of issues and topics that are offered in these groups. However, I found only limited material regarding groups which were dealing specifically with sexuality. Most of the material provided suggestions for exercises and topics that could be used either in a group setting or individually (Covington, 1991; Dolan, 1991; Westerlund, 1991; Maltz, 1991 and Bass and Davis, 1988). I also spoke directly to a therapist who works in Cambridge, Massachusetts and was listed as a resource in, Women's Sexuality After Childhood Incest by Elaine Westerlund (1991). Her name is Marcie Mittler and she works with a program called, Reclaiming Your Body. She offers different kinds of groups on sexuality, from educational and discussion groups to body movement groups that incorporate dance and movement. Based on my readings and my discussion with Ms. Mittler, as well as on my own lack of experience using movement in therapy, I decided to develop a time-limited educational/discussion group that focused on issues related to sex, intimacy and relationships.

I decided to offer a twelve week, closed group for survivors of childhood sexual abuse. As I reviewed the literature I could not find any information outlining groups that

specifically focused on sexuality. However, many of the authors suggested exercises and information that counsellors could use when working with issues related to sex, the body, and intimacy (Maltz, 1991; Dolan, 1991 and Westerlund, 1992). After researching the material and in the discussion with Marcie Mittler, referred to earlier, I compiled the topics and exercises based on this information. I chose twelve sessions as a minimum for various reasons. In the past I have facilitated groups for women in abusive relationships and for survivors. When I first began facilitating closed groups for women in abusive relationships much of the information came out of Minnesota's Domestic Abuse Project in the United States. Groups were based on two phases of approximately 16 sessions each. The literature on group work supports this and recommends anywhere from twelve to sixteen sessions (McElvoy, 1990; Sprei, 1987 and Sinclair, 1986). I thought twelve sessions was a good starting point.

In addition, the group process is important. In order to work through the group process and provide group members with enough time to process the content it seemed that twelve sessions would be appropriate. Corey and Corey (1992) describe four stages of a group. They are the initial stage, the transition stage, the working stage and the ending. Schubert (1987) explores the differences between mixed groups and women's groups. However, she identifies three to four stages which resemble the stages of group development similarly described by Corey and Corey (1992). Each stage possesses certain characteristics. During the initial stage, group members are getting to know one another and because there is not a great deal of trust, they are focused on others or are telling their stories. During the transition stage, anger, fear and anxiety may increase. It is important to

work through conflict and dependency/independency issues. During this stage in the process, group members will begin to focus on their own feelings and thoughts that are affecting them in the present. The facilitator's role is to explore feelings, thoughts and reactions (p. 159).

Stage three is the working stage of the group. Corey and Corey (1992) suggest that not all groups reach the working stage and if a group does reach this stage, group members will move in and out of the working stage to the earlier stages. During this stage, group members assume more responsibility. The group needs less structure and intervention. As well, the leadership becomes shared amongst group members. Closeness and intimacy increase as group members talk freely and focus energy on personal and social change (Schubert, 1987).

The last stage is the ending. The tasks of this stage are to consolidate that which has been learned in the group, to practice new behaviours and learnings outside the group, and to deal with endings (Corey and Corey 1992). The group members may experience anxiety and grief as the group comes to a close. The facilitator must be aware of her own feelings regarding closure and must help group members deal with their sense of loss. I will often mention closure as early as the first session. I remind group members at each session of the number of sessions that are left. It becomes a count down in order to help group members deal with endings. In my experience, group members become anxious and concerned as we near the end of a group. At the same time, they may experience a sense of relief as they realize that they will be moving on.

Finally, I chose twelve sessions because I did not have any model or format to follow. I did not know what topics would be appropriate, although I did ask for feedback from group members. I also thought that twelve sessions would be enough to initially explore the various issues that the literature and women have identified.

### **The Setting**

I am presently working for a Women's Counselling program in an agency called South Peace Community Resources Society located in Dawson Creek, British Columbia, in what is called the Peace River Country. Dawson Creek is a Northern B.C. town of about 10,000 people. It relies mainly on farming and ranching, but also draws upon the mining, timber and oil industry to survive. It also depends on the tourist industry in the summer months as the Alaska Highway, built by the American Army during WW II, begins in Dawson Creek and draws many Americans and Europeans to this very beautiful area on their way to Alaska.

South Peace Community Resources Society, or SPCRS as it will be referred to, is a community based social service agency that houses a number of programs including a women's shelter. The agency receives funding from the Ministry of Women's Equality, a department of the B.C. government, to provide services to women who have been abused. This includes women who are abused by a partner, women who have experienced sexual assault and women who have a history of childhood abuse. I have been employed by SPCRS since June, 1993 and have been fortunate to work intensely with this client group. Women who are adult survivors of childhood sexual abuse were recruited to participate in this practicum both from my practice and from the community at large. SPCRS gave me

permission to offer this group. I was able to use the facilities and photocopying and had access to petty cash for cookies and refreshments. I provided this group on my own time.

In addition to my present experience, I began working with women in shelters in 1978. I also spent three years working with female adolescent and adult prostitutes, many of whom were survivors of abuse. Therefore, I have been aware of the toll that childhood sexual abuse has taken on women. Working with survivors has proven to be a special challenge. The women have developed coping mechanisms and defenses which, for the most part, have provided them with some protection from the pain and reality of their experience. However, most of the women that seek out help are tired of the energy it takes to suppress their feelings and experiences and find that their old ways of coping are no longer serving a useful purpose. The majority of the women I see in my practice have come to a point in their lives where they are highly motivated to make changes and, as they tell me, "to get on with it".

### **Supervision**

I video taped each session for supervisory purposes to provide me with feedback on content and process. Women were informed of my intentions during the screening interviews and a video release form was developed and signed by participants prior to beginning the group. I discussed the reasons I was offering this group and how the tapes would be used. Confidentiality is extremely important, especially in small towns. Because many women in the community have either lived here all or most of their lives, they know or are known by many people. It was important for me to guarantee to the women that I would do my utmost to ensure that the video tapes were safe and would not be used for

any other purposes. It is an issue that I am constantly cognizant about and always needs to be addressed.

In order to facilitate this group I required supervision. In small northern communities it is difficult, if not impossible, to find someone with the qualifications and experience that is required for clinical supervision. However, Dawson Creek has a College that is affiliated with the University of Northern British Columbia. Therefore, options were available. I identified an instructor at the College as a potential supervisor and discussed this with him. Michael Anthony possesses a Masters Degree of Social Work and teaches social work at the Northern Lights College in Dawson Creek. He is interested in supervising practicum students and agreed to review the video tapes and supervise me. He was able to offer advice and direction regarding process and technique. He is well versed in cognitive therapy and has training in Neuro Linguistic Programming (NLP). He also has a private practice in the community.

### **The Client Group**

There were 15 women in total who expressed an interest in the group. Some of these women had been in individual and group counselling with me, some were on a wait list and some were referred by others. Seven women screened themselves out before attending the interview. Some changed their minds because of changing circumstances or because they felt they were not ready for a group such as this. Women were also recruited from the community. A letter was mailed to community agencies, doctors, churches, the College and to the local health unit and hospital informing them of this particular group and requesting referrals. I decided that women who participated in previous groups and those

who received individual counselling would be given the first opportunity to participate, but I was open to interviewing and considering any women who expressed interest in this group.

Part of my reasoning for offering the group first to those who had experience in individual and group therapy was based upon practicalities. There were enough women from my past and present case load to fill a group. I also knew that women who had participated in previous groups and were involved in individual counselling had identified problems with sexuality through the course of therapy. It seemed to me that they would be able to continue working on these issues in a group setting. I offered two previous groups to survivors that focused on general issues such as boundaries, anger, trust and coping skills. Therefore, the women who attended these groups were at an advantage and possessed some understanding of the abuse and its effects. In addition, women who had been in previous groups and/or individual counselling had developed a relationship with me. They also had the experience of telling their stories, making the process easier for them. However, story telling is not expected of group members. I do not expect them to provide me or any other group member with details of their experience, unless they want to. Women are not forced to share their experiences. The group experience need not be a competition regarding whose story is the worst nor should it be a negative experience whereby group members feel pressured to "tell their stories". Dolan (1992) states that although it is important for a survivor to discuss her victimization in a supportive and respectful environment, the therapist must also utilize her "... present life resources and images of future goals and possibilities." (p. 25). It is important to acknowledge the abuse

without focusing entirely on the trauma of the experience. It is up to each woman to decide what and how much she wishes to share in the group. Usually pieces of their experiences are disclosed throughout the process of the group. Therefore, those women who had group experience knew what to expect. The fear and anxiety associated with groups had been alleviated to some degree, although I understood from the feedback, women continued to experience a certain amount of anxiety.

### **Screening Interviews**

This section will focus on the screening process as it related to this particular group. I would go so far as to say the “screening” interviews that I conducted with the women who had a previous therapeutic relationship with me may not even be considered screening in the true sense of the word. I hope to address this issue and present my ideas about this process. Specifically I hope to relate it to the special interests and issues that are present in a small community. The following discussion will explore the reasons for conducting interviews and my own observations about the process I was involved in with the women who participated in this group. Although I can not provide any evidence to support my observations, perhaps this is an area that could be further explored in the research.

Screening interviews are usually conducted with prospective group members for various reasons. Interviews provide both facilitator and client an opportunity to meet each other and decide if the group is appropriate (Corey and Corey, 1992), although in this particular group some of the women were already known to me. I did prepare and use an interview guide-line in order to explore a woman’s previous experience with groups and/or individual counselling and to assess her understanding of the abuse. Specifically, I

was interested in her perceptions of the effects abuse had on her sexuality. It provided me an opportunity to assess her situation and her supports and it gave the women an opportunity to determine if this particular group would meet their needs.

Another reason that interviews are important is to inform women of the purpose for offering the group. I provided each woman with a letter explaining the purpose of the practicum, video-taping, confidentiality and supervision (see Appendix A). A video release form and contract was provided to each woman and signed (see Appendix B). As well, group guide-lines were discussed (see Appendix C).

Another important part of the interview is assessing and exploring a woman's supports outside of the group. I was interested in knowing if the women were involved in supportive relationships with friends, families or partners. These important people can become a woman's life line outside the group, offering encouragement and support during the process of change. They can be helpful in times of crisis as well.

If a woman is in a relationship with a partner, I want to assess if it is abusive, although being in an abusive relationship does not necessarily screen her out. If a partner is abusive, a woman's safety is an important issue to explore. In my experience, women's efforts at change can often be sabotaged by partners who are abusive. Women may be unable to attend group sessions if a partner perceives any changes she is making as threatening. In addition, she may be more focused on her partner, which is the case in abusive relationships. She may have difficulty healing from sexual abuse, when she continues to be victimized in her relationship. On the other hand she may come to understand herself more fully and decide to leave a relationship that is abusive.

If a relationship is not abusive, I find that the partner often hopes that therapy will “fix” their partner. They may experience frustration when they find that quick fixes do not exist. They may also become fearful of change and feel threatened. Dolan (1991) addresses the issues that may arise for women in their supportive relationships. Therapy for friends, families and partners is recommended in order to help them understand survivors and how best to help them. I often will refer partners or families for counselling and will provide them with information and literature. I informed the women of resources and provided information for those with partners, if they felt it would be helpful. Therapy and literature helps partners, friends and families understand the dynamics of abuse and alleviate any guilt or self-blame they may experience.

Corey and Corey (1992) address the decision making process involved in screening interviews. They suggest that choosing group members is often a subjective process that involves the use of a therapist’s intuition and good judgment (p. 81). Group members who are motivated to change and are willing to put energy into participating are ideal. A group experience should be beneficial to participants and not damaging. When screening, the facilitator should be aware of situations and/or conditions that would indicate the potential member is not ready to participate in a group. They advise “... group counselling is contraindicated for individuals who are suicidal, extremely fragmented or acutely psychotic, sociopathic, facing extreme crises, highly paranoid, or extremely self-centered” (p. 81). Because survivors often experience suicidal thoughts, I had to take into consideration the actual state the woman was in emotionally, whether or not she engaged in suicidal behaviour, how recent her attempts were and the degree to which she

dissociated. For example I would not accept a woman who was on psychotropic medication and was unstable or who was diagnosed with a dissociative identity disorder. A group may be too overwhelming for this client.

Although I met with each woman to discuss the group and provide them with the necessary information, I do not believe that I followed a particular format in the screening or decision making process. I knew six of the eight women from my previous contact with them. In my own experience it seems that assessing supports, understanding of abuse and coping mechanisms is an on-going process, particularly because of changing circumstances in the lives of clients. I was aware of the six women's supports, their understanding of the abuse, the way in which they coped and their situations. I had the opportunity to get to know them and the way in which they interacted with others and with me through individual and group counselling. As a result I felt fairly confident that a group would be appropriate, as did they. It seemed to me that in regards to these six women, I did not have to base my decisions on intuition as suggested by Corey and Corey (1992). Instead I was basing decisions on prior knowledge and contact.

However, I believe that when a woman is unknown to me the task was different and more difficult. I did not have any previous contact with two women. In this case I believe that I do make decisions based on the suggestions made by Corey and Corey (1992). During the interview I was assessing individual needs, coping skills and supports. However, it is difficult to be in a position whereby judgments are made regarding an individual's appropriateness for a group. The women who were not known to me very much wanted to be in a group. The reason for my difficulty is the discomfort I experience

when I have to make those kind of decisions. It is also very difficult being the only facilitator, although in a smaller community, it is sometimes difficult to find a co-facilitator. In the past, when I worked with a co-facilitator, we both would be involved in the process and would explore our perceptions and judgments with each other. When I work alone I know that I miss a certain amount of information and cues that are important in making a decision. Although I could discuss the interview with my supervisor who could help in the selection, decisions become more objective when two people are involved in the interview process.

I did have some concerns about the two women mentioned above and their participation in the group. One woman did not have any previous counselling experience and the other did in both individual and group settings. Partly I was concerned because the two women did not know other women in the group, in so far as I was aware, although in a small community one can never be certain. Other women in the group knew one or two others as a result of their past group involvement. I was concerned that the two may not feel a part of the group.

I was also concerned about the woman who did not have any previous counselling. I was uncertain if this particular group would be helpful to her given her recent disclosure. However, she identified issues related to intimacy that were affecting her marriage and was concerned about her future. Maltz (1991) suggests that sexual healing can begin at any time during the healing process. With this in mind, and after exploring the purpose of the group and other group issues, we agreed that it might be beneficial for her to attend. Individual counselling was also offered to her as a back-up if she needed to discuss

anything in an individual session. This was also extended to other group members, although it is my experience that group members tend to use the group for support and very rarely ask for individual sessions during the duration of a group. In addition, because the second woman did receive both individual and group therapy and also had had some experience facilitating groups, I was concerned that confusion over roles might be a problem. We discussed this and agreed that we could not foresee any problems. It would be important to discuss this issue further if problems regarding roles developed.

I discussed concerns with each woman and with my supervisor. The two women who were unknown to me appeared to be appropriate for the group and did not display any extreme behaviours or were not in acute crises. They wanted to participate in the group and were motivated to make the commitment to attend.

Another issue I would like to raise regarding recruitment, screening and selection in groups concerns work in small communities. A problem women in small communities face is related to visibility and confidentiality. Many have lived in the community all their lives and personally know a great many people in town. If they do not know someone they may know of them. I often hear women discuss relationships between people such as, "... she is the niece of someone's uncle....". Issues of confidentiality become a concern and women fear that they will be seen by someone they know. Often women enter a group for the first session and recognize someone they know. I find that once the discomfort is addressed and issues of confidentiality are explored, the women tend to be more relaxed. However, the fear of being seen may affect a woman's decision about attending a group.

Related to this is the dilemma a facilitator may be in, if she is aware of the relationship between two women. For instance, a facilitator may know that two potential group members are related through marriage or are cousins. This becomes a problem especially if they do not have a fairly good relationship or do not know that the other has been sexually abused. Although it was not the situation for this particular group it does occur and raises some questions. How does a facilitator proceed? Does she ask one to participate over the other? How does she choose which one will participate? How does she explain her choices to the women?

Another issue affecting the numbers of potential group members involved in the recruitment, screening and selection process is related to actual available numbers of potential group members. I have found in a small community it is much more challenging to recruit enough members to form a group, due in part to the concerns raised above but also due to the actual numbers of people living in the community. I have usually started with about seven group members and ended with three or four. When I worked in a larger city we would start with twelve or fourteen and end with eight to ten group members. In a smaller community, the potential population is less and therefore, I had to lower my expectations regarding numbers. I have been told to expect that three or four in a group is fairly average for a community the size of Dawson Creek. A question and concern I have related to numbers is when is a group no longer a group? What is the difference when working with twelve women compared to three or four? In my experience, working with three or four allows more opportunity for individuals to receive a greater amount of individual time. There is also more time to complete exercises and process information.

Pressures on the facilitator are lessened, especially regarding group interaction and dynamics. Working alone with larger numbers is difficult. The facilitator must divide her attention amongst a larger number of participants. As a result she may miss important information and cues. However, when working with smaller numbers, a facilitator often will have to guard against engaging in “individual” counselling with group members. This can occur because time pressures are not as great. I would recommend that more research be conducted on the effects smaller numbers of participants have on group process, especially in small communities.

When offering a group I hope that the experience will be constructive and that group members will learn from each other. As a facilitator it is my job to provide a safe environment in which members can share their thoughts, feelings and reactions. It is also my responsibility to ensure that problems and conflicts are identified and if not resolved, at least processed within the group. We can never be certain how people in the group will interact with each other. I would recommend a pre-group be offered in order to not only work out “housekeeping” issues but also for group members to meet other women in the group. Corey and Corey (1992) suggest that facilitators offer a pre-group to help with the screening process. Expectations of both group members and facilitators can be discussed fully. If group members do not believe that the group will meet their own expectations they have the option of withdrawing.

In spite of the issues raised regarding group process and numbers, I believe the selection process is less competitive in small communities and I find I do not have the same pressures regarding selection. It seems to me clients tend to screen themselves out

before a decision is made or the interview is conducted. As I discussed earlier, screening is easier because women are known to the facilitator in a number of different settings. In addition to the recommendation made above regarding group process, I would suggest that more research be conducted regarding groups in small communities and the special issues that affect recruitment, screening and selection.

### **Structure and Format**

I developed a 12 week group based on the information I gathered from the literature (see Appendix D - Topic List). The group met for two and half to three hours, once a week. I identified four areas on which to focus group activities. They were:

1. introductions, the meaning of sexuality and effect the abuse has on sexuality.
2. family of origin - what is learned about being female in families.
3. the body - understanding of anatomy and physiology, body drawings and feelings and self-care.
4. sex, intimacy and relationships.

The content of the group sessions followed a certain progression from least threatening to more difficult. However, often topics overlapped and were discussed as they were brought forward. This is expected and is part of the group process. Flexibility and timing are important in facilitating any group.

### **Sessional Structure**

Each session followed a particular structure although there was room for flexibility depending on the needs of the group members. There were times during a session that we did not directly discuss the topic planned. Often I have found that the issues group members bring forward are related to the topic we are about to discuss and I make an attempt to connect the two. Business such as community announcements and activities that group members or I knew about were shared. This was followed by an opening circle to warm up the group and check-in. An activity was used to build self-esteem or to explore how group members were feeling. Once this was done, issues or concerns from the prior session were shared and discussed. Time was set aside for any group member to share concerns or problems they were experiencing. This encouraged the group members to interact with one another and offer support. Once this was done the planned topic was introduced for discussion. The session was closed by checking feelings and also engaging in an activity that focused on their strengths. It was important to ensure that when group members left they were not feeling too overwhelmed, but this could not always be guaranteed. The sessions were video-taped for supervision purposes. My supervisor reviewed the tapes and met with me to discuss them. The group members were also offered an opportunity to review the tapes as part of the group process. This will be discussed further. Before beginning each session evaluation tools were completed and handed in. At the end of every fourth session, group evaluation forms were also completed. I kept a weekly log and wrote a weekly report on group content and process

(see Appendix E for Weekly Group Report Form). A copy was supplied to my supervisor for feedback.

An example of the weekly structure was:

I. Business

II. Opening Circle - activity to check-in on members' feelings and/or build self-esteem.

III. Re-Cap - issues/concerns from the last session.

IV. Time - individual time for group members.

V. Topic - discussion and activities.

VI. Closing Circle - activity to check-in on members' feelings and build on strengths.

I consider myself a feminist and therefore I believe it is important to include a social, political and economic analysis of a problem. Understanding the context in which women experience their lives, is, in my view, essential. Each woman's experience is unique, but at the same time they hold a subordinate position in society and generally have less power to act in their own best interest. Our power lies in our connectedness with others and our ability to empower those around us (Miller, 1991). Although we are taught to nurture and care for others, society does not recognize or value these activities. It is these very qualities that contribute to the abuse of females. "Power over" is that which we have come to know and accept and is the very thing we fear. Women and children are in a vulnerable position that can lead to abuse. Society continues to perpetuate and condone sexual abuse and indeed abuse of all kinds. Society contributes to a survivor's self-loathing and shame by disbelieving her, blaming her and by sexualizing relationships. Images of violence and

sex are also combined and we are bombarded with images that do not reflect the reality of women's bodies or lives.

It was important for me, as a feminist counsellor, to be aware of the dynamics of power and the conditions that allow abuse to occur. As a feminist counsellor it also meant that I was aware of the position I held in the group. The issue of power is one that I struggle with and am constantly attempting to understand. I think it is important for me to empower women and help them to know the meaning of their power. I wanted to convey these ideas in the sessions whenever the opportunity arose. Through questions and exploration I hoped that women might come to understand the context in which their abuse occurred, lessen their sense of self-blame and believe in their personal power.

I believe that in order to address issues of power, a therapist needs to empower the women they are working with. In order to empower group participants, it is important that a facilitator "allow" them to be active participants in the decision making process. They are the ones who define the direction the group will take. They decide the content and lead the process. For instance, while I developed the topics and planned an agenda for each session, they determined issues that would be addressed during each session and whether or not we proceeded with a particular topic. If group participants decided they needed to discuss issues other than the planned topic, that was the direction the group took. However, I do believe that the content or topics were addressed either directly or indirectly. In my experience issues that are raised are related in one way or another to the topic. The process, or the way in which a group gets to the content, can be different.

It is also important to include a social, political and economic analysis of women's roles. In discussions on saying no, body perception and sex and intimacy I often referred to women's roles and societal expectations. The film Still Killing Us Softly (Kilborne, 1987) directly confronts societal pressures placed on women, through the media, to be thin and sexually available. I used this film to open up discussion regarding the way in which the media sexualizes women and treats them as objects. The film also facilitated discussions regarding the meaning of sexuality and the way in which women's sexuality is defined by others in society. I hoped that the film would help women think about the broader issues that affect them as women. Each session will be explored in greater detail and I hope, will provide the reader with more information regarding these issues.

After each session I would review the video-tape, keep a journal and I would take notes regarding the group content and process. I found that doing this immediately after the group and then reviewing my journal and the group process with my supervisor assisted me to have a clearer understanding of the content and process as well as to explore my own perceptions. The next section will offer a description and explanation of each session.

### **The Program - Content and Process**

Following is a discussion of each session. The topic and goals will be identified and a discussion of what happened in each session will be explored. I will also attempt to identify areas that require further research or discussion, and add my recommendations for future groups.

**a. Session One: Introduction**

The goals of Session One were:

1. To get acquainted.
2. To review and discuss group agreements and topics.
3. To discuss journals.
4. To explore group and personal goals.

The first session involved “housekeeping”. Although some group members knew each other, the focus was on getting to know one another and defining boundaries.

Introductions, guide-lines, goals and safety were discussed. We agreed to meet from 7:00 to 9:00, but we agreed to extend the meeting whenever it was necessary. Group members explored ways they could ground themselves if they were feeling overwhelmed by the discussions. Some techniques that were suggested were; stop and become aware, be present, divert or look at something in the room, touch a ring or necklace, or think of a symbol for safety and comfort. These techniques are described by Maltz (1991), Dolan (1991) and Bass & Davis (1988). I would also intervene if I noticed that they were experiencing difficulties or if they brought it to my attention. These grounding techniques are useful if women feel triggered and begin to experience a flashback. They can help her re-focus in order to experience the present.

Each of the evaluation tools chosen for this group were completed in Session One. The scales used were the Index of Self-Esteem ( Hudson in Bloom and Fischer, 1982, p. 153), the Generalized Contentment Scale (Hudson in Bloom and Fischer, 1982, p. 152),

The Miller Social Intimacy Scale (Miller and Lefcourt in Corcoran and Fischer, 1987, pp. 230-232) and the Negative Attitudes Toward Masturbation Scale (Abramson and Mosher in Corcoran and Fischer, 1987, p. 247-249). A group evaluation form was completed once a month. Group members experienced the most difficulty with the Miller Social Intimacy Scale and the Negative Attitudes Toward Masturbation. They found some questions difficult to answer. These issues should have been explored further regarding the specific difficulties they had with the particular scales. It is something that would need to be done in the future, if these scales will be used and the same type of responses were perceived.

Group members raised concerns about reviewing the tape as a way to re-cap the previous session. I presented this idea as a way to summarize the previous weeks topics. I suggested that I would pick a section of the tape to view briefly and then discuss it. I also suggested that if upon reviewing the tape, my supervisor or I found any thing to be incongruent regarding what is said and body language, I could point it out to the group. This would provide group members with feedback about themselves and interactions between group members. Group members did not want to review tapes unless there was something incongruent that was occurring in the group. They stated that they found it difficult to look at themselves on television and would not find it helpful. They also thought that reviewing the previous week's videos would only be "re-hashing" things they already knew.

I suggested to the group members that my supervisor, Michael Anthony, was willing to meet group members for the first part of the second session. We thought it might be beneficial for group members to meet him and ask questions of him, especially if they had

concerns regarding the fact that he was a male who was supervising me and viewing the tapes. The group members were interested in meeting him and agreed that he could attend the meeting for the first half hour. Some group members knew him and this helped others feel more at ease regarding his role.

Group members spoke openly about their feelings and fears. They addressed issues that affected them as group members. Alienation, specifically related to native identity was explored. Concerns regarding “joking” and sarcasm were addressed. Group members supported one another and these issues were processed in the group. We discussed ways that group members could be inclusive. In addition we explored the way in which humour could be used as a means to avoid unpleasant feelings and difficult situations. Group members agreed that a balance was needed.

**b. Session Two: Sexuality I - What is Sexuality?**

The goals for Session Two were:

1. To define sexuality.
2. To explore the impact that society has on women’s sexuality.

Michael Anthony, my supervisor, attended the first part of the session. The group members were receptive and asked him questions. This added to their sense of well-being. Group members who were not known by others in the group were continuing to get to know one another and remembering each others names. We explored the definition of sexuality and then viewed the film, Still Killing Us Softly (Kilborne, 1987). A great deal

of discussion was generated regarding the film and its expose of societal pressures in the advertising, to be thin and sexually available.

During the group and upon reviewing the tape it became apparent that a lot more issues regarding group dynamics seemed to be present in this session. Initially the session was going well, but there appeared to be a lot more silences and some body language messages, appeared to be more closed. Personality dynamics between group members emerged and some members appeared to be distracted. There appeared to be a great deal of intellectualizing, rationalizing, and “spacing out”. It seemed that group members were holding back or afraid to speak. I was informed by some group members that they were afraid to say anything that would be perceived as hurtful and they did not feel they were being heard.

During the group I was trying to pay attention to the dynamics that were emerging. It was at this point that I realized the importance of having a co-facilitator in order to debrief and share the responsibilities. However, I was facilitating this alone and I was able to identify some issues that would need addressing. A concern I had and wanted to explore was the way in which women “get along”, especially, in relation to the issues of care-taking and taking responsibility for others. Through supervision, a plan was developed in order to address some of the concerns that I had. I recognized that I would need to focus on the feelings that members were experiencing if they were intellectualizing and rationalizing. Questions and concerns to bring to the group were:

1. If group members have issues that they are unable to address in the group, do they prefer to bring them to my attention privately? We could then explore whether or not they wish to bring it to the group.
2. Would group members prefer that I address them privately if I notice anything during group or upon reviewing the video-tape?
3. What do members need, to feel heard and to be safe?

It was important that group members did not feel that they were censoring themselves. If group members are fearful of hurting someone, they are then focusing on others' needs rather than their own. This is an effect of sexual abuse. It is described in the literature and has been discussed earlier (Bass & Davis, 1988; Dolan, 1991; Maltz, 1991; Samson, 1991; Sleeth and Barnsley, 1989 and Westerlund, 1992). When survivors focus on others, resentments can build and increase anxiety in group members. This runs contrary to the purpose of the group which is to provide a safe place for women to speak freely and openly about their experiences and feelings. In addition, women need to be aware that there are no right or wrong answers or reactions. Group members can not know what is going to trigger others or be responsible for their reactions. Issues related to shame and "badness" seem to be at the root of the problem. If someone reacts to a particular group member's statements or actions, it does not make anyone bad. Group members also need to allow others to own their reactions and work together to support one another. I decided to bring my observations and concerns to the group at the next session, where I could then explore their thoughts about these issues.

**c. Session Three: Sexuality II - Effects of Sexual Abuse on Sexuality**

The goals for Session Three were:

1. To understand the range of sexual abuse from overt to covert.
2. To explore the effects sexual abuse has on sexuality.
3. To understand the effect that abuse has on sexual development.

The plan for this session was to brain-storm effects and complete the Sexual Abuse Inventory taken from Maltz (1991) which was used with permission of the publisher. The inventory is a series of questions, developed by the author, based on her work with survivors. Survivors check the statements which hold true for them. There are no right or wrong answers and the inventory is not scored. It can assist survivors to identify their beliefs and feelings about sex. The inventory points to problems in six areas. They are; attitudes about sex, sexual self-concept, automatic reactions to touch and sex, sexual behaviour, intimate relationships, and sexual functioning problems. Completion of the inventory offered the group members an opportunity to share their attitudes and beliefs about sexuality.

However, we did not work on this. Instead I spent time addressing the concerns I had that were emerging from Session Two. We also spent time on individual time. The tension that was present the week before appeared to be alleviated once the issues I identified were brought forward. Group members shared that they were intimidated by the video taping. Specifically, they were concerned about discrepancies being pointed out in the group. Although we would continue video-taping, the members agreed that they felt safer

discussing issues individually first, if they could not in group, rather than to confront or to be confronted in front of others. Group members explored issues regarding shame and responsibility as well as trust. Fear of being shamed and put on the spot was an issue for some members. Sleeth and Barnsley (1989) discuss in detail issues related to shame, trust and responsibility. It is not surprising that these issues came up for group members. After the discussion, one group member summarized the direction she felt this particular group was taking. It appeared to her that this group was more supportive vs. confrontive. She had experience in both. Group members agreed that they felt safer in a more supportive environment. I perceived a change in the “atmosphere”. Group members appeared more attentive and supportive of one another.

We did not have any time left to work on The Sexual Abuse Inventory nor did I negotiate with group members to work on this at a later session. I would in the future do this. I believe it would be important for group members to do this inventory in order to understand the effects sexual abuse has on their attitudes and beliefs about sex and intimacy. I felt that the survey would possibly stimulate a great deal of discussion and I believe I should have included it in a later session that deals specifically with these issues. However, group members were encouraged to do the questionnaire on their own and to discuss it with me individually if they needed to or to bring it to the group for further discussion.

**d. Session Four: Family of Origin**

The goal for Session Four was:

1. To understand the role that family had on self perception.

The fourth session was devoted to family of origin issues. We explored the messages members received about love, affection, intimacy and sex in their families. Group members were asked to divide the paper in half and draw their family of origin as they would appear sitting around the kitchen or dining room table on one side. On the other side of the paper, they were asked to draw their own families. If they did not eat meals at a table they were instructed to draw a picture of the living room if they ate in that area. They were asked to write in their journals, answering questions regarding meal time, where people sat and why, and family interactions. They were also given a list of questions as a guide (see Appendix F). I often used these questions in group work with women in abusive relationships. I felt the questions were appropriate for this group as well and would help group members to explore the messages they received from their family. This particular set of twenty-four questions explores relationships among family members, gender issues and communications patterns. They were asked to make comparisons noting differences and similarities to their present families. Group members then shared their drawings and discussed some of their answers to the questions.

Group members found the exercise difficult because it brought back memories. Some women, who had a great deal of difficulty with the exercise, were able to share once they heard others share. The questions were lengthy and they did not complete all of them. In the future I would cut down the number of questions asked of group members. Another issue is that the questions do not take cultural experiences and different types of families into consideration. In the future, questions should be inclusive in nature taking into

consideration differences in cultural background and the meaning family has to different people.

Group members appeared to be relating to one another despite differences. They seemed to be comfortable discussing their experiences and were supportive of one another. They also seemed more focused on their own feelings, thoughts and reactions.

**e. Session Five: The Body I - Anatomy and Physiology**

The goals for Session Five were:

1. To become aware of a woman's body, anatomically and how it functions.
2. To become aware of the way in which sexual abuse blocked understanding of the body's functions.
3. To share and discuss health concerns.

The plan for Session Five was to explore anatomy and physiology. The New Our Bodies, Ourselves (1992) was used as a resource to learn about female anatomy and sexual functioning. However, we did not focus on the agenda. Instead we focused on issues that came up for group members during the week. I also realized upon reviewing the tape that I experienced a "technical difficulty". I had no sound! I realized too late that I did not push the Audio Out connector far enough into the camera. Alas, I could only blame myself and human error. I would be conscience of this in the future.

However, because I took notes immediately after the group I was able to capture the essence of the group content and process. We spent the time discussing issues regarding relationships with partners and mothers, roles and personal boundaries. We explored

individual boundaries and the confusion that results when boundaries are violated as they are when someone experiences sexual abuse. We discussed ways members could be clear about their boundaries and take responsibility for establishing their own boundaries.

The discussion about mothers was particularly interesting. Perhaps this was triggered by the previous week's discussion on the family of origin. Group members discussed the anger they felt towards their mothers for not "knowing" or not protecting their daughters. Some survivors, even after "telling", did not feel that they were supported or that enough was done to confront the offender or to seek help. The anger group members experienced was similar to that often mentioned in the literature. Sleeth and Barnsley (1989), in describing relationships between mothers and daughters, discuss the importance of working through anger and guilt towards their mothers, regardless of whether or not the mothers were supportive. It may mean that survivors must distance themselves from their mothers in order to understand themselves and heal. In so doing, they may reach a point where they understand their mothers and are able to resolve their anger and resentment.

Other significant issues were raised regarding their relationships with their mothers. Group participants feared being like their mothers. At times, group members stated they were horrified when they caught themselves acting in ways similar to their mothers. Others became "mothers to their mothers", which left them feeling angry and resentful. Sleeth and Barnsley (1989) point out that in a survivor's family of origin, she may learn to be a caretaker and become a parent to her mother and siblings.

In discussing relationships with mothers, the group members turned their attention to their relationship to food. They felt that the importance of food in their lives was also related to mothers' and women's roles. Food may have been used as a way to nurture a child. As well, women are around food. Women grocery shop, prepare meals and are concerned about feeding their families. They learn to relate to the world through food. In addition, the group members stated that food had become a comfort and filled a void in their lives. Some used food to hide. In particular, they would eat to gain weight and in so doing, hide their sexuality. Others became bulimic to avoid gaining weight.

Some group members raised concerns about not focusing on the topic for the week. We spent time exploring how we would use the time and whether or not we would focus on the topic or scrap the topic if other issues seem to be of more importance. Group members thought that it was more important to focus on immediate issues rather than on the planned topic. It is my belief that issues raised in the group are in some way related to the topic and, often, I am able to make a connection to the topic. In addition, the process is important. The topic and content become less important, although the topic can stimulate discussion. Corey and Corey (1992) point out the importance of the process. Group members are exploring their thoughts, feelings and reactions. As they move through the stages of the group process, group members require less structure and leadership. They begin to confront their problems and relationships with others.

However, the planned topic for this particular session did not really have much to do with the discussion. Perhaps group members felt uncomfortable discussing female anatomy and sexual functioning. This topic may trigger embarrassment and shame regarding bodily

responses. It is possible that group members wanted to avoid the issue, although they did state that they felt they knew enough about it and did not need to use group time to discuss it. It may be important for group members to have a sense of control over the direction the session will take. In retrospect I should have explored in greater depth the reasons group members did not want to discuss this topic. In addition, I should have negotiated with group members about offering this particular topic at a later session. I would also expand further on family of origin issues based on the response of group members. The questions on family of origin would need to be reduced in number and be more inclusive in order to take into account different cultural backgrounds and women's different experiences of families.

**f. Session Six - The Body II - Healing the Whole Body**

The goals for Session Six were:

1. To identify emotions and where in the body one holds them.
2. To explore how the abuse affects the body.

In Session Six, the plan was to use body drawings in order to discuss the effect sexual abuse had physically, emotionally, intellectually, sexually and spiritually. We planned to discuss ways that group members could begin to heal themselves. This exercise is described by Dolan (1991) in, Resolving Sexual Abuse (p.168). Two body drawings are provided and participants are asked to pick a colour that represented where in their bodies they felt good and another colour that represented where in their bodies they felt the pain

of their abuse. Once done they are asked to pick a healing colour or symbol to place over the hurt areas that they would like to heal. The participants then share their drawings.

Once again I discovered another technical difficulty! Technology can be so confusing, especially for social workers! I discovered I did not hit the record button. Although I was vigilant in ensuring the audio lines were securely in place, this did not change the problem. I became aware of my mistake half way through the group and did correct it. However, the mistake was made, but because I kept notes immediately following the group, I was able to record the themes that were identified and discussed in the first portion of the meeting.

In spite of the problem with the video taping, this was an excellent exercise and stimulated a great deal of discussion and interaction between group members. They were open and supportive of each other. Group members discussed issues they stated they would never discuss with any one else. They were open about the way they experienced their bodies and the feelings they had. Areas that were covered were; their experience of sexual abuse and its effects on the body, their experience with sexual relationships, sex and orgasms, the role food played and the act of eating, numbing or cutting off feelings, the experience of pregnancy, childbirth and breast feeding, fear of the body and being attractive to males, and the experience of being in an abusive relationship and the impact this has had on self esteem.

The theme underlying these issues related to a fear of being out of control of their bodies. Those women who experienced pregnancy and childbirth felt at times that they had very little control over their bodies. This was also true for women who did experience

orgasm during sexual intercourse with a partner, especially if they did not initiate sexual contact. None of the women liked their bodies nor did they particularly enjoy sex. They shared that they “hurt” during sex. Some avoided sexual contact with their partners, which caused a strain on their relationships. Some experienced a great deal of shame and embarrassment about their bodies and the feelings they experienced. Often they learned to “numb” any feelings they had. They experienced a great deal of sadness because they felt they were unable to fully experience a range of responses, sexually or emotionally. They felt anger at the offender for robbing them of their ability to feel. They had “disconnected” their minds from their bodies as they were being abused in order to protect themselves from any feelings they may have experienced during the abuse. They found that they were using the same coping skills in their present day, adult sexual relationships.

Group members also experienced a great deal of frustration in their relationships. Often partners had difficulty understanding their lack of interest in sex. If partners made a comment about the way a woman “looked”, it would cause a reaction in them. It would have an impact on the way in which they viewed themselves, usually perceiving themselves in a negative way. All the members who attended shared that they felt they were “damaged goods” as a result of the abuse.

Sexual abuse is a violation of a child’s body. It affects the way in which the adult woman perceives her body and results in self hatred and shame. The literature supports these findings. Maltz (1991), Westerlund (1992), Sleeth and Barnsley (1989) and Woititz (1989) discuss the negative attitudes that women hold regarding their bodies as a result of sexual abuse. They learn to “numb” any feelings they have and disconnect from their

bodies. The women interviewed by Westerlund (1992), experienced a great deal of shame, guilt, self-blame and anger regarding the abuse (pp. 145-147). She found that women who had been sexually abused felt that they did not own or have control over their bodies. This was found to be true regarding sexual responses, pregnancy, the birthing process and breast feeding. A number of women in her study felt they were unattractive and that any "... flaws were evidence of a negative internal quality .... (Westerlund, 1992, p.56).

Women in our society generally do not like their bodies. Pressures to be thin and to be pleasing to males contribute to a distorted sense of body image. This compounds the problems women face when they have experienced sexual abuse as a child.

The body drawings appeared to assist participants to begin identifying where in their bodies they carry the pain of the abuse and to explore the ways in which their bodies have been hurt by the abuse. This is an exercise I would recommend doing in future groups. It could also be done individually. However, we did not have time to complete the exercise and agreed to finish the following week. One woman was absent and two did not get a chance to share their first drawings because it was getting late and group members were tired. In addition group members did not complete their healing drawings. They were encouraged to try to complete the healing drawings at home if they could.

**g. Session Seven - Body Drawings and Self-Care and Learning To Relax**

We agreed to complete the body drawings, to finish discussing them and also agreed to continue with a relaxation exercise and self-care. The goals for Session Seven were:

1. Complete the body drawings.

2. To practice relaxation and self-care.

**a. Body Drawings**

Body drawings were completed and group members shared their healing drawings. The discussions continued to follow the themes identified above. Additional issues that members identified were difficulty saying no to sexual requests, guilt and fear of saying no, gender identity and sexual orientation.

Participants had difficulty saying no because of the guilt and fear associated with saying no. They learned as children that no was not respected and some did not even dare to say no. Women have been socialized to please males and to comply with their sexual demands. Survivors have learned this lesson very early. Therefore, it is difficult to say no as an adult. Participants shared that often they agreed to have sex with a partner even though they did not want to. If they said no they felt guilty and feared that their partner would find sex elsewhere. Covington (1991) discusses these issues and the contradictions regarding sexuality that women are subjected to in our society. The experience of sexual abuse compounds the sense of guilt and fear that women experience when they say no.

Issues regarding gender identity were raised by group members. Some participants felt a great deal of shame in their developing bodies. Some women shared that when they were little girls they would try to hide their femaleness and were considered "tom boys". As they entered adolescence their developing bodies betrayed them. They could no longer hide the fact that they were female. They felt that if they were more "boy like" they would be safe and would not be abused. Being a female was considered negative because they reasoned that only females were abused. Developing breasts, hips and pubic hair and the

onset of menstruation were considered traumatic. Not only could they not deny their femaleness but they had to live with the fear that they might become pregnant, especially if sexual intercourse was involved. This common fear is also noted by Westerlund (1992). She found that women who were sexually abused as children experienced a great deal of confusion and fear regarding their female identity (p.55-56).

Sexual orientation and sexual fantasy were the final issues identified by group members. Some participants were confused regarding their sexual orientation, especially if they experienced sexual fantasies involving women. They wondered if they were lesbian, although all had been or were involved in heterosexual relationships. Group members identified themselves as heterosexual but the abuse and fantasies caused them to question their orientation. Group members thought that fantasies did not necessarily mean that one was a lesbian or a heterosexual. It seemed that fantasies involving women were normalized in the group as participants discussed this issue. This could relieve any anxiety or fear they had about their sexual orientation, although I can not be certain because of the stigma attached to identifying oneself as lesbian or gay.

Maltz (1991) and Westerlund (1992) discuss the impact sexual abuse has on sexual orientation and fantasies. They support the issues raised above by group participants. In the future I would recommend that sexual orientation and fantasies be explored further. Perhaps more discussion could be generated regarding how the abuse affected their fantasies and sexual orientation. An alternative would be to offer one session focusing on sexual orientation.

**b. Self-Care and Relaxation**

The healing body drawings lead to discussions on self-care. Group members shared their healing drawings by placing colors and symbols on the areas of their bodies they wanted to heal. This generated discussion on ways they could feel better about their bodies.

I utilized a progressive relaxation exercise and visualization of a safe place to begin this part of the session. The group then discussed the difficulties they have caring for themselves. Some found it very hard to be still or sit down without being busy. Taking time for a hot bath or to read a good book seemed foreign to some women. Others made an effort to take time for self care. Participants encouraged each other and supported one another in finding ways to care for themselves.

Sleeth and Barnsley (1989) explore the difficulties survivors have with self-care. “Busyness” is a survival skill. When women are busy they do not have to think about the abuse. A challenge for group participants was to find a way they could take care of themselves and then find the time to practice self-care.

The group ended by asking group members to do one special thing for themselves during the week. The following session would begin by asking group members if they actually did what they planned. I made a list of each participant’s plan for self-care. At the same time that I attempted to encourage group members to practice self-care, I was also aware that they could feel pressured into doing this. The exercise is not meant to cause stress and it was important to communicate this to group members. In my experience this exercise is positive and gives group members permission to take time for themselves.

**h. Session Eight - Sex and Intimacy**

The goals for Session Eight were:

1. To explore definitions of intimacy, love, friendship and sex.
2. To identify beliefs about intimacy.
3. To understand the effect sexual abuse has on intimacy.

There were no technical difficulties during this session. However, this session ran over time and the tape ran out. I, therefore, did not tape the last fifteen to thirty minutes of the session.

This session was started by reviewing whether or not group members took time to do their self-care homework. Most group members did take some time for themselves. Some did find it difficult to relax and spend time with themselves. If someone did not find time they were encouraged to try again. All group members were encouraged to continue to take time for themselves in the weeks to come. However, pressure was not placed on them.

A discussion followed regarding relationships and intimacy. Issues of control, trust, confusion in relationships, intimacy, sex and love were discussed. The effects the abuse had on their beliefs about these issues were explored. Group members were attentive to each other and supportive. They also focused on their own thoughts, behaviours, emotions and attitudes.

Group members explored the confusion they experienced in their relationships. They often did not know how to react nor what to expect. This confusion was present in both

female and male relationships. Often participants sexualized relationships as a result of the abuse. In relationships with men, it could lead to engaging in sex with a male, even if it was unwanted or if they felt that the person was not “good” for them. The sexual abuse taught them to expect sexual contact and therefore, many knew how to react to this expectation. In their friendships with women, they shared that they would also feel uncertain because they did not know how to act outside of a sexual relationship. This was also true in their relationships with male friends, but they felt that relationships with women were much more difficult because of issues related to sexual orientation. Group members discussed discomfort with female friendships in relation to uncertainty in how to react in a non-sexual way. However, in retrospect, I should have explored this issue more fully with group members. I would suggest that in the future questions be asked that explore the meaning female friendships have for them. I would include a deeper discussion regarding sexual orientation and how this relates to the difficulties they experience in their friendships with women.

Women expressed fear of being close to both men and women. Some felt vulnerable when they became close to someone. Fear of losing control, being hurt and uncertainty about the meaning of intimacy caused confusion. They experienced confusion regarding how people interact in a non- sexual way. In addition, if a participant experienced abuse by a partner or friend, fear of losing control in relationships was compounded. Abusive relationships reinforced their fear and mistrust in others. For group members it seemed easier to avoid close relationships than to risk being hurt.

Related to this fear of intimacy is the belief that any man who is attracted to them or to whom they are attracted must be “bad”. I will discuss relationships with men because that was the focus of the discussion. Group members shared that they felt bad and dirty and therefore any man, even a “nice” man could not be trusted or must be “bad”. They believed that they would be manipulated and hurt. A relationship with a male who was safe, and one with whom they could assert themselves, was different from their experience and from their expectations. Often they could not accept a man who was “good” to them because of their belief in their own “badness” and the lack of trust they had in their own instincts. They found themselves attracted to “bad boys”, ones who signaled danger but who also paid attention to them. Participants shared that they would have sex with these men because they were getting attention from them. As bad as these relationships were, they were predictable and participants knew what to expect. They confused love and sex, convincing themselves that they “loved” the person because they had sex with them or that this man must love them as well. They acknowledged that this thinking could be dangerous to them and could lead them into relationships that were abusive and unhealthy.

Fear of closeness affected how they reacted in their sexual relationships, making them uncomfortable and difficult. I also became aware of the great number of contradictions that were present. Some group members felt that “one night stands” were often easier because they felt less vulnerable and more in control. In addition, they discussed feeling more in control if they initiated sexual contact with a partner. On the other hand they also experienced confusion regarding their role in initiating sex. They were aware of the double

standards present in our society and the negative attitudes that are held towards women who initiate sexual contact.

They expressed frustration over the lack of spontaneity in their relationships. However, they had difficulty when their partners initiated or tried to plan sex with them. The literature connects the experience of sexual abuse to difficulties survivors experience in their relationships (Maltz, 1991; Sleeth and Barnsley, 1989; Westerlund, 1992; Dolan, 1992 and Briere, 1992). The abuse they experienced was predictable and planned. They knew what was going to happen, when it would happen and how they would react. When their partners asked for sex or tried to initiate sex, participants would be reminded of their sexual abuse which triggered a reaction in them. Maltz (1992) points out that some survivors react to their partners as if they were the offender. They utilize old coping mechanisms in response to the triggers by numbing or dissociating. Some group members would often avoid sex completely in order to alleviate the discomfort and shame that they experienced during sex. Still others would comply with sexual demands in spite of their own feelings that may be to the contrary. This would lead to a cycle of guilt, self-condemnation and self-hatred.

The group members discussed ways they could experience more intimacy in their lives with trusted friends, family members and/or lovers. They discussed the importance of touching and loving their bodies, not in a sexual way, but in a caring way. The session ended by each member sharing a way that they could find a greater amount of intimacy in their lives.

**i. Session Nine - Arousal and Desire**

The goals for Session Nine were:

1. To understand the effect sexual abuse has on sexual desire and arousal.
2. To explore and discuss the female sexual response cycle and normal body responses.

The plan for this session was to explore the differences between desire and arousal. We planned to discuss the female and male sexual response cycle using Covington's (1991) description as a guide. The effects sexual abuse has on the female sexual response cycle, beliefs about masturbation and sex were also planned in this discussion. However, once again, we did not focus on the planned topic. Instead the group members explored their feelings, the body, relationships and insecurities, and the difficulties they had in stopping old patterns. Once again there was a great deal of interaction and support. They also were respectful of differences in opinions and beliefs.

Group members expressed concerns about the group coming to an end. We explored endings and losses, connections that were made in the group and ways group members could continue contact with each other. I suggested to the group members that they could continue to meet on their own if that was something they wanted to do. They explored the possibility of forming a self-help group based on a twelve step program. They could decide when and where they would meet. The facilities at SPCRS were offered to them as a meeting place and I offered my services on an as needed basis if they required consulting or assistance in any way. This was left up to them to think about and we agreed to discuss this at the last session.

The discussion on feelings appeared to be a break through for some women.

Emotions were very difficult for some group members to discuss and express. Often the experience of feelings are strange for some adult survivors. They do not know how they feel because they have become accustomed to cutting off their emotions. They have difficulty knowing where in their bodies they feel their emotions. Many do not cry or find it very difficult to cry. Sleeth and Barnsley (1989) explored the way survivors cope with abuse. One way is to disconnect any feelings that are present. Fear and pain are extremely overwhelming and it becomes easier to live with their secret if they do not have to feel. Part of the healing process is learning to acknowledge and express emotions, which can be intense and scary at times. Group members agreed however, that this needs to happen and that they then could learn to experience good feelings as well as bad ones.

The participants discussed insecurities, fears and fears of the unknown as it relates to experiencing new emotions and ending old patterns. Insecurities and misunderstandings in relationships have contributed to the fear group members have experienced. Many felt that men have defined for so long what is "normal" and "good" for them, that they have learned to devalue their own feelings and ways of knowing. I believe this has been true for women generally. Women have been told what to think, how to act and what to do for such a great part of their lives, that it becomes difficult to listen to one's own instincts. Women need opportunities to re-affirm in themselves, to find their own values and voices. When a child has been sexually abused it becomes even more difficult to define one's own reality. A child's reality has been severely distorted, usually by an adult who has taken

advantage of a child's lack of knowledge and experience. How then does an adult learn to value what she knows when it has been denied as a child?

Breaking old patterns can be difficult and scary. Old behaviours and attitudes are safe. They are known and are predictable. When something went wrong, such as a break up in a relationship or an argument with a partner, it was easy to revert back to old patterns. Suicidal thoughts, plans and actions, negative self-talk and over eating are examples of old patterns that group members talked about automatically returning to. However, understanding the context that patterns developed in, is a good beginning. By becoming aware of their reactions and the situations that triggered these reactions, group members could then make a conscious decision about the kinds of changes they could make. As they "try on" new behaviours they will be able to discard what is not so useful to them. One group member suggested that others ask themselves how they could make their hearts happy. I liked this idea, as did other group members. This might assist them to begin looking at their own needs and acting in ways that could make them happier.

#### **j. Session Ten - Relationships**

The goals for Session Ten were:

1. To discuss the effect sexual abuse has on relationships.
2. To explore healthy and unhealthy relationships.

The focus in this session was on defining healthy and unhealthy relationships and the effect sexual abuse has had on their boundaries. We did discuss triggers and automatic reactions in sexual relationships as described by Maltz (1991) but did not complete this

discussion. They expressed their anger about being victimized as children and as adults. Their experience with sexual assault as adults was discussed. This triggered anger, as well as other automatic reactions, in group members. During this discussion, members used phrases such as, “feel sick”, need to “throw it up” and “put it out there where it belongs” to describe their feelings about the victimization that they and others experienced as children and adults. Some participants became numb during this discussion as they acknowledged the extent of their own victimization. At the same time they realized their own sense of personal power.

The group brain-stormed their ideas about healthy and unhealthy relationships. This was placed on flip-chart paper and I offered to organize and type it for the next session. As I wrote the words that described healthy and unhealthy relationships, I was running out of space and the paper became cluttered. Group members commented that the “clutter” reminded them of the way in which they often felt about relationships. They felt it symbolized their own state of mind regarding these matters.

As we brain-stormed, group members continued to discuss their attraction to “bad boys”. Once again they reiterated that they felt less vulnerable with this type of man. They knew abuse and acknowledged that danger is predictable and safer for them. They expressed confusion regarding their instincts and feelings about men that may not be healthy for them. Their instincts may be cautioning them but they do not pay such much heed. Some group members however, shared that at times they could feel attracted to someone but they did not have to act on it. However, they believed that they deserved to be in a good relationship.

Group members explored healthy and unhealthy sex. Experiencing sexual desire and/or pleasure in their relationships usually triggered guilt. They felt that if they desired sex as an adult, then it meant that as a child they must have wanted it, or the abuse would not have happened. This then led them to the belief that the abuse was their fault. We agreed to discuss this issue further the following week as well as other automatic reactions in sexual relationships.

As group members shared their experience with sexual assault, “rescuing” behaviours were triggered. Group members tried to help each other and took on responsibility for individuals. I realized this as I reviewed the tape and noted that in the future rescuing attempts should be processed in the group. Sleeth and Barnsley (1989) discuss issues related to rescuing and caretaking. Survivors learn to take care of the needs of others at the expense of their own needs. This became evident as they tried to alleviate group members’ experience of sexual assault and the intense emotions that were triggered.

I realized again the importance of working with a co-facilitator. I missed information, or if I did pick up on some important cues or information, I did not have time to respond. The session moved very quickly. In the future I would be aware of this and make attempts to slow the process down somewhat. This would also allow me to respond to the rescuing or other problems which might arise in the group.

#### **k. Session Eleven - Healthy Sex**

The goals for Session Eleven were:

1. To discuss unhealthy and healthy sex.

2. To develop a Sexual Bill of Rights.
3. To continue discussing sexual desire and automatic reactions.

Another technical difficulty became obvious upon reviewing the tape!! The first hour was not taped. I can not explain this and therefore, either will blame mischievous fairies or own up to it and fault human error!!! Once again I thank my obsession with keeping notes.

The opening exercise involved choosing a coloured paper that represented the way which individual group participants felt. Each participant was feeling very positive and “up”. This was the second last session and it appeared that group members were placing some containment on the process. We did make an attempt to address the topic and automatic reactions but it did not take hold or stimulate a great deal of discussion. The group was winding down. A part of me felt that we “should” have stuck to the planned agenda because it was the second last group and there were some issues that the group did not address. However, this was my own agenda and not theirs. They decided what they needed and the direction the group was taking.

We planned the last session and we also discussed and planned a two day retreat to be held one month after the end of the group. I had been involved in one retreat in the past and felt that it was a good way to provide follow up and to celebrate completion of the group. We reserved the school board grounds at a place called Gwillam Lake, which is a glacial lake nestled in the foothills of the Rocky Mountains. South Peace Community Resources Society agreed to provide financial support in order to make it possible for us.

Group members discussed health issues such as hysterectomies and childbirth. As well they discussed the meaning the word, “slut” had for them. They noted that there was a difference in impact when the word was used to refer to a male as compared to when it was used to refer to a female. They felt that when women were called “sluts” it seemed to be negative and shameful. However, according to the participants, males seemed to be somewhat proud of this label. It seemed that the word when used to refer to males, was similar to the phrase “sowing your wild oats”. Participants were aware of the double standards in our society and how such have impacted on them as women. However, group members did not want to work on anything more. The session turned out to be fun.

### **I. Session Twelve - Closing**

The goals for the last session were:

1. To evaluate the group.
2. To celebrate the end of the group.

This was the last session. Each evaluation tool was completed, including the group evaluation forms. The “Wise Woman Visualization”, from Working Together For Change: Volume II was used to begin the final session (p.99). This exercise is meant to guide members in finding answers to questions they may have, by searching within themselves. I believe that women know the answers to their questions and that these answers lie within. In my experience this visualization is very powerful and at the very least, women do feel a sense of their own power once they have completed the visualization. I find it to be an

excellent exercise to use at any time, but seems to be particularly powerful at the last session.

We discussed the ending of the group and plans that group participants had about continuing meeting together as a group. They shared phone numbers and planned to continue to meet at a participant's house. We were hoping to view the film, Goddess Remembered (Pettigrew and Read, 1992), but the group members decided against this. Instead we celebrated. We ate, laughed and had fun. The group closed with each member sharing a wish for herself and for the other group participants. When the participant completed her wishes the group responded in unison by repeating "Let It Be". The idea was taken from the manual Working Together For Change: Volume II. I have done this exercise in other groups and it seems to be an exercise women enjoy doing. In my opinion it is very empowering and is an excellent way to end a group.

Group endings are sad and at the same time energizing. It is a time to think about the few weeks that they came together to meet as a group. It is also a time to move on. Although the group would not meet formally, I believe that keeping doors open for participants to decide how they will proceed provides group members with a sense of connection and continuity. In my experience facilitating other groups, it seems that group members have made new connections and developed new friendships. They may not meet as a group but they do report that they keep in touch with each other. It appears that a bond is often made between members. If nothing else, this is important for women's sense of self. They know that there are other woman with whom they can talk, and who will understand them.

## **Conclusion**

Group intervention is one path in survivors' journeys to self-acceptance and self-love. Although I do not believe that in 12 weeks, problems will be completely resolved; I do believe that with support, understanding and help from others, survivors will begin to feel better about themselves and learn to be proud of their accomplishments. This is an on-going process.

Sex, intimacy and relationships are important parts of our lives. We all want to feel close to others and to share our lives. However, the experience of sexual abuse affects a woman's perceptions of herself and others. This group offered an opportunity for women to come together to share their concerns about their sexuality and their fears about their ability to experience closeness. It also provided a format to discuss their relationships and their experiences of sex.

The recruitment, screening and selection process were somewhat different in that I had previously developed a professional relationship with six of the eight women. Because of these prior relationships and the knowledge I had regarding the women, screening and selection did not follow a format that I would use with someone not known to me. Recruitment in a small community was also challenging. Large numbers of potential members, that one can find in a city, are not available in smaller communities. Issues of confidentiality and anonymity are of greater concern for potential group members as well as for facilitators. Another issue regards the competing roles that a social worker plays, as a worker in the community and as a member of the community. A social worker plays many roles, working as a community worker, counsellor, group facilitator, advocate and

often much more. Does this multiple role playing pose a problem in the process involved in screening? Some questions that are raised are;

- Are issues of recruitment, screening and selection in small communities different than they are in cities and if so how are they different?
- What do social workers need to know and do in order to address these issues?
- How does a social worker screen group members when she has knowledge of a potential member through prior contact as a member of the community and as a worker in the community?

There is not a great deal of literature, specifically on groups, that addresses the issues present in small communities. Kamin and Beatch (1991) discuss an Inuit community in Spence Bay, North West Territories, and the implementation of a program that addressed issues of violence and abuse. The community worked closely with workers from a variety of agencies located in Yellowknife. These agencies, including the women's shelter in Yellowknife, offered a wide variety of services dealing with abuse. Workers employed by these agencies were involved in training para professionals in Spence Bay. The community decided to offer groups and healing circles for women who had experienced physical, sexual, emotional and other forms of abuse. By focusing on all forms of abuse they were able to address problems related to numbers and perhaps could alleviate any stigma that a woman might feel if she is attending a single issue group. However, issues regarding confidentiality, multiple roles and safety are not addressed. In addition, I wonder if some women may minimize the abuse they experienced, if they perceive that someone else has

experienced multiple forms of abuse. Although a formal evaluation had not been completed, the authors state that it appeared to have a positive effect on the community. Perhaps a more general group or combination group would be more suitable in smaller communities.

Literature is available that does address the issues that are present in small communities (Collier, 1991; Martinez-Brawley, 1990 and Zapf, 1991, 1993). These authors discuss the differences between urban and rural, northern and remote social work practice. They explore issues that face social workers who work in small communities and ways they can be successful in their work. However, it is not within the scope of this report to address northern social work practice, but I feel it was important to identify the unique circumstances that surround group work in small communities. In my view, these issues require further research and professional discussion and collaboration in order to assist social workers who work in small northern or rural communities.

The content and process of this group was a positive learning experience for me. I have never facilitated a group that focused entirely on sexuality. I learned what topics were important, what needed to be omitted and what required further exploration. However, I can only say that this was the case for this particular group. The issues that group members explored are unique to them and it may be quite different for others in another group. However, it appeared that many of the issues that the participants addressed seemed to be supported in the literature (Maltz, 1991; Dolan, 1992; Briere, 1992; Westerlund, 1992 and Sleeth & Barnsley, 1989). Fear of losing control, lack of trust and fear of intimacy, confusion over gender identity and relationships, body shame and a

distrust of their own instincts are problems that the participants identified and are identified in the literature. Although I would recommend that the sessions be expanded upon, it would ultimately rest with group participants regarding the content and process. As a facilitator we follow their lead. The group is for them and part of the intention is to provide them a place to deal with issues that are relevant but that they feel are important in their healing processes.

Earlier, I described the four stages of the group process as defined by Corey and Corey (1992). To re-cap they are; the initial stage, the transition stage, the working stage and the ending stage. This particular group appeared to work through a similar process. In the initial stage, although some group members were known to each, they appeared to be learning more about one another. It seemed that they moved quickly into the transition stage. As I described in Session Two, group members seemed anxious and guarded. In the third session we addressed some of their fears and it appeared that group members were then able to begin focusing on their own feelings and thoughts. The group also bonded by the third session and group members were working with and supporting one another. It is possible that participants bonded quickly because some women knew each other. This would cut down the time needed to learn about each other. Additionally, I had developed a counselling relationship with six of the eight women. Therefore, it is possible that they felt comfortable enough with me and knew what to expect of me.

As the participants worked through the second stage, it did seem that at certain times we moved into the third stage or working stage. Group members assumed more responsibility regarding the content and the direction the group would take. In addition,

the group was less structured at times. According to Corey and Corey (1992) group members will move in and out of this stage to earlier stages. This seemed to be the case. Perhaps if there were more sessions, we would have been able to continue to stay in the working stage.

The ending stage generally appeared to follow the process described by Corey and Corey (1992). Group members began to feel anxious about the group ending as we moved closer to the last session. However, it also appeared that there was a sense of relief. As I described in Session Eleven, they did not want to focus on the topic. Instead we discussed various issues that pertained to women's health concerns. The atmosphere was lighter and group members appeared to be containing any issues they had. At the last session we discussed plans the participants had to meet on their own. Feedback from the group evaluations suggested that group members felt the experience was positive and that they understood themselves a little better.

I have a great respect for this group of women. At times the process was very painful. As I watched women struggle with their pain , I was struggling with my own responses and feelings. At times I wished that I could make it easier or I felt a great deal of anger at those who victimized them. I felt life was unjust, that the hand it dealt these women could be so unfair. But as I listened to their stories of survival, I heard the laughter and their hope. I felt the warmth of their courage and strength. This was their gift to me. It was truly wonderful. They are honourable women.

## **CHAPTER 4**

### **The Outcomes**

#### **Introduction**

If finding information related specifically to sexuality issues was difficult, it was even more difficult trying to determine what evaluation tools would be appropriate for this particular group. It was important to find and use questionnaires that would be quick to implement and easy to use and score. I did not want to use any tools that appeared to be overly intrusive. Corcoran and Fischer (1987) suggest that when choosing a scale, one issue the practitioner needs to consider is whether or not the scale is socially acceptable to clients (p.60). Some scales, such as the Sexual Arousalability Scale and Sexual Behavior Inventory - Female (SBI-F) ask specific questions regarding sexual acts and measures sexual anxiety (Corcoran and Fischer, pp. 308-314, 1987). I felt that the questions would be traumatizing to clients as a result of their experiences. I did not want the group experience or the questionnaires to be purposefully traumatizing. Perhaps if the goal of group intervention was to provide sex therapy then these questionnaires may possibly be helpful in determining how group intervention changed clients' anxiety towards certain sexual acts. However, this particular group was not intended to provide sex therapy to women and I decided they would not be useful.

Corcoran and Fischer (1987) and Bloom and Fischer (1982) advise that any evaluation tools should be tested for reliability and validity in order to be sensitive to particular problems and to change. With the assistance of my supervisor, I chose the tools that I thought were appropriate for this group. The tools chosen were taken from the texts

of Corcoran and Fischer (1987) and Bloom and Fischer (1982). In these works they describe the use of standardized measures to evaluate clinical intervention with individuals, couples, families and groups. They offer a number of standardized evaluation tools, developed by various researchers, that measure a wide range of attitudes and behaviours. In this next section I will discuss and describe the evaluation tools used, how the data was collected and the results. I will also discuss the advantages and limitations of using a group as a form of intervention.

### **Method**

I used four standardized questionnaires to measure whether or not the group intervention contributed to change. The four questionnaires that I used were:

- the Index of Self-Esteem (Hudson in Bloom and Fischer, 1982, p.153 & Corcoran and Fischer, 1987, pp. 188-189), [see Appendix G] ).
- the Generalized Contentment Scale (Hudson in Bloom and Fischer, 1982, p.152 & Corcoran and Fischer, 1987, pp. 165-167), [see Appendix H] ).
- Miller Social Intimacy Scale (Miller and Lefcourt in Corcoran and Fischer, 1987, pp. 230-232, [see Appendix I] ).
- Negative Attitudes Towards Masturbation (Abramson and Mosher in Corcoran and Fischer, 1987, pp. 247-249), [see Appendix J] ).

I also used a group evaluation questionnaire (see Appendix K) to elicit participant feedback about the effectiveness of the group. I developed this form based on a variety of feedback forms that I had used and seen throughout my work experience.

All the scales were completed during the first session and the last session. The group evaluation questionnaire was completed at the end of every month. Group members were instructed to answer all questions as honestly as possible. They were informed that there were no right or wrong or good or bad answers. I cautioned that these tests did not indicate that there was something wrong with them but only said something about what was happening for the moment and that the scores were sensitive to situational changes. I also attempted to normalize scores that may indicate problems by providing them general information about the effects of sexual abuse. I tried to reinforce their own ways of knowing themselves. I also let them know that I would give them copies of the tests and scores. Following is a description of the tools, the feedback form and how the data was collected. I have also included an analysis of the results for each questionnaire.

### **1. Index of Self-Esteem**

This questionnaire is described in Bloom and Fischer (1982, pp. 148-151), and Corcoran and Fischer (1987, pp. 188-189). This scale was developed by W. W. Hudson in 1974 and is widely used to measure the degree, severity and magnitude of an individual's self-esteem. Scores range from 0-100. The cut off score is 30 with anything above 30 indicating problems with low self-esteem. It was tested on a total of 1745 clinical and non-clinical populations from different backgrounds. Scoring is described in Bloom and Fischer (1982, pp. 150-151). Certain items on the test are reverse scored. Missing items can be calculated by following the instructions provided in Bloom and Fischer. Reliability and validity results are described in Corcoran and Fischer (1987, p.188). It is reported to possess internal reliability with a mean alpha score of .93 for, a standard error of

measurement of 3.70 and a test-re-test correlation of .92. It has known-groups validity in that there is a difference between those with problems with self-esteem and those without. It also was proven to have good construct validity. The scale, therefore, seems to be measuring what it says it is measuring, giving it good content validity.

I decided to use this particular scale for a number of reasons. As the literature points out, women who have experienced abuse, and I would add many women generally, suffer from low self-esteem. A tool such as the Index of Self-Esteem provides both therapist and client with information regarding changes in self-esteem. The goal many women have is to feel better about themselves. I wanted to know if this particular group would contribute to higher self-esteem. Additionally, it is simple to administer and I have also previously used this tool with individuals and in groups. Women seem to enjoy doing this questionnaire and appreciate the immediate feedback they get regarding their progress. Many have also requested using tools such as this to monitor how they are doing and to determine what they can do to feel better about themselves.

The Index of Self-Esteem was completed once a week. The forms were completed before the group session started. Scores were calculated and copies were given to the members the following week. Group members were encouraged to keep track of their scores and graphs were provided to help them plot their progress as well.

## **2. Generalized Contentment Scale**

This scale is described in Bloom and Fischer (1982, pp. 148-151) and Corcoran and Fischer (1987, pp. 165-167). It was developed by W. W. Hudson in 1974 and measures the degree, severity and magnitude of non-psychotic depression. It examines feelings

about behaviours, attitudes and events associated with depression. As with the Index of Self-Esteem, it too has a cut off score of 30 with a range from 0-100. Scores over 30 indicate the person is depressed. This scale was tested on 2140 clinical and non-clinical populations. The majority of those tested were Caucasian with small numbers from Japanese and Chinese backgrounds and from other ethnic groups. Scoring is identical to the Index of Self-Esteem described above. Reliability scores are good with a mean alpha of .92 indicating good internal consistency and a standard error of measurement of 4.56. It is stable with a 2 hour test-re-test correlation of .94. It has proven known-groups validity, concurrent validity and has construct validity. It also appears to test what it says it is testing, giving it good content validity.

The reasons for using this particular scale are similar to those stated for using the Index of Self-Esteem. Many women who are survivors experience depression and generally feel bad about their situations and their lives. As the literature points out, and as women report, they often feel different from others and state they do not feel optimistic about their futures. Once again I was interested in knowing if group intervention would contribute to women feeling more in control and optimistic about their future. The scores would indicate whether or not this particular form of intervention is making a difference.

The Generalized Contentment Scale was completed once a week. The forms were completed before the group session started. Scores were calculated and copies were given to the members the following week. Group members were encouraged to keep track of their scores and graphs were provided to help them plot their progress as well.

### **3. Miller Social Intimacy Scale**

This tool is described in Corcoran and Fischer (1987, pp. 230-232). It was developed by R.S. Miller and H. M. Lefcourt in 1982 and measures the level of social intimacy and closeness with others. Six of the items measure the frequency of intimacy and eleven measure the intensity. It was tested on 252 clinical and non-clinical populations of which 72 were male and 116 were female undergraduate students with a mean age of 21.3; 17 married student couples, and 15 married couples seeking conjoint therapy. The norms reported for the different groups were originally for a ten point scale. The particular scale that was administered in this group was a five point scale with two items reversed scored. The maximum score for the five point scale is 85 with higher scores indicating a greater degree of intimacy. The questionnaire was reported to have good internal reliability with alphas in two samples of .86 and .91. It is also stable with a two month test-re-test of .96 and a one month test-re-test of .84. It is reported to have good known-groups validity and construct validity and is not affected by a social desirability response set.

I decided to use this particular scale because it measures intimacy. A great deal of survivors report having problems feeling close to and trusting others. Because the group would be addressing this issue, it appeared that this scale would determine if the group contributed to changes in the way participants experience intimacy with others.

The Miller Social Intimacy Scale was completed four times throughout the duration of the group. It was completed on March 30, 1995; April 20, 1995; May 18, 1995 and June 15, 1995. I used the scale on April 20 and May 18 because it related to the topic area. On April 20 the topic was Family of Origin and on May 18 it was Sex and Intimacy.

The tests were taken as members arrived. Scores were calculated and copies of the test and scores were provided the following week. The goal for using this scale was to determine if there were any changes occurring as a result of the group intervention.

#### **4. Negative Attitudes Towards Masturbation**

This scale was developed by Paul R. Abramson and Donald L. Mosher and measures negative attitudes towards masturbation (Corcoran and Fischer, 1987, pp. 247-249). The belief is that those who hold negative attitudes towards masturbation also possess a lack of information regarding their sexuality. They may engage less frequently in masturbation and be sexually inexperienced. Knowing whether or not an individual holds negative attitudes may assist a therapist in their intervention. The test is reported not to be influenced by gender.

The inventory was tested on 95 male and 99 female college students. The mean score for females was 72.44 with a standard deviation of 16.36. The mean score for males was 72.06 with a standard deviation of 15.29. The scale consists of 30 items, reverse scoring some items (Corcoran and Fischer, 1987, p. 247). The range for scores is 30 - 150 with higher scores indicating more negative attitudes towards masturbation. Reliability for internal consistency is reported as good, based on a Spearman Brown correlation of .75. Test-re-test reliability correlations are not available. It is reported to show concurrent validity with correlations between scores on the scale and sexual guilt, sexual experiences and frequency of masturbation for females.

I decided to use this particular scale because it did not appear to be intrusive. It questions attitudes without asking questions about certain behaviours or acts. Survivors

report experiencing difficulties with sex and feelings of shame over bodily responses. It seems then that if scores indicated negative attitudes towards masturbation it could then say something about their attitudes regarding their sexuality. An improvement in attitudes over the duration of the group might indicate that the group was contributing to this change.

The Negative Attitudes Towards Masturbation questionnaire was completed three times on March 30, 1995, May 18, 1995 and June 15, 1995. The test was taken on May 18, 1995 because it related to the topic area. I wanted to determine if attitudes were changing as a result of the group intervention. The tests were taken as members arrived. Scores were calculated and copies of the test and scores were given to the members the following week.

### **5. Group Evaluation**

This is a non-standardized evaluation tool that I developed to use in groups. I reviewed other client satisfaction forms and developed this particular feedback form. I have also used it in previous groups that I have facilitated. The questionnaire consists of 10 questions. Participants are asked to circle the response from 1-4 that best matches their feelings. Questions F, H and I, ask participants for comments only. After each question and at the end of the questionnaire, room is offered for open-ended comments.

The Group Evaluation Form was completed at the end of every month. Initially the evaluation form was given at the end of the session. However, group participants stated they were tired by the end of the evening and suggested the form be filled out at the

beginning of the session. This was implemented and subsequent forms were completed at the beginning of the session.

## **Results**

In this section I will describe some of the findings from the standardized tests and feedback from the group evaluation forms. Generally, it appears from the data that self-esteem increased and depression decreased. It also appears that attitudes towards masturbation improved overall. However, intimacy scores did not appear to change. Following is a presentation of the data and statistics calculated for each test.

### **1. Index of Self-Esteem (Table 1, Figure 1)**

Table 1 shows the score for each participant and each participant's average for all sessions. The number of tests from 1 to 12 is shown, along with group averages over the 12 weeks. Figure 1 demonstrates average scores for each session and a downward trend indicating that self-esteem improved over time. The standard deviation is also included for each session. Some group members did miss sessions for various reasons. In addition, there were times when participants thought that they had handed in a scale but I could not locate it. A possibility was that the scales were accidentally placed in their folders and were misplaced. At other times a group member would occasionally protest and did not do the scale for that particular session.

It appears that the majority of group members showed an improvement in self-esteem. Clients 1,3,4,6, and 7 seem to show an increase in self-esteem. Client 2 scored below 30 for all tests and client 8 scored over 30 for most tests. Their individual average scores also

indicate that generally they appeared to be experiencing higher self-esteem. Over the course of group intervention, scores for group means also show improvement over the 12 sessions. Although individual scores for client 5 improve over time her overall average was 31.8, which is slightly above the cut off score of 30.

Group means can be affected by very low scores and high scores and the small number of participants in the group. I suspected that group members would score high for the first session and perhaps for the first two or three sessions. I hoped that over time, self-esteem would improve, which did occur. However, because of the presence of a few extreme scores, I have calculated the standard deviation to provide a clearer description of the variability in the data. By using this statistic I was able to identify that over time the variation in individual scores decreased.

Session One provides a base-line upon which to compare group means. In Session One, the range of scores was between 2 and 53. The group mean was 38.750 and the standard deviation was 16.228. In Session Six, the group mean was 19.0, the range of scores was between 2 and 41 and the standard deviation was 13.587. Session Twelve showed a group mean of 10.875 with a range of scores between 0 and 32, and a standard deviation of 11.012. Although there were high and low scores during these three sessions, generally, it appears that by the time Session Twelve happened, the scores indicated more positive responses from group members than responses from Session One. It also demonstrates less variability in scores. In effect, the responses “evened out”, so that their

**1. Index of Self-Esteem (Table 1, Figure 1)**

**Table 1. Individual scores for each session, individual averages over 12 sessions and group averages for each session for the Index of Self-Esteem (cut off score of 30 - 30+ indicates low self-esteem).**

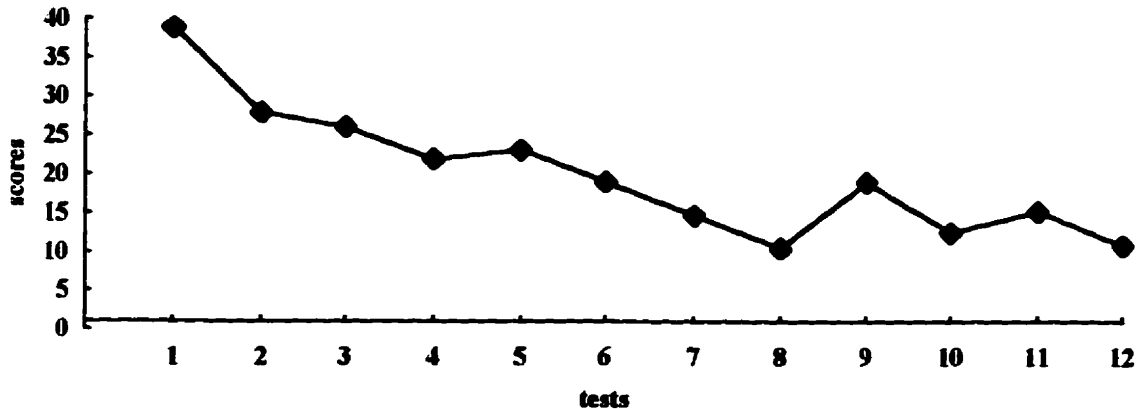
Tests	Client 1	2	3	4	5	6	7	8	Gr.Av	St.Dev
1	53	2	40	43	48	33	40	51	38.750	16.228
2	22	7	32	30	47	34	23		27.857	12.375
3	18	5			42	33	5	53	26.0	19.9
4	15	4	24	22	44	30	14		21.857	12.838
5	15	0		19	47	25	17	39	23.143	15.710
6	15	2	26	17	34	10	7	41	19.0	13.587
7	13	1		18	23	7	12	29	14.714	9.499
8	4	4		17	20	9	9		10.5	6.656
9	51	2	13	38	16	4	9		19.0	18.457
10	4	1		20	20	5		25	12.5	10.291
11	4	2			19	4	20	42	15.167	15.368
12	0	2	9	12	21	1	10	32	10.875	11.012
Clav	17.8	2.8	24.0	23.6	31.8	16.25	15.1	39.0		

Clav = individual client average

Gr.Av = group averages

St.Dev = standard deviation

**Figure 1. Line graph showing group averages for the Index of Self-Esteem.**



self-esteem issues were less problematic. It appears that the group sessions perhaps had a positive effect on self-esteem over time.

Extremes in individual scores could be the result of situational factors. For instance, in Session Nine, client 1 had a score of 51, indicating low self-esteem. This was a large change from the week before. As mentioned earlier in the description of each session, she was experiencing some personal problems on that particular evening and was able to discuss this during the group session. The following week, her scores were low again, indicating an improvement in self-esteem.

It would appear that scores were very sensitive to situational factors. Self-esteem could be negatively affected by negative situations. It may be that some group participants experienced difficulty feeling good about themselves over the long term. However, the group experience may have helped women to improve their self-esteem. They were able to use the group to share their concerns and received feedback and support from others. It is my conclusion that participating in this group helped the women to better understand their

personal traumatic experiences. In some cases this may have contributed to finding solutions to their problems, and improving self-esteem, which appears to have occurred in this group.

## **2. Generalized Contentment Scale (Table 2, Figure 2)**

The scores for the Generalized Contentment Scale can be seen in Table 2. Mean scores for each participant were calculated as were the mean scores for each session. Standard deviations for each session are also included. Depression appeared to lessen over time for group members. This can be seen by their individual scores for each test and their average scores at the end of the 12 sessions. Also the group mean decreased over time and can be seen in Figure 2. However, after the first session, average individual scores and group means remained below 30. Scores for client 2 remained below 30 for every test, indicating that she may not have been depressed upon entering the group. The average score for client eight was 31.4, slightly above the cut off score of 30.

The range of scores in Session One were between 13 and 45, the group mean was 31.875 and the standard deviation was 11.294. In Session Six the range of scores was between 7 and 33 with a group mean of 19.0 and a standard deviation of 9.539. However, in Session Nine the range of scores were as high as 49 and as low as 3. This could affect the group mean and scatter the scores further from the mean. The group mean was 20.571 and the standard deviation was 17.915. However, it appears that in spite of a wide range in scores during particular sessions, they generally move closer to the mean and are less varied. The small numbers of participants and missing scores also affect the mean scores.

**2. Generalized Contentment Scale (Table 2, Figure 2)**

**Table 2. Individual scores for each session, individual averages over 12 sessions and group averages for each session for the Generalized Contentment Scale (cut off score of 30 - 30+ indicates depression).**

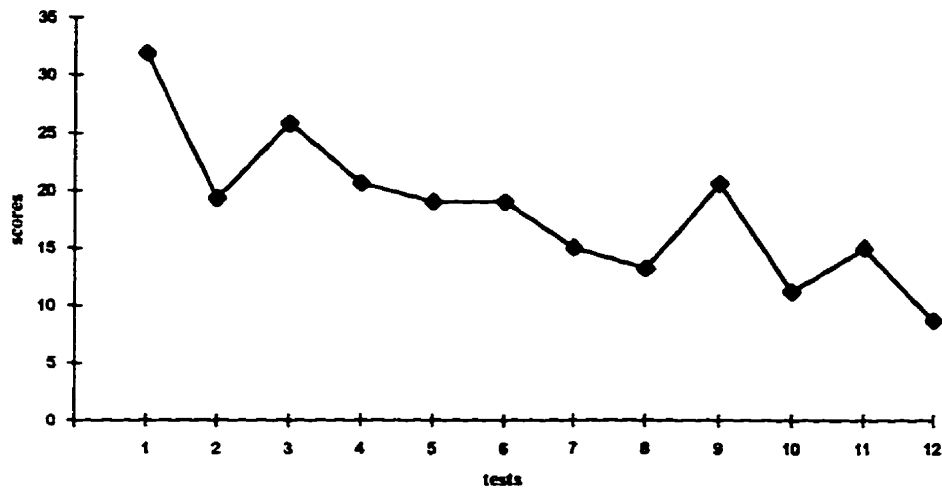
Tests	Client 1	2	3	4	5	6	7	8	Gr.Av	St.Dev
1	35	13	30	45	40	37	17	38	31.875	11.294
2	9	22	25	26		32	2		19.333	11.413
3	10	23			38	25	11	48	25.833	14.959
4	6	10	15	14	46	37	16		20.571	14.920
5		5		6	49	21	9	24	19.0	16.697
6		16	15	25	33	10	7	27	19.0	9.539
7	11	3		27	27	8	4	25	15.0	10.939
8	2	21		25	17	8	6		13.167	9.152
9	49	3	20	38	24	7	3		20.571	17.915
10	3	0		15	18	5		26	11.167	10.108
11	0	8			11	4	10	42	15.0	15.017
12	0	7		8	16	1	8	21	8.714	7.566
Clav	12.5	10.9	21.0	22.9	29.0	16.3	8.5	31.4		

Gr.Av = group average

Clav = client average

St.Dev = standard deviation

Figure 2. Line graph showing group averages for the Generalized Contentment Scale.



As with the Index of Self-Esteem, similar situational conditions can affect a score.

Client 1 shows an increase in scores on both the Index of Self-Esteem and the Generalized Contentment Scale in session 9. As discussed above, she was experiencing a difficult time but was able to process it in the group. Generally, the scores indicate that depression appeared to decrease over time.

### **3. Miller Social Intimacy Scale (Table 3, Figure 3)**

This test seems to indicate that there was very little change for group members, both in their individual scores and group averages. The total possible score is 85 for this test. Figure one plots individual scores for the four tests that were given. As can be seen, most participants who scored high, indicating they experience a high degree of intimacy, appeared to score high throughout the group. There were some variations. Those who had lower scores generally scored lower for each test taken. Client 1, 5 and 6 appear to improve over time. Client 2, 3, 4, 7 and 8 show relatively little change. However, the score for client 3 dropped between the second and third time she took the test, client 4

reached a high score of 83 the second time and then dropped off and client 7 shows a drop in score between the first and second time the test was taken.

When I examined the scores, I was surprised that they were generally as high as they were. The literature reports, as do the women themselves, that survivors usually have a great deal of trouble trusting others and experiencing intimacy. They experience considerable anxiety and fear in their relationships, whether it is a friendship or sexual relationship. However, the scores do not indicate this for everyone. The reason for this may be that because they are instructed to choose a close friend to base their response to the questions on, they may have developed a good relationship with that person. They may experience trust and closeness with them. This scale only measures intimacy with one particular person, not general attitudes towards intimacy with others. Therefore, this test may possibly be inappropriate for this specific group and a more general scale could have been used to test this. On the other hand, this could be seen in a positive light. Women who are survivors of childhood sexual abuse may not be any different from anyone else in that they are very capable of experiencing intimacy in their relationships. This can be empowering knowledge for survivors, because they often feel very different from others. By knowing this, they may begin to connect more to their own feelings.

Another problem inherent in using this scale is that it may be possible that the participants held a different person in mind each time they took the test. They are instructed in the beginning to describe their friend's gender and whether or not they are describing their spouse. I discovered that client 7 did change the person she was

describing. On March 30, May 18 and June 15 she chose a friend and on April 20 she chose her spouse. This is evident in her scores and could explain the noticeable decrease

### 3. Miller Social Intimacy Scale (Table 3, Figure 3)

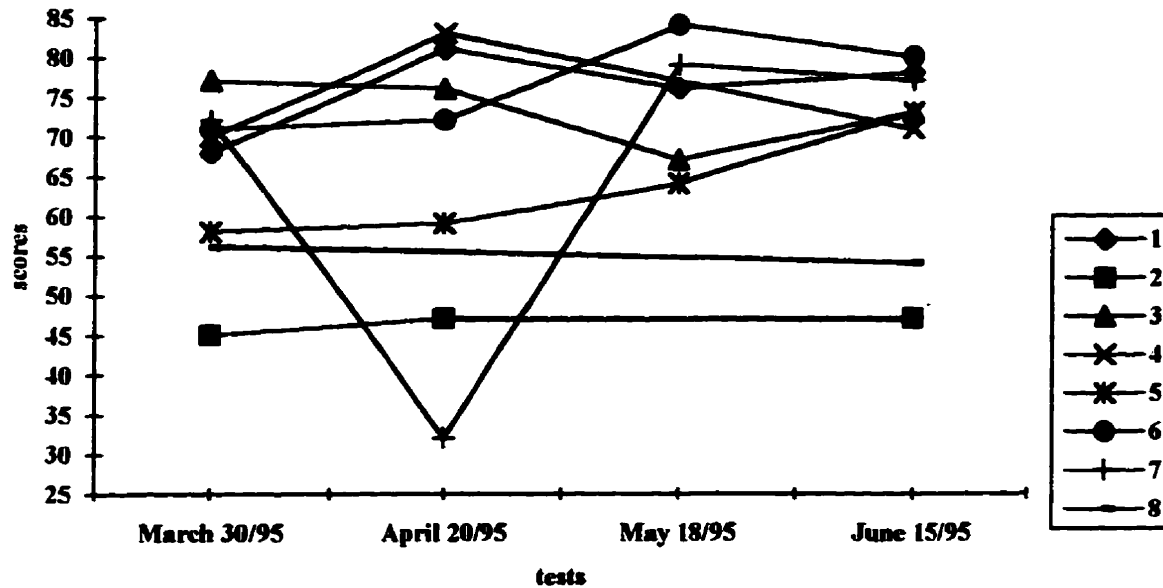
Table 3. Individual scores for each session, individual averages for all tests and group averages for each test for the Miller Social Intimacy Scale. Highest possible score is 85 with higher scores indicating a greater degree of intimacy.

Client No.	March 30/95	April 20/95	May 18/95	June 15/95	Clav.
001	68	81	76	78	75.8
002	45	47		47	46.3
003	77	76	67	73	73.3
004	70	83		71	74.7
005	58	59	64	73	63.5
006	71	72	84	80	76.8
007	72	32	79	77	65.0
008	56			54	55.0
gr.av	64.63	64.3	74	69.13	

Clav = individual client averages

Gr.Av = group averages

Figure 3. Line graph showing individual scores for Miller Social Intimacy Scale



between the first and second test. A question that would need to be considered is whether or not those participants who described a friend used that same friend with each test.

Lastly, another problem for scoring and comparing, is that the norms described by the researchers in Corcoran and Fischer (1987) are reported for a 10 point scale making it very difficult to make comparisons (pp. 230-232). This is a weakness because norms are not available for a 5 point scale and we can only guess what scores mean. There are no indications of cut off scores or the meaning of scores on the lower or higher end.

#### **4. Negative Attitudes Toward Masturbation (Table 4, Figure 4)**

Individual scores for each test, individual average scores and the average group scores all appear to show change in a positive direction (lower scores indicate a more

**4. Negative Attitudes Toward Masturbation (Table 4, Figure 4)**

**Table 4.** Individual scores for each test, individual averages over all tests and group averages for each test for Negative Attitudes Towards Masturbation. Range of scores are reported at 30 - 150 with higher scores indicating more negative attitudes.

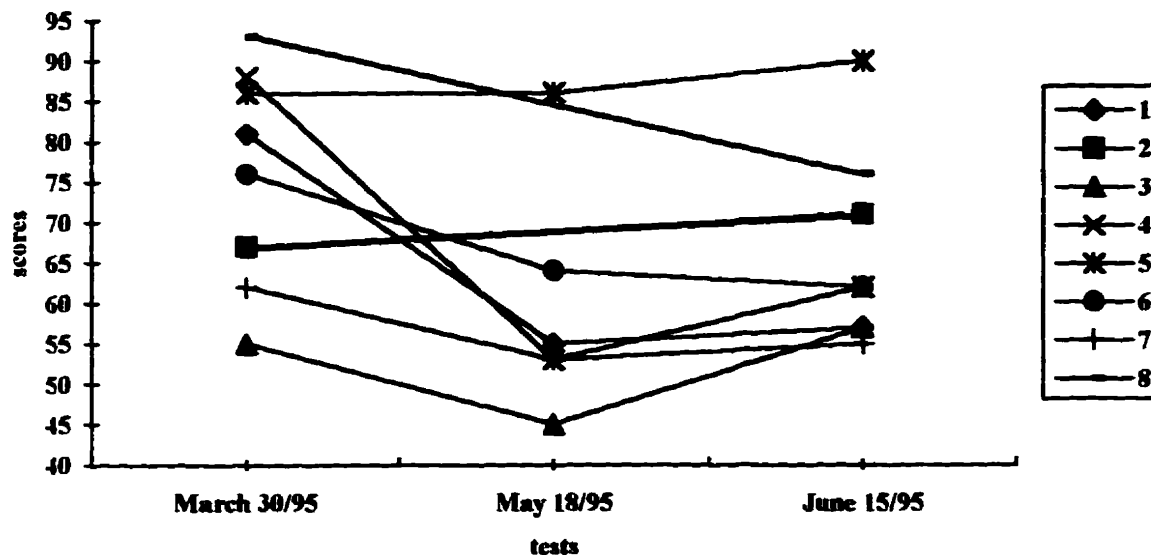
Client No.	March 30/95	May 18/95	June 15/95	Cl.Av
001	81	55	57	64.3
002	67		71	69.0
003	55	45	57	52.3
004	88	53	62	67.6
005	86	86	90	87.3
006	76	64	62	67.3
007	62	53	55	56.6
008	93		76	84.5
Gr.Av	76.0	59.333	66.250	
St.Dev	13.501	14.404	12.045	

Cl. Av = individual client averages

Gr.Av = group averages

St.Dev = standard deviation

Figure 4. Line graph showing individual scores for Negative Attitudes Towards Masturbation



positive attitude). Most group members scored close to the reported norms of 72.44 and some became lower over time. One participant shows little change and scores are higher than the group average. The standard deviation for the first test was 13.501, for the second test, it was 14.404 and for the third test, it was 12.045.

It is possible that the group intervention did have an impact in changing attitudes towards masturbation and in the way participants view their sexuality. In the group sessions we discussed sex, sexual attractions and sexual fantasies. Open discussions about these issues possibly helped participants to better understand their feelings and experiences contributing to more positive attitudes about masturbation. This can also be empowering to group participants, knowing that they are not any different from others. This may help them hold more positive attitudes towards their sexuality.

When the scores for individual participants are examined it appears that changes occurred throughout the duration of the group. The scores for client 1, 4 and 6 are as follows:

- Client 1 - 81, 55 and 57.
- Client 4 - 88, 53 and 62.
- Client 6 - 76, 64 and 62.
- Client 8 - 93 and 76

As can be seen, the scores for each client changed from test 1 to test 2. Scores for client 1 and 4 went up slightly from test 2 to test 3, but can be considered low. The scores for client 6 show a clear downward trend for each test. Client 8 shows a considerable decline from the first time she took the test to the second time. She did miss taking the test on May 18. However, her scores do show a clear downward trend as well. Generally, apart from a couple of exceptions, scores seemed to decrease over time. It appears that group intervention may contribute to more positive attitudes towards sexuality. However, the scale was given only three times, restricting the range of data. Perhaps a clearer downward trend could be traced for clients 1 and 4 if the scales were given more often. It could also demonstrate if client 6 and 8 continued to maintain low scores if the scale was given more often.

#### **5. Group Evaluation (Table 5-15)**

As discussed earlier, the group evaluation forms were completed at the end of every month. Tables 5 - 15 provide a description of the way participants answered. It appears

that group members tended to answer the questions very positively. As can be seen by the comments, it appears that generally group members were very satisfied with the group. Table 8 indicates that one group member was very dissatisfied with my facilitation. I am not sure the reason for this as there were no explanations or comments included in the evaluation form. However, because so many of the comments were positive, there may be a few possibilities for this. Group participants were aware that I was offering this group as a requirement for my master's degree. They knew that I would be evaluated on it. Perhaps participants were wanting to help me by providing extremely positive feedback. In addition, they may not have wanted to hurt my feelings by providing

**5. Group Evaluation (Table 5 - 15)**

**Table 5.** Total answers for each evaluation of participants to question (A) of group evaluation: How helpful did you find this group?

Answer	April 20	May 25	June 15
1. Very helpful	6 (7)	4 (6)	7 (8)
2. Helpful	1 (7)	2 (6)	1 (8)
3. A little helpful			
4. Not helpful			

Number in brackets (7, 6, 8) denotes total number of participants who completed the evaluation.

**Table 6.** Total answers for each evaluation of participants to question (B) of group evaluation: To what extent were you satisfied with the material presented by the facilitator?

Answer	April 20	May 25	June 15
1. Very satisfied	7 (7)	5 (6)	8 (8)
2. Satisfied		1 (6)	
3. Dissatisfied			
4. Very dissatisfied			

Number in brackets (7, 6, 8) denotes total number of participants who completed the evaluation.

**Table 7.** Total answers for each evaluation of participants to question (C) of group evaluation: Was there enough opportunity for participation?

Answer	April 20	May 25	June 15
1. None			
2. A little			
3. A fair amount	2 (7)	1 (6)	4 (8)
4. A great deal	5 (7)	5 (6)	4 (8)

Number in brackets (7, 6, 8) denotes total number of participants who completed the evaluation.

**Table 8.** Total answers for each evaluation of participants to question (D) of group evaluation: How satisfied were you with the facilitators?

Answer	April 20	May 25	June 15
1. Very satisfied	5 (7)	5 (6)	7 (8)
2. Satisfied	1 (7)	1 (6)	
3. Dissatisfied			
4. Very dissatisfied	1 (7)		1 (8)

Number in brackets (7, 6, 8) denotes total number of participants who completed the evaluation.

**Table 9.** Total answers for each evaluation of participants to question (E) of group evaluation: Do you feel that group members' rights were respected by the facilitators?

Answer	April 20	May 25	June 15
1. No, almost never respected			
2. No, sometimes not respected			
3. Yes, generally respected			2 (8)
4. Yes, almost always respected	7 (7)	6 (6)	6 (8)

Number in brackets (7, 6, 8) denotes total number of participants who completed the evaluation.

**Table 10.** Comments of participants to question F of group evaluation: What did you learn as a result of the group?

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Comments

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1. We all share the same problems and have mega support form one another.
  2. Others have been through the same experiences I have.
  3. Learning things about my family, finding new strength.
  4. That I do have more scars to heal.
  5. There is hope.
  6. That I am not the only one who has this problem and to trust the group a lot more.
  7. All women are different, this is good.
  8. That I have a lot still inside that needs to come out.
  9. I am not alone, I'm not crazy and there are steps for me on my way to 'recovery'.
  10. I learned I can enjoy sex and life without allowing my past to interfere.
  11. The group was support through some real scary emotional changes. Thanks!
  12. I learned that no matter what we think of ourselves because of the abuse, it's not valid here.
  13. That I am like others and understand my feelings more. Didn't know I could feel so much.
-

**Table 11.** Total answers for each evaluation of participants to question (G) of group evaluation: How would you rate the quality of the group?

Answer	April 20	May 25	June 15
1. Excellent	5 (7)	6 (6)	7 (8)
2. Good	2 (7)		1 (8)
3. Fair			
4. Poor			

Number in brackets (7, 6, 8) denotes total number of participants who completed the evaluation.

**Table 12.** Comments for question H of group evaluation: What suggestions do you have to improve the group sessions?

Comments
1. More groups!
2. Make it longer.
3. No improvements really. Title might be better as 'Intimacy and Sex'.

**Table 13.** Comments for question I of group evaluation: Are there relevant topics that were not addressed that you would have found helpful? If so, what are they?

Comments
1. Maybe more focus on the activities, somehow not spend all night on 'time'.

**Table 14.** Total answers for each evaluation of participants to question (J) of group evaluation: Would you recommend this group to a friend?

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Answer	April 20	May 25	June 15
1. Definitely yes	7 (7)	6 (6)	8 (8)
2. I think so			
3. I don't think so			
4. Definitely no			

---

Number in brackets (7, 6, 8) denotes total number of participants who completed the evaluation.

**Table 15.** General comments for group evaluation.

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General Comments

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1. Please have this type of group available to other 'first timers' because I'm living proof that you can still be normal but not feel normal until you are part of a group such as this.
  2. Very informative.
  3. Everyone spoke and shared.
  4. I find it educational.
  5. It's like going to school for being human beings.
  6. Cleared up a lot of things for me.
-

me with some critical feedback. Although participants did not sign their names to the forms, a possibility is that group members may have felt that I would be able to identify them and I would be upset if I received critical feedback. Lastly, this evaluation form is not a standardized evaluation and it has not been tested for reliability or validity. However, I believe the questionnaire may have face and social validity. Consumer feedback questionnaires tend to have a positive bias. However, it does ask for feedback from participants and therefore, the results could be accepted on face value alone. The answers to the questions and the comments are examples of their perceptions of the group format, structure and process. This is important and valuable.

### **Advantages and Limitations**

Evaluation tools that were used have advantages and limitations (Kazdin, 1982 and Bloom and Fischer, 1982). There may be problems with internal and external validity which can have an effect on the responses that participants made and the results. Other factors may affect the outcome. Advantages of using these types of evaluation tools are:

- Scores and means on the scales allowed me to draw some conclusions about the effectiveness of the group and to determine overall success of the group.
- The tests were easy to administer and score.
- They had practical significance rather than statistical significance which provided me with information about this particular group. Upon visual inspection of the data, I was able to make inferences about trends. Although these judgments are subjective in

nature and are problematic, the effects of the intervention can be clear (Kazdin, 1982, p. 239). Statistical analysis allows the therapist or researcher to determine if change is reliable and consistent. However, some problems exist regarding the appropriateness of using statistical analysis for single-case research. First, data from single-case research "... violates the assumptions on which various statistical tests depends." (Kazdin, 1982, p. 242). Developments in statistical analysis for between-group designs is much more advanced than that for single-case research. A second problem identified by Kazdin (1982) is that statistical analysis detects "... subtle and minor changes in performance and to identify as significant the effects of variables that ordinarily would be rejected through visual inspection." (p. 241). Therefore, visual inspection of the data can determine whether change has been dramatic. In addition, statistical analysis may not make it possible to determine if other factors are affecting change (Kazdin, 1982, p. 242). When I visually inspected the data, I could see that at times some group members scored higher than at other times. This allowed me to draw some conclusions about extraneous factors that may have affected scores. Therefore, the use of statistical analysis to determine significance may not apply to this particular situation and may not provide enough information to draw any conclusions about change.

- The data strongly supported that groups are an excellent form of intervention for women who are survivors of childhood sexual abuse because they help break through isolation.

**Threats to Internal and External Validity**

Although the information I received gave me an idea about changes, I am not able to determine whether or not this particular form of intervention is a causal factor in bringing about change. Other factors may contribute to change. These other factors are called threats to internal and external validity, making it difficult to say for certain that the intervention effected change. Some examples of threats to internal validity are (Kazdin, 1982, p. 78):

- **History:** Some other event may be happening in group members' lives that contributed to a change in the scores. For instance, a woman may leave an abusive relationship which may influence how she feels about herself. It did appear upon reviewing the data that scores on these particular scales were affected by situational factors that may have contributed to positive or negative change. Because we spent some time discussing individual problems in the group I often became aware of the problems. At times when a group member was experiencing a problem, the scores, particularly on the Self-Esteem Index and Generalized Contentment Scale, would reflect this. Scores would change in either direction depending on the situation in which the participant found herself.
- **Maturity:** I have stated earlier that most of the women except one had previous individual and/or group counselling either with me or at another agency. I believe it is safe to say that they were highly motivated and had already began the process of healing. For this reason it is difficult to say for certain that the group intervention had

an effect on change. However, overall it appeared to provide group members with information and support that in turn, assisted them to make changes in their lives.

- **Testing:** Participants may have answered the questions to the tests in a socially desirable way. This may especially be true with the group evaluation form. The scales used are highly reactive in that the very process of answering questions to the tests can bring about change. In addition the participants could learn how to answer the questions in a positive way. This is particularly true for the Index of Self-Esteem and the Generalized Contentment Scale because they were completed every week.

According to Kazdin (1982), internal validity is of greater importance than external validity because a therapist may want to know whether or not the intervention is a causative factor in bringing about change. However, in clinical settings, external validity is important in order to make generalizations about changes outside the clinical setting (p. 85). Hopefully, participants were able to continue feeling better about themselves outside the group setting. However, factors may have been present that would affect the outcome.

Some threats to external validity are (Kazdin, 1982, p. 82):

- **Generality across subjects:** The results may not extend to others who may be different from these particular group participants. I can not draw any conclusions about how other women would react to this group.
- **Generality across settings:** The results may not be generalized to other situations outside the group setting. For instance, a group member may not experience high self-esteem outside the group setting.

- **Generality across times:** It can not be known for sure that group members were able to use some of what they may have learned in the group, beyond the time that the group was held.
- **Generality across behaviour change agents:** It may be that the changes were only present when participants were part of this particular group. In addition, change may be dependent on the person delivering the service and would not be seen if someone else began facilitating the group.
- **Reactive experimental arrangements:** Participants were aware of the purpose of the group and may have been influenced by this knowledge.
- **Reactive assessment:** Group members were aware that I was keeping track of their scores and assessing them. They may have been reacting to this and responding differently than if these conditions were not present.

The results of the intervention can not be generalized to other women or settings. Other factors and situations may have affected the way in which participants responded to the questionnaires. Although I will offer a group of this nature to other survivors in the future based on the feedback gathered from the group evaluations, every group is different and therefore, I can not predict how other women will respond.

### **Additional Problems**

Some additional problems with standardized tests that Bloom and Fischer (1982) discuss are that instruments such as these may not be as reliable or valid as one may think. Usually large groups are used to conduct the research to determine reliability and validity.

When using the tests with individuals and in small therapy groups the data collected from large groups does not necessarily apply. There may be cultural, age, gender and class differences, which are not taken into consideration. In addition, the person taking the test or the one administering it could be experiencing an off day and therefore, the results will not really be a true measure. As well the test may not encompass a particular problem. It is important not to accept any results as if it is written in stone because of these variations.

As a facilitator in the group, I was responsible for giving the scales to the group members, scoring them and recording the scores. This threat to external validity is referred to as reactive assessment. I had access to the data and to the names of the participants who wrote the tests. They knew I had this access and as a result, they may have felt pressured to do well on the questionnaires. They may have wanted to prove to me that they were doing well and that the group was helping them. Perhaps a better way to handle the data would have been to give the completed tests to my supervisor to mark and distribute. This may have provided me with a different set of data.

Another problem with the tests is that it may not directly measure the range of problems that a person is experiencing on any given day and therefore, it may not detect any change in the individual. For example, an individual may be changing some behaviours but their attitudes are still the same. As well, some women from time to time were tired of taking the tests and would not complete the scales or forms.

It seems that upon reviewing each session, certain themes emerged that are supported by the literature. As mentioned previously, fear of losing control was a major concern for group participants. This affected their ability to be spontaneous in their relationships and

to enjoy sex with a partner. Trusting others and themselves was identified as a problem. This had an impact on their relationship with others. Related to this was a sense of shame regarding the body and sexual responses they may have had that were pleasurable. It led to self-condemnation and self-blame. Confusion over relationships and gender identity was also described as a concern. Although the Miller Social Intimacy Scale, which measured the level of intimacy towards others, may have shown that generally, some women did not have problems in their intimate relationships, the findings did contradict some of the issues women reported they had regarding intimacy, relationships and sex. It may be possible that the Miller Social Intimacy Scale had problems with validity. Perhaps the scores indicate that they are really no different than others clinically tested, or perhaps the self-reports during the sessions are a truer indicator of their feelings, beliefs and attitudes.

### **Conclusion**

Women who have experienced childhood sexual abuse may also be struggling with their own sexuality. Because the research in this area is limited, I was unable to find any standardized tests that would be able to adequately measure the attitudes and beliefs that women who are survivors have about their sexuality. It was difficult finding an appropriate scale that would specifically measure intimacy. Corcoran and Fischer (1987) provide a number of evaluation tools to choose. Questionnaires measuring anxiety in social settings, fear of negative evaluation, and loneliness may be more appropriate. In addition, the Index of Peer Relations described in Bloom and Fischer (1982) measures the way a person feels about their peer group. This particular scale might be a better scale to use in the future. However, it is difficult to know whether or not these questionnaires would provide any

information that would be appropriate. Perhaps self-rating scales would be the best measure, whereby participants are asked to devise a scale that describes their feelings of intimacy on a daily or weekly basis.

Qualitative research methods could be an alternative used in this research. As a feminist I believe that qualitative research is important and provides us with information that is useful and relevant. In depth interviews could be utilized. For example, Westerlund (1992) interviewed women and used qualitative and phenomenological methodologies in her research on the effects sexual abuse has on a woman's perception of her sexuality. She states, "Qualitative research is concerned with understanding a given phenomenon from the subject's own perspectives. The main focus of the phenomenological approach is the individual's subjective reality. Qualitative research methods enable us to enter and explore the inner world of the individual, and allow us to describe individual experience in depth" (p.181). Themes and patterns emerge from data collected that provide us with a better understanding of the complexity of the issue. Variations between participants can also provide information regarding differences in beliefs and attitudes.

Ultimately women are the only ones who can describe their experiences. We, as therapists and counsellors, have to follow the women's lead. They are our guides. They are the ones who know what they need; who have the answers and who can tell us whether or not we are on the right track in the work we do. In the final analysis these brave women are the heroines. It is up to us to listen and hear what they are saying.

## **CHAPTER FIVE**

### **Conclusion**

This chapter summarizes the group experience and my findings. I will explore some of the things that I learned about the issues group members identified. I will try and identify what worked and what didn't, and the areas that I believe require further exploration. I would also like to summarize the special challenges that face social workers and other human service workers who live and work in small communities. I will also comment about my style and learning goals. Although these findings are unique to this particular group, I hope that the general themes that group participants identified can be transferred into different settings.

The group came about as a result of the work I am involved in with female adult survivors of childhood sexual abuse. Women who experienced sexual abuse as children are deeply affected by the abuse. The very core of their being has been hurt. Damage has been done to their sexuality; the way in which they view themselves as women, how they experience the world and the way in which they believe others view them as women and as sexual beings. I decided that a group that specifically focused on sexuality seemed to be an appropriate format to work through some of the issues that women have identified.

### **Overview of the Findings**

This section will summarize the findings from the questionnaires that I used and from the sessions. I also will summarize the screening process. As previously mentioned I will

explore the issues that were identified and the challenges that are present in small communities.

**a. Questionnaires**

I used four questionnaires to measure the effectiveness of the group intervention. The questionnaires used were; The Index of Self-Esteem, The Generalized Contentment Scale, The Miller Social Intimacy Scale and Negative Attitudes Towards Masturbation. It appears from the results that group members did show improved self-esteem, and decreased levels of depression. It would seem that because group members had permission to discuss issues related to sex, intimacy and relationships their isolation and sense of shame was alleviated, thereby improving the ways in which participants felt about themselves and their lives. It is difficult to discuss these kinds of issues with friends or family and is even harder when sexual abuse is involved. It is a secret that some women do not wish to share. Because sexual abuse causes a woman to perceive herself negatively, she may fear being viewed as “abnormal” and may not want to discuss her feelings about sex, intimacy and relationships with others. She may fear being judged. In the group, participants could talk freely about the effect sexual abuse has had on them. They learned that others had similar feelings and thoughts, thereby “normalizing” their experiences. Women can then begin to view themselves differently and place the experience of abuse outside themselves. Therefore, it would appear that the group, at least in the area of self-esteem and depression, seemed to have promoted change.

The scores on Miller Social Intimacy Scale are not so clear. As I mentioned in the previous chapter, participants measured intimacy against a person they knew. This person

could be a spouse or friend. Women tended to score fairly high, with the exception of two. There can be various reasons for these findings. It is possible that this scale does not measure intimacy accurately. The scale that we used was a five point scale. The original scale was a ten point scale. There were no cut off scores offered nor were there any indications of what a low or high score would be. The only guide-line was that the higher the score, the higher the level of intimacy the person experienced. It seems then that I am making some judgments about what a high score is and is not. Perhaps other scales that measure intimacy in a general way could be used. Another option would be to do the same tests with others and compare the results. But perhaps intimacy is something that develops over time as we get to know someone. It is not a given and therefore, the scale may be appropriate in that the person who was chosen is someone to whom the participant had developed intimacy over a period of time. It makes sense, that as we come to know someone, we learn whether we can trust them or not and whether or not we can experience intimacy.

Based on this, it seems that the group intervention did not affect the levels of intimacy that participants experienced with others. It may be that contrary to their beliefs, and their statements about their experience of intimacy, women who experienced childhood sexual abuse were capable of experiencing intimacy with others (I will explore this further when I discuss the sessions). In addition, I failed to instruct group members to use the same person throughout each test. Although I discovered that only one participant changed the person she used in the scale, it is possible that others may have changed the individual they used to measure intimacy. In spite of this, the scores did not seem to demonstrate any

trends across phases and therefore, according to the scores, the group did not have an impact on levels of intimacy.

The scale measuring negative attitudes towards masturbation seems to show that the group did have an effect on their attitudes. The premise behind the scale is that if participants' scores show they have a negative attitude towards masturbation, it is an indication of their lack of knowledge about their sexuality. The higher the scores the more negative the attitudes and the less knowledge about sexuality.

Because the scores indicate change, it could be that the women's experiences were normalized throughout the group process. Once again, group participants were given permission to discuss sex, orgasms and their bodies. This might be too embarrassing and shameful to discuss openly with others outside a group. It may be even more embarrassing with a partner. Given that participants reported difficulties saying no and asserting their needs, it makes sense that they would experience difficulties discussing sex with a partner. It would seem that group intervention is an effective format in helping participants overcome negative attitudes about their sexuality.

The findings above are based on scores to tests. Although they can be helpful in determining if an intervention is helpful or not, they often do not provide us with the total picture. In the next section, I would like to summarize the screening process and group sessions and some of the common themes that seemed to emerge.

**b. Recruitment, Screening and Selection**

Recruitment, screening and selection were discussed in detail in Chapter Three. I recruited women who were known to me through individual and group therapy as well as women who were on a wait list and from the community. Six of the eight women who participated were clients who had participated in previous groups that I had facilitated and/or were receiving individual counselling with me. Because I knew the women, I did not follow the regular screening procedures that I would with someone who was not known to me. Instead, I would say that I had been involved in a more on-going intensive screening process with them over the months that I had known them. I had known some of the women for about two years. Therefore, I knew their stories, who their supports were, how they interacted with others, and how they reacted to crises in their lives. As I mentioned in Chapter Three, my decisions then were based on prior knowledge. I felt confident in their ability to participate in this group.

A challenge facing workers and participants is related to living and working in a small community. Although this issue is outside the scope of my work in the group, I felt that it should be mentioned because of the impact small communities can have on a worker and on clients. Workers see and get to know participants as both a community member and a client, just as clients get to know workers as a community member and a worker. In addition, a worker may wear many hats and be involved in many different aspects of service delivery. Therefore, the worker offers not only individual counselling but may be involved in facilitating groups. As a result, a worker is privy to information about an individual in many different settings, as is the client of the worker. As a result, screening

may not be a one time meeting between a potential group member and facilitator. A relationship may be developed between the worker and participant or the two may know of each other in a different context. These issues raise challenges regarding confidentiality and boundaries.

Confidentiality is a concern for potential group members and can have an affect on recruitment and participation. Women may not respond to an advertisement or a referral to a group because of the fear of being seen by someone that is known to them. The chances of this occurring are greater in small communities than in larger cities. People know one another and often women in the group will recognize someone known to her. In addition, the numbers that a worker may be accustomed to in a city group are not always available in small towns. Therefore, a worker may be working with a maximum of 4 - 6 group members at a time.

There are other issues that are present in smaller communities that make it challenging for women to attend a group and for workers to encourage women to attend. If a woman lives out of town, travel can be a problem, especially in the winter when hazardous road conditions are common. She would have to leave earlier in order to make it on time which can cause her a great deal of stress. She may also have financial difficulties making it hard to afford the cost of travel into town or she may not be able to afford a car or to fix it, if it breaks down. In addition, bus services may not be available. Dawson Creek is an exception, there are two buses that run every half hour but only until 6:00 PM. They also do not run on Sundays or holidays. This can make it difficult for women to attend a group in the evening. Availability of childcare is another common problem facing women in small

communities. A women may not have family that she can rely on and may not want to impose on friends. In addition, the building where an agency is housed may be highly visible in the community. Clients may not want to be seen entering the building for fear others will know they are receiving counselling. A building may not be accessible to physically disabled women, although most agencies make an attempt to find appropriate settings that are accessible. A social worker needs to be conscious of the environment in which groups are being offered. Perhaps this may mean exploring other potential meeting places such as a church. Lastly, workers working with women sometimes have to deal with negative attitudes or beliefs about the work they do. Feminism is often considered a “dirty word” in small communities, partly due to a lack of understanding about what feminism is. The agency may have a reputation in the community of being a “Feminist” agency. Women seeking counselling services may be fearful that workers are “men haters” and want to break up the family. This may interfere in recruiting members into a group.

I believe social workers must be aware of the many issues that will affect the delivery of service. She must be aware of her roles and the way she will work and live in the community. The unique nature of small communities presents social workers with many challenges. However, it is this very nature that makes it possible for workers to extend their skills and to use their creativity.

### **c. Group Sessions**

Group sessions followed a particular format. However, participants decided how the group time would be used. Therefore, depending on the needs of the group members, we did not always stick to the particular topic that was planned. It seemed that the issues

group members raised were appropriate and related well to the purpose of the group. For instance, instead of discussing anatomy and physiology, the group discussed issues regarding family of origin and their mothers.

Common themes appeared to emerge as we worked through each session. The abuse distorted the way in which the participants viewed themselves and their relationships. A negative sense of self had developed and a lack of trust in self and others was common. Fear of losing control was identified as a problem. This affected their sexual and non-sexual relationships. They had difficulty responding sexually if they felt that they were not initiating sexual contact or if the control was taken from them. They feared non-sexual relationships with men and women because they did not know how to interact in a non-sexual way. They expected others to be sexual with them because of their experience of sexual abuse. This contributed to a great deal of confusion regarding relationships.

Other themes which were common were: body shame, gender identity confusion, and fear of intimacy. All the women stated that they perceived themselves as “damaged” as a result of being sexually abused as children. They felt disconnected from their bodies and had trouble identifying how they felt. Puberty was a difficult time for some women because it meant that they could no longer deny their “femaleness”. As children they reasoned that if they were more boy-like, they could prevent the abuse from occurring.

Fear of intimacy was a common theme that was identified by group members. This affects relationships with others. Group members feared intimacy because they did not want to be hurt. It was much harder when they became close to someone than if they kept others at an arms length. Part of the explanation for this is that they were hurt by someone

who was close to them. Usually, a trusted person in a position of authority abused them. If this could occur in these relationships, they may reason that any one they become close to will hurt them. Another explanation is related to fear of losing control. Participants feel more in control with the “known” rather than the “unknown”. This could lead them to seek out or stay in relationships that they felt were not healthy for them. However, they know what to expect and could remain in control. They did not have to fear being hurt .

Participants discussed their fears of closeness and the confusion they experience about intimacy, love and sex. However, their scores on the scale seemed to paint a different picture. I have identified some of the problems that may be present regarding the particular scale that was used. Perhaps the way in which participants perceive themselves and their actual experience with intimacy are very different. Perhaps they are able to experience a degree of intimacy with someone whom they come to trust and care about. I would also add that perhaps intimacy and sexuality may not be perceived in very different ways. Group members confused sex and intimacy because of their experiences. Perhaps the need for closeness to others is more a human need than an issue that is related to sexuality.

Although I have offered some explanations for the differences between the scores and the women’s experience of intimacy, I did not provide an opportunity to discuss the scores more fully. In the future I would explore group members’ perceptions and thoughts about the scale itself and the differences between their scores and their experience of intimacy.

**Comments Regarding My Learning Goals**

This next section will summarize my observations about my learning goals. My goals included being clearer about my style of facilitation and how I work with clients in a group. I feel that I have learned a great deal from the group members who participated in this group. I believe that this relates to the way in which I work. I do not want to take ownership of groups. Therefore, I tend to be less structured and “go with the flow”. Power is an issue that I find to be a constant challenge. Perhaps I am too flexible because I fear taking power away from others. At the same time I want to provide group members with an experience that will be useful to them and that will allow them to identify their strengths and discover their own inner power. This is an on-going issue as I try to provide structure and flexibility.

It is difficult working alone. Often, upon reviewing the tapes, I would notice that I had missed some cue or important information. At times I needed to step back and review the tapes in order to identify issues that were not clear for me during the session. I found it very helpful to video-tape. It assisted me to discover how I was responding to group members, what I missed and what I needed to address. I also failed at times to negotiate with group members particularly about a specific topic that we were unable to work on or to complete. It is important to remember to negotiate with group members about offering a topic at a later session. I also noticed that I am a terrible time keeper and technician. I feel that I need to keep better track of time and to remember to ask group members for their help with time.

I have discovered that I would like to further explore and learn more about body work through art and movement. These are alternative approaches to therapy which may be helpful in bringing together the mind/body split. Hutchinson (1985) describes a series of visualizations and exercises that can assist women in learning to love their bodies. Khalighi (1989) uses movement and art to heal the body, mind and spirit. Her work is based on Gestalt Therapy. She utilizes what she calls the "Creative Expression Process" ... "in identifying life themes and in exploring these themes through the expressive arts" (Khalighi, 1989, p. 27). Although I do use art in the form of drawings or collages, I feel that I require further training to be able to use these forms of therapy in an effective and mindful way.

The group was a positive experience and something I would offer in the future, with of course, changes. I enjoy working with a co-facilitator. Although this is difficult to organize at times, it does make the facilitation much more effective. Two people can share the work load and complement each other. One facilitator can present a topic or issue and the other can watch reactions and responses of group members. However, I believe the group was a worthwhile project and if two facilitators are not available I would recommend that a facilitator try it on her own. In the next section I will discuss some recommendations I would make for future groups.

### **Recommendations**

Throughout this report I attempted to point out changes I would make and recommended alternatives. In this section I will summarize these recommendations, pointing out what I would keep and what I would do differently.

## **I. General Recommendations**

1. I suggest that more research and discussion be done regarding group work in small communities. Issues that affect recruitment, screening and selection, as well as attendance require further discussion. I discussed these issues from my own experience. Although this has value, knowing whether others in small communities face similar challenges would be validating.

2. In retrospect I would recommend that a pre-group be offered to focus on house-keeping issues such as topics, goals, and commitments. I would also negotiate with group members in order to increase the number of sessions if necessary or if group members wished to meet for more than twelve sessions. In the future I would perhaps start with projecting fourteen to sixteen sessions rather than twelve. A pre-group also serves a screening purpose. Women can decide whether or not they wish to participate based on their goals and that of other group members and facilitators. A woman can also decide if she will participate if someone known to her is attending. This does not solve the problem because two people may be lost as a result. I would then recommend that if there was a conflict such as this, the facilitator(s) try to negotiate and discuss these issues with potential group members.

3. I recommend that 14 - 16 or more sessions be offered in order to adequately address the issues that have been identified earlier in this report.

4. I suggest that if possible, two people work together as co-facilitators. Two people provide support to one another and can attend more effectively to the responses and

reactions of group members. However, this may not be a possibility, especially in smaller communities, I therefore, would recommend that a counsellor try to facilitate on her own.

5. I suggest that other tools be used to measure sexuality. Finding tools that would “get” to some of the issues related to intimacy, trust and relationships would provide a fuller picture of the effectiveness of group interventions. Perhaps qualitative research methods would be more appropriate for this particular group.

## **II. Content and Process: Recommendations**

Following are recommendations I would make regarding the actual group content and process. I will discuss the topics I would keep or expand upon, keeping in mind that each group can be very different and group members can have very different needs.

1. I would explore difficulties group members had with any of the tools that were used in a more structured manner. In this particular group, members shared that they had difficulty completing Negative Attitudes Toward Masturbation. I would discuss their difficulties and what it was about that particular scale that they found difficult. I would also explore whether or not they were triggered and what it was that triggered them.

2. If a particular topic was not completed, or because of circumstances we did not address a certain topic, I would negotiate with group members about whether or not they wished to complete this topic at a later session.

3. I would suggest expanding upon family of origin issues. Questions on family of origin would need to be reduced and be more inclusive in order to take into account different cultural backgrounds and women’s different experiences of families.

4. The body drawings sessions were positive. I would suggest expanding upon this and include more information on the body/mind split and identifying feelings.

5. If contradictions emerged between scores and members' statements about their experiences about intimacy, I recommend that it be discussed in the group. It would be important to explore further the meaning this has for women in the group.

6. It would be important to expand upon issues related to sexual orientation and fantasies. I suggest offering one or two sessions on these topics, including differences between sexual orientation and fantasies. I would also provide more opportunity to discuss triggers and automatic reactions to sexual partners. Again, it would mean that a greater number of sessions would be required in order to address these issues in greater depth.

### **Conclusion**

The group from beginning to end was challenging, educational, painful and fun. I admired the courage of the women who so graciously participated and gave of themselves. Each had their own story but never did they minimize other's experiences. They listened to one another, shared their pain and joy and offered suggestions, if it was wanted. Although differences existed between group members, they were able to respect these differences and be honest about their beliefs and feelings. The experience was positive for me. I learned what needs to be addressed further, what to delete and what to add. I also found the issues women addressed in the group, regarding control, intimacy, trust, sex and relationships were supported in the literature. I hope that more information will be made available so that we can work more effectively on these issues. The recommendations that

I made are a result of my experience in the group and the feedback from women who participated. I can not be sure that in the future, these recommendations would be useful or appropriate. Every group is different and group members may respond differently to certain topics. In my experience, each group I offer is unique. Therefore, anything that I suggest is only a suggestion and I can not assume it would work in the future. In addition, as I mentioned earlier in the introduction, I would not assume for a moment that any group is going to resolve the range of challenges and problems that women who are survivors of childhood sexual abuse face in their lives. I only hope that they can alleviate their isolation and normalize their experiences so that they realize they are not alone. They are strong women who have survived a great deal of trauma. They are mothers, lovers, friends, and partners. They know what they need in order to heal. The group process is one step in their journey beyond survival.

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**APPENDICES**

**Appendix A**

**Letter of Introduction**

### **Letter Of Introduction**

Dear

Hi! I would like to introduce myself, to those of you who do not know me, and to explain the purpose of the group. My name is Linda Hayes and most of you know me as the Women's Counsellor at South Peace Community Resources Society. I am also a student at the University of Manitoba located in Winnipeg, Manitoba and am working towards my Masters Degree in Social Work. A requirement for the completion of my Masters Degree is that I be involved in a practicum. I have decided to offer a group on sexuality for survivors of sexual abuse. I based my decision to do this on discussions with women, such as yourself, and concerns that they raised regarding the effect sexual abuse has on sexuality. As a result I am pleased to be given the opportunity to work on this project and most importantly to bring women together to share their stories and their healing.

This group will be offered once a week for 12 weeks. We will be discussing some of the effects sexual abuse has on a women's sexuality and hopefully begin to heal our sexual selves. We will meet once a week, every Thursday evening beginning at 7:00 PM and ending at 9:30-10:00 PM. It will start on March 30, 1995, and run until June 15, 1995.

I am offering this group for my practicum and will be video-taping each session. This is mostly for supervisory purposes. My supervisor is Michael Anthony, MSW, who is an instructor at Northern Lights College. He teaches Social Work and Psychology. Michael will view the video-tapes and then review them with me. We are both bound by a code of confidentiality and under no circumstances can we discuss any participant with any one unless I am given written permission by the participant. Michael will not be participating in the group nor will he be present during the video-taping. As I mentioned earlier, the purpose of video-taping is to provide me with supervision. I will be given feed-back about facilitation skills and suggestions on ways to improve them. We can also view the tapes together as a group and review the previous week's discussion. The video-tapes will be kept and then erased after I have completed my practicum. They will be kept in a locked file cabinet.

Once I have completed the group I will then be writing a final report for the University and will be required to present my report to my Masters Committee. I will keep any work, such as group evaluations, questionnaires, etc. in separate locked files and will destroy such upon completion, unless otherwise requested. If there is anything that you do, such as poems, drawings, etc., that I would like to include, I would ask for your permission and upon receiving this, I would erase any identifying information. I will not use your name and I would arrange to return the work to you unless otherwise arranged with you.

**I want to thank you for participating in this group. I appreciate your help in making this possible. I am more than willing to answer any questions or discuss any concerns you may have at any time. I am looking forward to working with you. Again, thank-you.**

**Respectfully,**

**Linda Hayes**

**Appendix B**

**Contract for Service and Audio/Visual Authorization**

**Contract for Service and Audio/Visual Authorization**

I, \_\_\_\_\_, agree to participate in a 12 week sexuality group from \_\_\_\_\_ to \_\_\_\_\_, and give permission to Linda Hayes to record the group sessions on audio/visual tape. I understand that the audio/visual recordings are for supervisory purposes only and will be erased upon completion of the group. Linda Hayes explained the purpose of the group and informed me that she is a student in the MSW program at the University of Manitoba. I am aware that Linda Hayes will be submitting a written report to the University and present an oral report to the Masters Committee upon completion of her practicum.

Dated in Dawson Creek, BC, this \_\_\_\_\_ Day of \_\_\_\_\_, in the year, \_\_\_\_\_.

Signature. \_\_\_\_\_

Witness (facilitator). \_\_\_\_\_

**Appendix C**

**Group Guidelines**

## **GROUP AGREEMENTS**

### **1. Confidentiality**

- I agree not to reveal personal information about any group member to anyone outside the group in such a way that the member's identity might possibly be revealed.
- If I am socializing with a group member and I introduce her to someone else outside the group, I agree to not identify her as a group member.
- This group is for You. The focus needs to be on Your thoughts, feelings and reactions and what You can do. Therefore I agree not to bring up another group member's issues to her outside the group sessions, even if my intentions are to help, as this could bring up strange feelings that she may not want to deal with.
- If I am upset about something the group facilitators or anyone else has said or done in the group I agree to discuss this either directly to the person involved or in the group, rather than go to someone else.

**NOTE:** Facilitators respect confidentiality. However, there are exceptions.

These exceptions are:

- If any person has reasonable grounds to believe a child may be in need of protection or if a child is being or has been abused the Family and Child Services Act states clearly that a report must be made to the Ministry of Social Services.
- Although we will not be keeping files on any individual, a facilitator and/or any records can be subpoenaed by the courts if a court hearing is or will be occurring..
- If anyone indicates that she is in danger to herself or others, the facilitators are under an obligation to inform the appropriate authorities (family doctor, police, family member, etc.).

**NOTE:** If confidentiality is broken a member could be asked to leave the group.

### **2. Attendance**

- I am committed to attending all of the sessions for as long as I am a member of the group.
- I agree to be on time and to begin and end with the group as much as is possible.
- I agree to let the designated facilitator know as much in advance as is possible, if I am going to be late, if I have to leave early, or if I am unable to make it for reasons of sickness or and emergency.
- During group sessions we will break at an agreed upon time for coffee, a cigarette, or to make calls.

### **3. Intoxicants**

- I agree not to consume alcohol or any other mood altering drug for at least the day of the group and preferable 24 hours prior to the group.
- I agree not to come to the group “buzzed out” or hung over.

### **4. Socializing**

- Although friendships may occur, I agree not to impose on any group member or to form an intimate relationship with her while in the group. The focus needs to be on your own healing and while it is important to respect and care for group members we need to become aware of our own and other’s boundaries.

### **5. Mutual Support and Respect**

- I agree to adopt an encouraging and non-judgmental attitude toward others in the group. Although no one will be forced to share their thoughts, feelings, or experiences, we will all encourage each other to try.
- I agree to respect differences in opinions and experiences as we are not here to judge others.
- I agree to listen to what others are saying and wait until they are finished before commenting, asking questions, or discussing other issues. Everyone needs equal time.
- I agree to restrain from engaging in any form of self-mutilation or from acting on suicidal feelings while I am a member of the group. An attempted or successful suicide of a member can have a devastating effect on the whole group. Likewise witnessing self-mutilation of a group member can be scary and demoralizing. If I should come to feel suicidal or want to self-mutilate, I agree to contact the group facilitator to discuss my feelings with her.

### **6. Touching**

- I agree to ask permission of another group member if I want to touch or hug her. I understand that if I am refused it is not personal but only that some women do not want to be touched or hugged and may find it distressing.

**7. Additions**

- Are there any other agreements that you would like to see added? Any that you would like to see omitted?

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_

**THANK-YOU FOR RESPECTING THESE AGREEMENTS AND MAKING THIS A SAFE GROUP FOR EVERYBODY**

**Signed:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Appendix D**

**Topic List**

**GROUP TOPICS**

<b>SESSION</b>	<b>TOPICS</b>
Session I	Introductions, Guidelines, Goals
Session II	What is Sexuality? Messages from society Film: "Still Killing Us Softly".
Session III	What is Sexuality II? -Effects of sexual abuse on sexuality.
Session IV	Family of Origin - What we learn about sexuality- gender, affection, love, our bodies.
Session V	The Body I - Anatomy and physiology of the female reproductive system.
Session VI	The Body II - Feelings, Spirituality
Session VII	The Body III - Self-Care, Learning to Relax
Session VIII	Sex and Intimacy -Differences and Effects of Sexual Abuse
Session IX	Desire and Sexual Arousal - Confusion and Shame.
Session X	Relationships - Coping with Flashbacks, Sexual Orientation, Healthy Relationships
Session XI	Healthy sex - Saying No, Self-Care Re-Visited.
Session XII	Close - , Film: <u>The Goddess Remembered</u> Affirmations, Group Evaluation, Celebration.

If you have any ideas or suggestions please write them down for further discussion at our first meeting.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Appendix E**

**Weekly Group Report**

**WEEKLY GROUP REPORT**

**DATE:** \_\_\_\_\_

**NAME OF GROUP:** \_\_\_\_\_

**SESSION:** \_\_\_\_\_

**TOPIC:** \_\_\_\_\_

**GROUP FACILITATORS:** \_\_\_\_\_

**Session Goals**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Plans/Activities/Resources/Exercises**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Concerns**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Follow-up required    yes \_\_\_ no \_\_\_

If yes, comment ( reason and action taken )

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Appendix F**

**Family of Origin Questions**

### **Family of Origin**

1. What was your relationship with your father like? What was your relationship with your mother like?
2. Who were mom's and dad's "favourite" kid? Who were your grandparent's "favourite".
3. What was your parent's relationship with one another like?
  - a. How did they treat each other emotionally?
  - b. How did they fight or have conflict? Who usually "won"? Was your father violent toward your mother in any way? Whose "side" were you usually on?
  - c. Who was the "boss" in the household?
  - d. How did they generally discuss issues that arose for them and the family?
  - e. How did they express caring and affection for one another?
4. What did your dad do for work and with his free time? What did your mom do for work and with her free time? Were there problems in these areas (e.g. often changing jobs, getting fired from jobs, not having enough money, working all the time)? Did your family have family outings and vacations? What were they like?
5. How was anger modeled and expressed in your family? By whom? At what times? Where? How were conflicts resolved in your family (between mom and dad, between you and mom and/or dad, between you and your brothers and sisters)? How were other emotions modeled and expressed in your family (sadness, hurt, disappointment, love, joy, etc.)? Were some emotions "OK" and other emotions "not OK"? How was affection expressed and what messages were you given?
6. What are some of the phrases and/or mottoes that you remember hearing your parents say quite often (e.g. "buck up", "you shouldn't feel that way", "tomorrow is another day")?
7. What were your family's values (things important to your parents that they wanted to teach you to live in your life), both those that were talked about and those that were truly "lived" by your parents (e.g. work hard, make a lot of money, be religious, get a good education)? Were their verbal messages different from their non-verbal messages about these values?
8. What were your family "rules"(both explicit and implicit); e.g. "don't show feelings", "kids shouldn't talk back" their elders"?
9. What were and are your family "secrets" (things that you and/or other family members implicitly or explicitly keep hidden from the "outside world")?
10. What major losses (e.g. divorce), illness (e.g. cancer, heart attack, long and lingering sickness), operations, and/or deaths did your family experience? How did you and the rest of the family react to these?

11. What kinds of emotional problems (e.g. chemical abuse/dependency, depression) did you or other family member experience while you were growing up? How did you and other family members handle these experiences (for yourself and/or for others)?
12. What sorts of behaviour problems (e.g. running away, truancy, trouble with the law) did you or your brothers and sisters have during your childhood? How were they handled by you and the rest of your family? Was either of your parents in trouble with the law as you were growing up?
13. How were you and your brothers and sisters disciplined when you did something “wrong”? What was considered “bad” behaviour in your household?
  - a. Was physical punishment used? How often, what kind, and for what “misbehaviour”?
  - b. What other kinds of discipline were used? How was it decided to use them instead of physical punishment? Who did these?
  - c. Were boys and girls disciplined differently? Were there standards used?
  - d. How were you treated emotionally by your parents (e.g. given affection and/or praise, called names, put down)?
  - e. What messages did you receive from your parents about who you were as a person (both verbal and non-verbal)? What were you told you were good at as a child?
  - f. How did you respond to anger, discipline, and the messages you received from your parents?
  - g. What was the difference between discipline and abuse to you then? Now? Are your conceptions of what you experienced in the past different now?
14. Among your brothers and sisters, whom were you close to and whom were you distant from? Whom did you compete with? What roles did you and your brothers and sisters take in the family? Did anyone take on parts of mom’s or dad’s role in the family? In the present, whom are you close to and whom are you distant from?
15. When and how did you and your brothers and sisters leave the family to move out on your own? How was this decision made? Was (were) the leaving(s) smooth or traumatic?
16. Did you have family pets? How were they treated? Who played with them? How and when did they die and how were their deaths dealt with in the family?
17. What was it like being around the house on a typical day? What was the “atmosphere” of your family home like?
18. What would your family look like if they were made into a sculpture (how and where would people be standing/sitting/lying in relation to one another, how would their faces look, etc.)? Think about this both in the past and in the present.
19. How were boys and girls treated in your family? How was affection expressed, love, intimacy, etc.?

20. How are you similar to the kind of person your father is (was)? How are you similar to the kind of person your mother is (was)?
21. How is the parenting and discipline you do with your children similar to the parenting and discipline that was done with you as you were growing up?
22. What would you change about your family and your childhood, if you could?
23. How can you relate differently to your parents and siblings now than you have felt you have had to relate to them in the past? Are you willing to take the risks necessary to relate to them differently?
24. How does your family, your childhood and your past affect your present behaviour? What thoughts (self-talk), feelings and behaviours still carry over to today? How do you express emotions, affection, etc. today.

Questions taken from the Domestic Abuse Project group material for women in abusive relationships.

**Appendix G**

**Index of Self-Esteem**

**Index Of Self Esteem (ISE)**

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_

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

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

**Please begin.**

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

**ISE Continued**

- 22. I feel that people really like me very much. \_\_\_\_\_
- 23. I feel that I am a likable person. \_\_\_\_\_
- 24. I am afraid I will appear foolish to others. \_\_\_\_\_
- 25. My friends think very highly of me. \_\_\_\_\_

In Bloom & Fischer (1984) and Corcoran & Fischer (1987).

Author: W. W. Hudson (1974)

**Appendix H**

**Generalized Contentment Scale**

**Generalized Contentment Scale (GCS)**

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_

This questionnaire is designed to measure the degree contentment that you feel about your life and surroundings. It is not a test , so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

- |                               |                            |
|-------------------------------|----------------------------|
| 1. Rarely or none of the time | 4. Good part of the time   |
| 2. A little of the time       | 5. Most or all of the time |
| 3. Some of the time           |                            |

**Please begin.**

- |  |       |
|--|-------|
| 1. I feel powerless to do anything about my life.                      | _____ |
| 2. I feel blue.  | _____ |
| 3. I am restless and can't keep still.                                 | _____ |
| 4. I have crying spells.   | _____ |
| 5. It is easy for me to relax.   | _____ |
| 6. I have a hard time getting started on things that I need to do.     | _____ |
| 7. I do not sleep well at night.                                       | _____ |
| 8. When things get tough I feel there is always someone I can turn to. | _____ |
| 9. I feel that the future looks bright for me.                         | _____ |
| 10. I feel downhearted.  | _____ |
| 11. I feel that I am needed.   | _____ |
| 12. I feel that I am appreciated by others.                            | _____ |
| 13. I enjoy being active and busy.                                     | _____ |
| 14. I feel that others would be better off without me.                 | _____ |
| 15. I enjoy being with other people.                                   | _____ |
| 16. I feel that it is easy for me to make decisions.                   | _____ |
| 17. I feel downtrodden.  | _____ |
| 18. I am irritable.  | _____ |
| 19. I get upset easily.  | _____ |
| 20. I feel that I don't deserve to have a good time.                   | _____ |
| 21. I have a full life.  | _____ |

**GCS continued**

- 22. I feel that people really care about me. \_\_\_\_\_
- 23. I have a great deal of fun. \_\_\_\_\_
- 24. I feel great in the morning. \_\_\_\_\_
- 25. I feel that my situation is hopeless. \_\_\_\_\_

In Bloom & Fischer (1984) and Corcoran & Fischer (1987).

Author: W. W. Hudson (1974).

**Appendix I**

**Miller Social Intimacy Scale**

**Miller Social Intimacy Scale (MSIS)**

A number of phrases are listed below that describe the kind of relationships people have with others. Indicate, by filling in the appropriate letters in the answer field, how you would describe your current relationship with your closest friend. This friend can be of either sex and should be someone whom you consider to be your closest friend at this time. While it is not necessary to specify the name of this friend, please indicate his/her sex in question 1.

Remember that you are to indicate the kind of relationship you have now with your closest friend.

1. Sex of your closest friend: M \_\_\_ F \_\_\_
  2. Your marital status: single \_\_\_ married \_\_\_ common-law \_\_\_  
separated or divorced \_\_\_ widowed \_\_\_
  3. Is the friend you describe your spouse? Yes \_\_\_ No \_\_\_
- |   | Very<br>rarely | Some of<br>the time | Almost<br>always |   |   |
|---|----------------|---------------------|------------------|---|---|
| 4. When you have leisure time how often do you choose to spend it with him/her alone?             | A              | B                   | C                | D | E |
| 5. How often do you keep very personal information to yourself and do not share it with him/her?  | A              | B                   | C                | D | E |
| 6. How often do you show him/her affection?   | A              | B                   | C                | D | E |
| 7. How often do you confide very personal information to him/her?                                 | A              | B                   | C                | D | E |
| 8. How often are you able to understand his/her feelings?   | A              | B                   | C                | D | E |
| 9. How often do you feel close to him/her?  | A              | B                   | C                | D | E |
| 10. How much do you like to spend time alone with him/her?  | A              | B                   | C                | D | E |
| 11. How much do you feel like being encouraging and supportive to him/her when he/she is unhappy? | A              | B                   | C                | D | E |
| 12. How close do you feel to him/her most of the time?  | A              | B                   | C                | D | E |

**MSIS Continued**

	Not much	A little			A great deal
13. How important is it to you to listen to his/her personal disclosures?	A	B	C	D	E
14. How satisfying is your relationship with him/her?	A	B	C	D	E
15. How affectionate do you feel towards him/her?	A	B	C	D	E
16. How important is it to you that he/she understand your feelings?	A	B	C	D	E
17. How much damage is caused by a typical disagreement in your relationship with him/her?	A	B	C	D	E
18. How important is it to you that he/she be encouraging and supportive to you when you are unhappy?	A	B	C	D	E
19. How important is it to you that he/she show you affection?	A	B	C	D	E
20. How important is your relationship with him/her in your life?	A	B	C	D	E
21. You have just described the relationship you have now with your closest friend. We are interested in knowing how long this person has been your closest friend. Please check the appropriate category: less than a month ____ 1-4 months ____ 5-8 months ____ 9-12 months ____ over a year ____					
22. Recall your previous closest friend. Are you less close ____, just as close ____ or closer ____ with the current friend you described on this scale?					

In Corcoran & Fischer (1987).

Authors: R. S. Miller and H. M. Lefcourt

**Appendix J**

**Negative Attitudes Toward Masturbation Inventory**

**Negative Attitudes Toward Masturbation Inventory**

Below are thirty statements regarding masturbation. Please indicate the degree to which you agree with each by placing the appropriate number to the left of the statement. The numbers are based on the following scale:

- 1 = Strongly disagree
- 2 = Disagree
- 3 = Neither agree nor disagree
- 4 = Agree
- 5 = Strongly Agree

- \_\_\_ 1. People masturbate to escape from feelings of tension and anxiety.
- \_\_\_ 2. People who masturbate will not enjoy sexual intercourse as much as those who refrain from masturbation.
- \_\_\_ 3. Masturbation is a private matter which neither harms nor concerns anyone else.
- \_\_\_ 4. Masturbation is a sin against yourself.
- \_\_\_ 5. Masturbation in childhood can help a person develop a natural healthy attitude toward sex.
- \_\_\_ 6. Masturbation in an adult is juvenile and immature.
- \_\_\_ 7. Masturbation can lead to homosexuality.
- \_\_\_ 8. Excessive masturbation is physically impossible, as it is a needless worry.
- \_\_\_ 9. If you enjoy masturbating too much, you may never learn to relate to the opposite sex.
- \_\_\_ 10. After masturbating, a person feels degraded.
- \_\_\_ 11. Experience with masturbation can potentially help a woman become orgasmic in sexual intercourse.
- \_\_\_ 12. I feel guilty about masturbating.
- \_\_\_ 13. Masturbation can be a "friend in need" when there is no "friend in deed."
- \_\_\_ 14. Masturbation can provide an outlet for sex fantasies without harming anyone else or endangering oneself.
- \_\_\_ 15. Excessive masturbation can lead to problems of impotence in men and frigidity in women.
- \_\_\_ 16. Masturbation is an escape mechanism which prevents a person from developing a mature sexual outlook.
- \_\_\_ 17. Masturbation can provide harmless relief from sexual tensions.
- \_\_\_ 18. Playing with your own genitals is disgusting.
- \_\_\_ 19. Excessive masturbation is associated with neurosis, depression, and behavioral problems.

**NAMI Continued**

- \_\_\_ 20. Any masturbation is too much.
- \_\_\_ 21. Masturbation is a compulsive, addictive habit which once begun is almost impossible to stop.
- \_\_\_ 22. Masturbation is fun.
- \_\_\_ 23. When I masturbate, I am disgusted with myself.
- \_\_\_ 24. A pattern of frequent masturbation is associated with introversion and withdrawal from social contacts.
- \_\_\_ 25. I would be ashamed to admit publicly that I have masturbated.
- \_\_\_ 26. Excessive masturbation leads to mental dullness and fatigue.
- \_\_\_ 27. Masturbation is a normal sexual outlet.
- \_\_\_ 28. Masturbation is caused by an excessive preoccupation with thoughts about sex.
- \_\_\_ 29. Masturbation can teach you to enjoy the sensuousness of your own body.
- \_\_\_ 30. After I masturbate, I am disgusted with myself for losing control of my body.

In Corcoran & Fischer (1987)

Authors: P. R. Abramson and D. L. Mosher

**Appendix K**

**Group Evaluation Form**

**Group Evaluation**

We are interested in your honest opinion regarding this group. Please take time to answer all the questions. This evaluation is done to let us know in what ways this group could be more helpful to its members. Please let us know of any changes you would like made.

Thank-you for taking the time to do this.

a. How helpful did you find this group?

- 1. very helpful
- 2. helpful
- 3. a little helpful
- 4. not helpful

comments? \_\_\_\_\_

b. To what extent were you satisfied with the material presented by the facilitators?

- 1. very satisfied
- 2. satisfied
- 3. dissatisfied
- 4. very dissatisfied

comments? \_\_\_\_\_

c. Was there enough opportunity for participation?

- 1. none
- 2. a little
- 3. a fair amount
- 4. a great deal

comments? \_\_\_\_\_

d. How satisfied were you with the facilitators?

- 1. very satisfied
- 2. satisfied
- 3. dissatisfied
- 4. very dissatisfied

comments? \_\_\_\_\_

e. Do you feel that group members' rights were respected by the facilitators?

- 1. no, almost never respected
- 2. no, sometimes not respected
- 3. yes, generally respected
- 4. yes, almost always respected

comments? \_\_\_\_\_

**Group Evaluation Continued**

f. Do you feel your rights were respected by the facilitators?

- 1. yes, almost always respected
- 2. yes, generally respected
- 3. no, sometimes not respected
- 4. no, almost never respected

comments? \_\_\_\_\_

g. What did you learn as a result of the group?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

h. Would you do anything differently? If yes, what?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

i. How would you rate the quality of the group?

- 1. excellent
- 2. good
- 3. fair
- 4. poor

comments? \_\_\_\_\_

j. What suggestions do you have to improve the group sessions?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

k. Are there any issues or topics you would like to discuss? If so, what are they?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

