ANGER IN HEALING FROM CHILDHOOD SEXUAL ABUSE A GROUP INTERVENTION

by

Sheila Sauteur

A Practicum Report
submitted to the Faculty of Graduate Studies
University of Manitoba
in partial fulfillment for the degree of
Masters of Social Work

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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

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ABSTRACT

Anger in Healing from Childhood Sexual Abuse

A Group Intervention

This practicum consisted of the creation, implementation, and evaluation of a twelve week group program for women, who were impacted by anger in their healing from childhood sexual abuse.

Two groups with a total of eleven participants took part in the practicum offered at the Laurel Centre in Winnipeg, Manitoba. The purpose of the Anger in Healing groups were:

1. To assist women who have survived childhood sexual abuse to acknowledge and to honor their experiences and expressions of anger in their healing from the abuse.

2. To examine these experiences using a cost / benefit perspective, and provide women the opportunity to choose whether to continue engaging in the same forms of expression of anger or to choose to try on different forms of expression in experiencing their anger.

3. To explore different ways of expressing and experiencing anger that fit with each individual woman's goals in relation to her healing from the child sexual abuse.

Session topics included: what is anger, fears around anger, what we learned as children about anger, sources of anger, goals, naming who and what we are angry about, how we express anger and how we can express it more positively, present anger - recognizing and releasing, personal safety around anger, anger in our healing - looking forward. Both quantitative and qualitative methods of evaluation were employed on a weekly basis. On going verbal feedback between the participants and the facilitators, process notes taken by the student / clinician, as well as the final session feedback forms combined with the weekly measures comprised the evaluation. The overall feedback from participants identified the therapy groups as being successful in assisting the participants to set and meet goals for themselves around understanding their patterns related to anger, self care, and building skills related to communication and problem solving.

DEDICATION

I hereby dedicate the Blah Blah Blah Book to:

Jasmine and Jeremy Sauteur.

Two angels on earth!!

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION

BACKGROUND 2
PRACTICUM OBJECTIVES 3
LEARNING GOALS 4
RATIONALE FOR GROUP WORK 4
THEORETICAL FRAMEWORK 5
OUTLINE OF PRACTICUM REPORT 7

CHAPTER TWO

LITERATURE REVIEW

DEFINITION OF TERMS 8
FEMINIST THEORETICAL FRAMEWORK 11
NARRATIVE THEORETICAL FRAMEWORK 16
SOLUTION FOCUSED THEORETICAL FRAMEWORK 23
LONG TERM EFFECTS OF CHILD SEXUAL ABUSE 27
TRAUMA MODEL 31
THE LAUREL CENTRE MODEL 33
GROUP WORK WITH SURVIVORS 35
SOCIAL WORKER AS GROUP LEADER 38
SCREENING FOR GROUP PARTICIPATION 41
WOMEN'S ANGER AND ANGER IN HEALING FROM CHILDHOOD SEXUAL ABUSE 42
RELEVANCE OF ANGER IN HEALING GROUP TO SOCIAL WORK PRACTICE 45

CHAPTER THREE

PRACTICUM METHODOLOGY

THE SETTING 47
THE PRACTICUM COMMITTEE 50
PARTICIPANT SELECTION AND INTAKE 50
GROUP CO-FACILITATORS 53
STRUCTURE AND FORMAT OF GROUP SESSIONS 54
GROUP OUTLINE 58

CHAPTER FOUR

GROUP PROCESS

SESSION BY SESSION DISCUSSION..... 63
PHASE ONE - ENGAGING AND ASSESSING..... 64
PHASE TWO - INTENSE DEBRIEFING..... 67
PHASE THREE - INTEGRATING..... 70
PHASE FOUR - MOVING ON..... 72

CHAPTER FIVE

RESULTS AND IMPLICATIONS

DESIGN PLAN..... 75
MEASUREMENT PLAN..... 76
QUANTITATIVE MEASURES..... 77
LIMITATIONS OF MEASUREMENT PLAN..... 80
QUALITATIVE MEASURES..... 81
DEMOGRAPHIC PARTICIPANT INFORMATION..... 83
QUANTITATIVE DATA ANALYSIS..... 84
QUANTITATIVE MEASURE CHARTS..... 88
QUALITATIVE DATA ANALYSIS.....103
IMPLICATIONS.....104

CHAPTER SIX

DISCUSSION OF THEMES, THE EDUCATIONAL EXPERIENCE AND RECOMMENDATION

THEMES.....105
FEEDBACK FROM FINAL SESSION.....122
PRACTICUM ANALYSIS.....124
PURPOSE AND OBJECTIVES OF PRACTICUM.....125
LEARNING GOALS.....127
PERSONAL IMPACT.....131
RECOMMENDATIONS.....132

REFERENCES.....134

APPENDICES

1. THERAPY PROGRAM CHART
2. THE LAUREL CENTRE CLINICAL STATEMENT
3. GENERALIZED CONTENTMENT SCALE
4. BAKKER ASSERTIVENESS AGGRESSIVENESS INVENTORY
5. ANGER IN HEALING GROUP INTAKE FORM
6. ANGER IN HEALING GROUP CONSENT FORM
7. GROUP OUTLINE
8. ANGER ICEBERG AND CAR
9. ANGER IN HEALING - GOALS FORMAT
10. ANGER CYCLE
11. SAFETY PLAN - FORMAT
12. THE PIT
13. ANGER IN HEALING - QUALITATIVE FEEDBACK EXAMPLE
14. ANGER IN HEALING - QUALITATIVE FEEDBACK EXAMPLE
15. GROUP FEEDBACK FORM
16. BRAINSTORM - WHAT HAVE WE LEARNED SO FAR ABOUT OUR ANGER
17. PARTICIPANT EXAMPLE OF GOAL FORMAT

"Survivors are persons who have made a conscious decision to move from being passive victims to empowered agents of change who are more in control of their lives. They have begun to own their painful experiences, have started a process to mourn their losses, honor what they needed to do to get through each day, and are ready to embrace life. They are persons who have moved past simply reacting to life and have decided to sift through the many scattered and missing pieces of a personal identity to search for wholeness. Survivors are persons who seek courage, strength, and wisdom from their experiences and are on a conscious search to reclaim a sense of hope, personal power, sexuality, personhood, femininity, masculinity, spiritual richness and the will to thrive."

(Matthews, 1995, p. 5)

CHAPTER ONE

INTRODUCTION

The intent of this practicum was to develop, implement and evaluate a twelve week group focusing upon women's experiences and expressions of anger in their healing from childhood sexual abuse and involvement with compulsive coping behaviors. The group was developed and run out of The Laurel Centre of Winnipeg, Manitoba. The Laurel Centre provides long term counseling for women who were sexually abused as children or adolescents and who have issues with compulsive coping behaviors or addictions.

The following practicum report outlines the practicum process exploring the learning, the experiences, and the findings in the evaluation of the group.

BACKGROUND

The decision to develop, implement and evaluate a group focused on women's experiences and expressions of anger for the completion of the practicum component of the student / clinician's Masters in Social Work degree had several interconnecting elements. First, as a social worker working from a feminist perspective within a feminist counseling agency, the student / clinician felt it was essential that her graduate work reflect her passionate commitment to the advancement of programming and research focused upon women's experiences.

Second, in her role as a counselor working with women survivors of childhood sexual abuse, the need for programming dealing specifically with women's experiences of anger became apparent. Staff members within The Laurel Centre concurred with the need for such programming. The Anger in Healing group was developed to specifically focus upon women's experiences and expression of anger related to healing from childhood sexual abuse.

Third, in the student / clinician's initial research of programs and / or literature addressing the issue of women's experiences and expressions of anger related to childhood sexual abuse, she was unable to locate any resources. In broadening the literature search to women's anger in general, still few resources were available. It was from those resources that were available, combined with research and literature focused on group programming for women who have experienced child sexual abuse, the 'Anger in Healing' group was conceived and developed.

PRACTICUM OBJECTIVES

The primary objective of the practicum was to develop, implement and evaluate two 12 week group for women survivors of childhood sexual abuse who have issues with compulsive coping behaviors. The purpose and objectives for the practicum were threefold:

1. To assist women who have survived childhood sexual abuse to acknowledge and to honor their experiences and expressions of anger in their healing from the abuse.

2. To examine these experiences using a cost / benefit perspective, and provide women the opportunity to choose whether to continue engaging in the same forms of expression of anger or to choose to try on different forms of expression in experiencing their anger.

3. To explore different ways of expressing and experiencing anger that fit with each individual woman's goals in relation to her healing from the child sexual abuse.

The practicum was developed to provide two groups that incorporate therapeutic, supportive, and educational components concerning anger and healing designed for the specific client population of The Laurel Centre. The group was developed as discussed previously at the recommendation of the clinical team at The Laurel Centre, as a response to the perceived need for women to look specifically at the role of anger in their healing process in a more in depth manner than is often looked at in individual therapy. Two groups were run concurrently to allow for a greater number of women to receive service at one time

Questions to be considered

The main question to be considered in the practicum process was whether group therapy assists in helping women to feel that they have met their

goals as they define them related to their experiences and / or expressions of anger.

LEARNING GOALS

The clinicians personal goals for completing the practicum were as follows:

1. To learn how to implement feminist theory within a group intervention on anger in healing for women survivors of child sexual abuse who are impacted by compulsive coping behaviours.

2. To both develop new and enhance existing skills in group facilitation with a co-therapist, focusing upon balancing structure and flexibility to best meet the needs of the participants.

3. To increase understanding of the usefulness of group therapy with adult survivors of child sexual abuse.

4. To increase understanding of the role of anger in healing for women survivors of child sexual abuse.

5. To learn how to gather and analyze research data.

6. To learn how to implement a single system research design into clinical practice.

7. To learn how to blend quantitative and qualitative research methods and designs.

RATIONALE FOR GROUP WORK

Within the social work field the use of groups to provide services for individuals is a valued and respected format. Many authors (Burden & Gottlieb, 1987; Courtois, 1988; Donaldson & Cordes-Green, 1994; Gil, 1988; & Herman 1992) support and promote the use of groups in working with women who were sexually abused as children.

Group work has been found to provide a sense of mutual support and community, and work more effectively at diminishing feelings of isolation and responsibility than individual therapeutic work. Groups provide an opportunity for individuals to be both 'teacher' to and 'student' of other women within the group. They also provide opportunities to 'try on' new behaviors and experiences within a relatively safe environment to help women begin changing patterns of behavior or experience related to specific goal areas.

Feminist group work allows for information sharing regarding the dominant social and political climate in which we live and for how these factors influence us individually and collectively as women. This is particularly important in looking at issues of anger which societal teachings view as a male only domain. Burden & Gottlieb (1987, p. 37) state that a group can "...provide a re-socializing process that gives women the right to be nurtured as well as to nurture, which helps women distinguish between the personal and the political sources of their difficulties, and that empowers women."

THEORETICAL FRAMEWORK

The 'Anger in Healing' group was created and informed by several different and complementary theoretical frameworks. The dominant theoretical framework of the group and the practicum is feminist theory. Generalist social work theory, trauma model theory, survivor therapy, as well as narrative and solution focused therapy, all work together to provide the theory and intervention practice base of the group.

Feminist theory / therapy holds at its heart the value of women's experiences individually and collectively. Women's experiences of childhood

sexual abuse and the effects of the abuse are seen under the feminist perspective as 'adaptive' and 'functional' as ways of surviving rather than pathologized as 'maladaptive' and 'dysfunctional'.

The fundamental beliefs, ecological perspective and the ever-present consideration of 'the person in environment' inherent in generalist social work theory form an underlying foundation of the practicum. The Social Work Code of Ethics was considered and adhered to throughout the practicum process. The strength of the feminist perspective, however, is that it does challenge the traditional value of assisting the individual to merely adapt or adjust themselves for a better fit within their living environments.

The influences of the trauma model and the survivor model (developed from the trauma model) are evident in many of the group procedures and exercises. The trauma model's emphasis on creating and maintaining safety as well as allowing time and opportunity to remember and mourn the losses associated with the abuse are observed.

Narrative and solution focused therapies were borrowed from heavily in the development of the exercises within the group. The strengths focus of both theories / therapies provided a strong compliment to the over-arching feminist perspective of the group. Much of the language and description of information within the group can be traced through a feminist-informed use of narrative and solution focused concepts.

OUTLINE OF THE PRACTICUM REPORT

The practicum report is laid out in chapter format. Chapter one as it has been presented, provides an introduction to the practicum and the report. Chapter two provides a review and discussion of the relevant literature informing the practicum process and report. The body and literature that is reviewed describes the various theoretical frameworks, the long term effects or impact of child sexual abuse, group work approaches to treatment , and womens' anger and how womens' anger is socially constructed. Chapter three outlines the practicum procedures, describing the setting, participant screening and selection, and a discussion of the group model. Chapter four provides a description of the group process. Chapter five discusses the findings of the group including the quantitative and the qualitative data analysis. Chapter six provides a discussion of the themes presented in both practicum groups as well as a summary of the practicum and the educational experience from the clinicians perspective. Chapter seven provides suggestions for further research and recommendations for future clinical work.

CHAPTER TWO

LITERATURE REVIEW

This chapter provides a review of the literature relevant to the development and implementation of the Anger in Healing group. In reviewing the literature it became apparent that the issue of womens' anger in general has very little research and written sources to draw upon. Additionally, women's anger specifically related to healing from childhood sexual abuse is not discussed at all in the literature currently available. Included is a review of: feminist theory / therapy; narrative and solution focused theory / therapy; the long term impacts of childhood sexual abuse, including a review of treatment models; the effectiveness of group work as an intervention; and a review of the available literature regarding womens' anger. The literature review concludes with a discussion of how each theory or therapeutic model works collectively to inform the development of a therapeutic group focusing upon anger in healing from childhood sexual abuse for adult women.

Definition of Terms

There are several terms that need to be defined and discussed before beginning the literature review. The following terms will be defined and discussed for the purposes of the practicum: Child sexual abuse; compulsive coping behaviour; and anger.

Child Sexual Abuse

Walker (1998) proposed the following definition of child sexual abuse :

> It is essential to recognize as crucial elements the misuse of power and authority, combined with force or coercion, which leads to the exploitation of children in situations where adults, or children sufficiently older than the victim to have greater strength and power, seek sexual gratification through those who are developmentally immature and where, as a result, consent from the victim is a non-concept. Such gratification can involve explicit sexual acts - anal or vaginal intercourse, fondling, masturbation - or may involve invasive and inappropriate actions not directly involving contact: watching a child undress, bathe, use the toilet, in order to gratify the perpetrator rather than meeting the needs of the child; forcing a child to watch adults having sex or making them watch pornographic videos. What is central is the exploitation of the child: the denial of their rights and feelings, and the essential gratification of the abuser through the child, the child being regarded solely as an object for the perpetrator's use and to meet their needs. (Walker, 1998)

The width and breadth of the Walker definition of childhood sexual abuse is helpful in the Anger in Healing practicum group as it allows a full range of sexualized behavior and situations to be included in and places childhood sexual abuse in a social and political context where adults hold power over children and men hold power over women.

Compulsive Coping Behavior

The Laurel Centre offers the following definition for compulsive coping behaviors:

> Compulsive coping behavior is any behavior or process that the individual habitually engages in to try and manage emotional states and distress that result from traumatic experiences . These behaviors are then used in less distressing situations, with decreased consciousness around the choice to use these behaviors. Engaging in these behaviors can escalate into a cycle of dependence, where the quick and easy short term effects of the compulsive behavior begin to erode the maintenance and development of other skills necessary to manage and resolve distress, which results in increased dependence on the compulsive coping strategy. Compulsive coping behaviors can include engaging in use of substances or processes: drug or alcohol addictions; self mutilation;

> promiscuity; gambling; crisis seeking; abusive relationships etc. (The Laurel Centre, 1998)

Compulsive coping behaviour is a term used by The Laurel Centre to describe behaviours that include addictions to substances (e.g, alcohol and drugs) or processes (e.g., disassociation, shoplifting). Compulsive coping behaviours are seen by the staff at The Laurel Centre as being adaptive behaviors which are adopted by individuals to cope with trauma. A difference between using the term compulsive coping behaviours as opposed to addictions is in the meaning attached, as addictions are typically viewed as maladaptive behaviors. It is believed that an individual originally engages in compulsive coping to avoid painful situations and to survive the trauma in their lives.

The Laurel Centre's definition of compulsive coping behaviors is particularly fitting with the Anger in Healing group which has been developed to fit within The Laurel Centre's clinical model. The presentation (behavior or expression) of anger as well as the process (feeling or experience) of anger can be examples of compulsive coping behavior which has been adapted to meet individuals needs. The group works toward assisting women to look at, acknowledge and experience their anger and then determine whether or not to make changes in their presentation or process with anger.

Anger

Webster's' New World Dictionary defines anger in the following way:

> "A noun or feeling of displeasure resulting from injury, mistreatment, opposition and usually showing itself in a desire to fight back at the supposed cause of this feeling."

Anger is a word used to describe an emotion experienced by all human beings. The word anger holds many different and often conflicting definitions which change in structure and function depending upon the context in which they are used. For many women survivors of childhood sexual abuse, anger is an emotion that can be very difficult to deal with. Women have been, and for the most part continue to be, socialized to avoid the expression of anger. Anger can evoke intense feelings of fear or terror, guilt and deep shame, sadness and despair, as well as many other feelings.

For the purpose of this document, anger will be broadly defined and specifically discussed with attention paid to the context and attributed meaning attached to anger.

The definitions as presented above serve as the base of the main terms within the practicum report. The informing theories and a discussion of their relevance composes the next section of the literature review section of the report.

Feminist Theoretical Framework and Therapy

Brown & Brodsky (1992) describe feminist therapists as practicing in numerous modalities - although there are six core values which inform feminist practices. The six core values outlined by Brown and Brodsky are:

1. The need to re-balance the construction of reality so as to include as normative and valued ways of being that are inherent to being female in this cultural context ;

2. An attention to power dynamics in the therapy relationship, with the goal of developing an egalitarian relationship and structure;

3. A theory of human behavior that equally attends to intrapsychic and social / contextual variables;

4. A reliance on empirical data gathering from feminist scholarship on the psychology of women and gender;

5. The valuing of a balance of both healthy autonomy and relational competence for all adults; and the understanding of the goals of therapy as including both intrapsychic change and a changed perspective of social / cultural realities that affect clients lives, whatever the specifics of context.

6. The understanding of the goals of the therapy as including both intrapsychic change and a changed perspective of social / cultural realities that affect clients lives, whatever the specifics of the context.

(Brown & Brodsky, 1992, Woytkiw 1997, p. 14)

The Anger in Healing group focused on recognizing how the origins of our anger and our perceptions of ourselves and of the world we live in have direct and indirect linkages to our past experiences. The context of the family, the community, and larger society we live in impact on all of our experiences. Looking at the immediate and larger context(s) fits within the feminist framework.

Authors or proponents of feminist theory or therapy are not in complete agreement upon the issue of power. Common to feminist theory is the goal that relationships between all parties be egalitarian in nature. Equal access to power and an egalitarian relationship structure are the ideal in feminist thought. However, this ideal is not often found within our society. Power imbalances are more the norm, with many individuals having considerably fewer advantages and less access to resources than others. This is the case with women coming to The Laurel Centre for counselling services. The Laurel Centre is a non profit -

no fee agency and thereby many of the women accessing services are of a lower socioeconomic background. A paradox is evident in how one is to build an egalitarian therapeutic relationship in the midst of a stark power imbalance. Jordon (1995) suggests a relational model in which the therapist and the client are invited to be more real, more vulnerable, and more mutual than in many psychodynamic models. Jordon cautions, however, that, "the therapist must assume the responsibility to regulate and modulate mutuality in such a way that the client's interests are at all times the core of treatment." (Jordon, 1995 in Woytkiw, 1997 p 15).

Many other authors discuss the conflict between power and access to resources between therapists or those providing help and clients or those seeking help. Pearlman and Saakvitine (1995) discuss this issue, stating that a balance is needed between mutuality and neutrality. They see mutuality as being more the same as one another (client and therapist) or equal and see neutrality as what is strived for in therapy. They define neutrality as a "non-judgmental attunement, evenly hovering attention, and acceptance of the contradictory aspects of the client's self and experience" (Pearlman and Saakvitne, 1995, in Woytkiw p. 17).

An issue for feminist therapists lies in the notion that all goals need to be agreed upon by the therapist and the client. The question that results from the central tenet of feminism of working towards bringing about social change, how then does one work with a client not at all interested in this level of change? Brown and Brodsky (1992) discuss the need for feminist therapists to make clear to clients what their values are, thereby giving clients the opportunity to

make informed decisions about continuing with therapy with that individual or agency. (Woytkiw, 1997)

A basic tenet of feminist theory / therapy is that 'the personal is political'. As has been previously discussed, all things that occur in an individual's life occur within a specific context. The notion that the personal is political encourages individuals to view themselves as part of an intricate and complex weave of connections to others and situations - which make up the 'context' of any experience.

According to Walker (1995), feminist theory has helped in forming 'survivor therapy' which is an "approach that is designed to help heal victims of mostly man made traumas" (Walker, 1995, pp. 285). Key principles of Walker's model are education, an emphasis on client strengths, and the understanding of oppression. A group intervention guided by a feminist orientation works to empower women and link women's personal struggles with the political context. (Levine, 1983). Feminist theory examines the "...societal perspective and its influence on the development of incest" (Courtois, 1988)

Brickman (1984) describes the need for a victim's (survivor's) experience to be validated. Validation and acceptance of the survivor's experience are central to the beginning of the healing process. The long held adjustment model is rejected and the effects of abuse are not viewed as 'pathology' but rather as 'adaptive'. According to Sturdivant (1980), personal change is necessary in the direction of increased autonomy and self direction. Personal change and re-empowerment occur when women come to an 'understanding of justice' (Walker, 1995; Fortune, 1991). Fortune (1991) discusses justice making as

involving a series of steps that include truth telling, acknowledgment of truth, accountability, and protection, as well as compassion for the vulnerable.

In summarizing many authors including Burstow (1992), Herman (1992), Levine (1993), Jordon (1995), and Walker (1998), feminist theory or therapy holds as its primary belief the value of women and women's experiences. Feminist theory or therapy states that women need to have power in making their own decisions and life choices. In a therapeutic setting using the feminist perspective, the client is viewed as 'the expert' on knowing her life situation and choosing her own goals and direction in therapy. Women's experiences of oppression in a patriarchal society are acknowledged, named, and explained. Oppression of women is framed in all levels of society micro - personal; mezzo - familial or community; and macro - societal or global levels. Drawing attention to the larger context of womens' individual experiences allows women to understand how their experiences are most often not unique to them, thereby breaking feelings of unnecessary responsibility and isolation.

Feminist theory or therapy encourages the use of group work as it fits with the belief that in having a shared experience women can find their voices, build connections and break silences surrounding issues in their collective lives. The feminist perspective views child sexual abuse and abusive treatment of women and children in our society as being rooted in, maintained by, and perpetuated by the patriarchal social system in which we live.

Feminist theory or the feminist perspective forms the theoretical and practical foundation of this paper. Narrative and Solution Focused theories / therapies form the other theoretical understanding of the issues and the needs

encompassed in developing a therapeutic group addressing womens anger in healing from childhood sexual abuse.

Narrative Theoretical Framework and Therapy

Narrative therapy is grounded in postmodernism and a world view, according to authors, including Freedman & Combs (1996) associated with the following four ideas:

1. Realities are socially constructed.
2. Realities are constituted through language.
3. Realties are organized and maintained through narrative.
4. There are no essential truths.

The belief that realities are socially constructed is one adopted both by constructivists and social constructionists, with narrative therapy applying to social constructionism. Constructivists consider the biological needs of humans and our efforts at modifying our environments and incorporating differing perceptions to create a collective external reality. Social constructionism, on the other hand, considers the ever evolving realities created in the ongoing interaction between individuals.

The idea that reality is a dynamic process rather than a static fact is somewhat unique to the postmodern understanding of the world. Reality under the narrative model is like a kaleidoscope - changing with every twist. Some elements of the previous 'reality' are evident in the current reality and the components of the future reality are present but not yet observable. The notion of using a kaleidoscope metaphor to understand reality demonstrates its

dynamic properties and its ever changing state. When considering reality as a kaleidoscope in which all parties can twist, it is clear that as Freedman and Combs (1996) state, there are no essential truths (or reality for that matter).

Reality, using the postmodern social constructionist model, is influenced by all members of a group or situation under consideration at any given time. Language is the medium in which reality is created and experienced. As individuals, families, or cultures we use language to communicate our individual and shared understanding of the world in which we live. Narrative therapy views reality as created and organized using stories or narratives.

The stories we hold onto create our individual reality and form our world view. In narrative therapy, the stories we choose and hold form the foundation of intervention. The un-storied parts of individuals' lives can be developed and old stories can be re-authored or re-storied, thereby creating new 'preferred realities'. Since there are no essential truths and because we as individuals can create our own realities, therapy focuses on assisting individuals to develop and cultivate their lives to fit with what they determine as their 'preferred reality'.

View of clients or individuals and problems:

Clients are viewed as the experts on themselves and the authors of their stories. Problems under this model are viewed as separate from the people involved. As White and Epston (1990) state, 'the person is not the problem, the problem is the problem'. Individuals are seen as having 'problem saturated' narratives or stories - with many other narratives or stories not yet told. The narrative model describes problematic narratives as resulting from individuals'

views of their reality in a patterned way that filters out any new or different information about the world or themselves which does not fit with this dominant view of themselves. Therapists often focus on helping the individual discover what stops them from being able to overcome what they feel the problem to be.

Understanding of power in model

Narrative therapy views language as the creator and keeper of power. Those whose voice(s) are heard - individuals or groups - hold power over those whose voice(s) are not heard. Individuals or groups whose voices are heard and whose stories are told become viewed as 'truth' and form the 'dominant narratives' The dominant narratives are then internalized by members of the society in which they are told and form the dominant ideas about gender, race, ability, social class and status, which in turn serve to empower the power holders and disempower those who do not hold power (Freedman & Combs 1996; White and Epston, 1990). Narrative therapy has many commonalties with feminist theory and therapy in their understanding of power and of individuals and their problems, as they define them.

Role of therapist

The role of the therapist in this model is not one of expert - in fact, the role of 'not knowing' is described in the literature. The therapist must keep a curious outlook and not hold an agenda about where a session or an individual is going in the therapeutic process. The use of questions within the model assists the therapist in not attaching to a 'pre-understanding' of the issues or the individual. (Freedman & Combs 1996). Therapists are facilitators within the therapy

process, allowing opportunities and room for clients' stories to be discovered or rediscovered and to assist clients in constructing new preferred realities.

Therapists using narrative therapy are expected to evaluate their practice from an ethical standpoint and seek supervision and guidance regarding their practice. The model encourages therapists to 'situate' themselves by explaining the beliefs and views of narrative therapy and to share their own experiences which influence their practice. Clients are told that they are in control and will direct their own therapy, and they are encouraged to ask questions of the therapist.

Structural Aspects of model

Narrative therapy does not have a rigid structure: however, there are stages of intervention within the model. The stages are viewed in theory and in practice as being cyclical in nature and form a guide for the therapeutic process. The narrative therapy model fits well with The Laurel Centre's model of treatment for working with adult women survivors of childhood sexual abuse. The understanding that individuals work through therapy in stages or cycles and that the process can and usually does repeat itself within the therapeutic relationship hold narrative theory and therapy as a strong partner for work within The Laurel Centre treatment model. While a specific time limit is not set in working with the narrative model, a review of the literature suggests that narrative therapy is somewhat brief. (Esler & Waldgrave 1990; Freedman & Combs, 1996; O'Hanlon 1994; White & Epston 1990). Therapists do have an agenda: to assist clients to externalize their problem(s) and create a new or preferred narrative for their situation.

Narrative therapy with survivors of childhood sexual abuse

Several authors have written about using narrative therapy to work with survivors of child sexual abuse. Durrant and Kowalski (1990) offer the following:

PRINCIPLES OF THERAPY
WITH THE EFFECTS OF SEXUAL ABUSE

1. Sexual abuse does not inevitably lead to emotional or psychological problems. In spite of having experienced something quite painful and confusing, people who have been abused have many strengths and resources with which to solve difficulties.

2. It is more helpful to consider 'what keeps this problem alive in this person's life, and keeps it from being resolved?' (a focus on context / restraints) rather than, 'what caused this problem?' (leads to examination of family dynamic, individual pathology, etc.).

3. One of the main effects of sexual abuse is the assault it makes on the person's self-perception. As the abuse can blind people from noticing their strengths and capabilities, they develop an 'abuse dominated' view of self and interaction.

4. People inadvertently notice and place greater emphasis on 'facts' which support the abuse dominated descriptions of themselves, others, relationships, and situations. People unwittingly co-operate with the 'life' or 'career' of the effects of the abuse, due to the incremental nature of problem development.

5. Complex problems like sexual abuse don't necessarily require complex solutions.

6. Every abuse dominated pattern includes examples of EXCEPTIONS which serve as hints towards solution. Focusing on these small 'chinks' in the client's behaviour or self-perception can serve as a foundation upon which she can build a new view of herself as competent and in-control.

7. The client's difficulties need to be defined and talked about in a way which helps her/him feel optimistic about and effective in resolving them.

8. The goal of therapy is to assist the client in overcoming the effects of the abuse and to make sense of her / himself and the experience in a way which frees her / him to live a satisfying life, rather than to help the client 'work through ' the abuse.

9. In order for effective changes to occur, the person first has to see her / himself through a lens of 'competence' rather than 'incompetence' , in 'in-controllness' rather than 'out of controllness', 'self respect' rather than 'self hate', 'forgiveness' rather than 'self blame' etc.

10. It is not necessary to directly discuss the details of the abuse in order to diminish the effects. Clients are the best judges of whether, and when, it is helpful to discuss the abuse explicitly.

The fundamental approach to working with childhood sexual abuse is to help the client understand and reject the dominant narratives about themselves, and create new or preferred realities. The narrative model is applied to all situations or problems in a similar manner (Durrant & Kowalski, 1990; Esler & Waldgrave, 1990; Freedman & Combs, 1996; O'Hanlon, 1994; White & Epston, 1990). A difference in working with child sexual abuse is an understanding that more time is needed to discuss the effects of the abuse. Durrant and Kowalski (1990) note that because the abuse cannot be made to have not happened, describing the abuse as the problem creates it as an un-solvable problem. Focusing attention on the effects and overcoming the effects of the abuse creates a solvable problem.

Characteristics of the model and stages of intervention

- First, externalizing the problem - using deconstructive listening and deconstructive questioning.
- Second, opening space for alternative stories - using relative influence questioning. Third, construction or co-authoring of a preferred reality - using preference questions and story development questions.
- Third, thickening the plot and spreading the news.

Externalizing the problem begins with the therapist using deconstructive listening to summarize their understanding of the clients stories. At this point they are using externalizing language but not yet externalizing the problem.

Deconstructive questioning involves the therapist asking questions designed to assist the client in externalizing the problem. The therapist uses language to personify the problem and give the problem characteristics of having intent outside of the individual themselves. Solving a problem is a less formidable task when one names, faces or overcomes a problem in their life rather than viewing themselves or their situation as 'having or being' a problem (Durrant & Kowalski 1990).

Opening space for alternative stories involves the therapist's use relative influence questions. These are designed to follow the 'life' or 'career' of the problem and the effects the problem has had upon the client's life, as well as how the client's life has influenced the life of the problem. The therapist is looking with the client for the 'unique outcomes' or 'sparkling events' - when the client has challenged or stood up to the problem.

Construction or co-authoring of the preferred reality involves the therapist employing preference questions to determine whether the 'unique outcome' or 'sparkling event' constitutes a preferred reality. If so, the therapist then employs story development questions to assist the client in examining the differences and explore ways to build upon those events or experiences. These questions and discussions highlight for the client how they have been and are able to stand up to the problem.

Thickening the plot involves the therapist and client planning projects and actions to continue using the unique outcomes to stand up to the problem. Setbacks are discussed and strategies to manage setbacks are planned. The therapist may use letters or certificates to reinforce achievements for the client.

Spreading the news is when the client is encouraged to utilize their informal, formal, and even imaginary support systems to celebrate their success and changes in their lives. Celebration and ceremony in the therapeutic relationship can provide a meaningful end to therapy.

While the literature does not discuss the use of narrative therapy in a group therapy setting, adaptations can easily be made to allow for the use of narrative theory and techniques with a group rather than an individual.

Solution focused theoretical framework and therapy

A summary of the fundamental concepts and understanding of solution focused therapy is as follows:

- Client is the expert on understanding their problems
- Paradigm shift from 'problems' and 'pathologies' towards capabilities and solutions
- Focus on client's strengths and abilities -- on what is already working for the client
- Focus on solutions to problems not causes of problems
- 'Resistance' in therapy is viewed as the client's way of letting the therapist know how or how not to help them.
- New and beneficial meanings are co-constructed between the client and
- the therapist for aspects of the clients problems
- Therapy is brief: 2 - 10 sessions
- Change is inevitable and constant
- Rapid resolution to problems is possible
- Change in one part of the system leads to change in the system as a whole
- Clients define goals
- Therapist focuses on exceptions to the problems and the concept: 'when will you know the problem is solved?'
- The problem is the problem, the person is not the problem
- Therapist uses client's language as much as possible
- Treat people as normal; when people are treated as such they will act in that way

(de Shazer et al, 1986; Molnar and de Shazer, 1987; O'Hanlon and Weiner-Davis, 1989)

Solution focused therapy holds as a main principle, according to de Shazer et al. (1986), that complaints develop and are maintained in interactions between people, therefore solutions can be found in changing interactions. The primary task using this therapy is to do something different. This model makes assumptions about the fact that clients want change, that new meanings can be constructed for aspects of the complaint, that small changes are often all that is needed and that the problem or complaint does not need to be fully described. The belief is that therapy can be effective if only the solution is described.

View of clients or individuals and problems

Clients are seen as experts in understanding problems or difficulties and as having the resources necessary to solve the problem. Little time is spent on describing the 'problem' and focus is quickly placed upon solving the problem.

Role of the therapist

The solution focused model views rapport as important in the work: however, at the same time, it believes that therapeutic distance needs to be maintained. Therapists begin the solution focused process quickly. The goal is that therapy be as short in duration as possible. Information sharing is encouraged from therapists while self disclosure is not encouraged, as finding solutions for the client is the overall focus. Alternatively, authors such as Yvonne Dolan (1991), in her work with survivors of childhood sexual abuse, feel that joining with the client is essential in working through the effects of the abuse. Dolan believes that clients do have the solutions within themselves and feels that

clients may not be able to recognize the strengths and the healing they are already doing in their lives.

Structural Aspects of model

The solution focused model is very structured in its pure format, with the discussion of the problem, exploring exceptions to the problem, outlining possible solutions and setting clear goals within the first therapy session. Several authors and therapists (Dolan, 1991; Kiser, Piercy & Lipchik ,1993) have written about and are practicing some of the solution focused theory or techniques in a manner that fits with what clients identify as the pace they would like to work at.

Characteristics of the model and stages of intervention

The solution focused model, in its traditional format, has the following stages: introduction to therapy, statement of the complaint, exploration of exceptions to the problem or complaint, establishing therapy goals, definition of potential solutions, a consultation break, and delivery of the message from the team (if a consultation team is used). This format is used in the first session, and second and subsequent sessions are the same, with a discussion of positive events or changes with regard to the problem being substituted for the statement of the problem that occurred in the first session.

The introduction to therapy involves the therapist explaining how the process will work and a brief period of time spent 'small talking' to allow the therapist to build a level of rapport with the client.

The statement of the complaint follows the introduction - here the therapist directs the client to fully describe the problem in interactional terms.

What happens, when and how it happens, who is involved, how often it happens and what factors the individuals can change in the way the problem or complaint occurs.

From the statement of the complaint very often comes the beginning of the exploration of exceptions. It is in the exceptions that the model believes that possible solutions can be found. The intention is to find out more about when the problem is not occurring, or is less problematic, and to discover ways to replicate that for the client. Clients are validated for having the solution within them already and are encouraged to do more of what is helpful when the problem is not occurring or is less of a bother.

Goal setting involves having the client choose one concrete goal to work on between the first session and the next session. The assumption that change is likely toward achieving the goal is stressed to the client. The model believes that clients will consciously and unconsciously make change efforts towards their identified goals.

The solution definition phase of the model entails having the client consider and discuss how they will know that change in their problem or toward their goal has occurred. Within this model the majority of the session is spent in this phase. Spending time in this phase sends the message to the client that the therapist believes they can and will achieve their goals and make changes.

As with narrative therapy, the employment of solution focused therapy in group work is not readily available. However, theory and techniques of solution focused therapy work very well in a group therapeutic setting.

Narrative and solution focused therapies or models have many commonalties. The focus upon client strengths and ability to solve problems are central in both models. The essence of each model is searching for a positive change in the problem. The narrative model looks for unique outcomes or sparkling events, while the solution focused model looks for exceptions. Using the strengths focus and several techniques from each model can work very well with feminist theory in providing service to women sexually abused as children.

Long term effects, including compulsive coping of child sexual abuse

Each survivor's experience is their own and unique. Survivors all deal with the trauma of childhood sexual abuse in their own way. This being said, however, research and clinical practice have found common themes. To briefly summarize, the most consistent long term effects include: low self- esteem, depression, guilt, shame, anxiety, chemical dependency, relational difficulties, lack of assertiveness and self-destructive behavior, (Bass and Davis, 1983; Binder, McNeil and Goldstone, 1996; Briere, 1996; Chew, 1998; Courtois, 1988; Evans and Sullivan, 1995; Gil, 1988; Herman, 1992; Mines, 1996; & Walker, 1995). Anger is discussed by the above authors; however, it is not often listed as a long term effect of childhood sexual abuse. This is interesting and is hypothesized by the student clinician / researcher to be due to women's denial of anger and the socialization process that encourages women to not express anger. Feelings and experiences of anger are then redirected into a different expression; perhaps one or a combination of those listed above.

Long term effects have been categorized into different groups by several authors (Briere, 1996; Courtois, 1988; Donaldson & Cordes-Green, 1994; Gil 1988). Gil based her categorization, as follows on a clinical sample of 99 individuals who came to her for counseling:

1. Psychosocial problems
2. Physical and eating disorder problems
3. Relationship and sexual problems

Briere (1996) divides the long-term impacts into 4 categories:

1. Post-traumatic stress
2. Cognitive effects
3. Emotional effects
4. Interpersonal effects

Donaldson and Cordes-Green (1994) also identify four categories, which they drew from an extensive literature review on long term effects:

1. Emotional and cognitive effects
2. Social and interpersonal functioning
3. Physical and sexual functioning
4. Psychiatric diagnoses

Courtois (1988) states that "...incest has been found to impact the victim intrapsychically and interpersonally" (Courtois, 1988 pp. 107) and identifies six categories of effects:

1. Emotional reactions
2. Self - perception
3. Physical somatic effects
4. Sexual effects
5. Interpersonal relating
6. Social functioning

It quickly becomes evident that across the literature on child sexual abuse there is some level of agreement on the long term effects of abuse. Courtois (1988) states that long term effects may be "...chronic manifestations of acute

after-effects or develop in a delayed fashion..." and that some "... appear and remit sporadically and rather spontaneously..." (Courtois, 1988 pp. 104) These statements by Courtois speak to the complexities and the uniqueness of each individual's response to the trauma of childhood sexual abuse. van de Kolk et al., (1996) cite Kardner who states that once traumatized, an individual

> acts as if the original traumatic situation were still in existence and engages in protective devices which filed on the original occasion. This means in effect that his conception of the outer world and his conception of himself have been permanently altered. (van de Kolk et al., 1996, pp. 196)

While the sexist use of language and the emphasis on pathology is evident in the above quote, the lasting effects of child sexual abuse are noted, as is the extreme difficulty to make changes for impacted individuals.

Herman (1992) states that the coping mechanisms employed by individuals to manage the trauma are not easily given up, and often become part of the individuals' personality. Viewed in society particularly using a medical model these as Herman describes 'adaptive' coping mechanisms are labeled as a disorder. The diagnosis of a personality disorder or other pathologizing diagnosis such as Post Traumatic Stress Disorder (PTSD) are often assigned to women seeking services from the medical or psychiatric systems. Beyond the diagnosis, medication is often prescribed and sometimes, although not always, therapy services are recommended. Herman's trauma model does recognize the presence of personality disorders and mental health issues she however advocates for looking beyond the presenting issues and considering individuals

historic and current life situations to determine additional treatment and or recommendations outside of medication.

In contrast, The Laurel Centre does not pathologize long term effects. The Laurel Centre views many long term effects as compulsive coping behaviors- see above definition. These behaviors, while difficult to change, can be changed. Walker (1995) states that survivor therapy takes the position that the diagnosis of personality disorders may not be relevant to survivors of childhood sexual abuse. "Many of their symptoms disappear after supportive therapy that takes a feminist and trauma survivor focus, suggesting that these disorders were actually learned coping strategies and not integrated within victims' personalities" (Walker, 1995 pp. 126). The Laurel Centre would concur with Walker in finding that symptoms can subside after therapy work.

Models of treatment for child sexual abuse and compulsive coping

The task of locating treatment models for working with women sexually abused as children who also struggle with compulsive coping behaviors proves to be difficult, as very few models are written about in the literature currently available.

An inpatient treatment model is outlined by Bollerud (1990) for women in treatment for chemical dependency who have a history of childhood sexual abuse. This model includes: patient education, individual and group psychotherapy, and outpatient follow up treatment.

A twelve step approach model to working with women who abuse substances combined with a counseling component focused upon healing from childhood sexual abuse is discussed by Evans and Sullivan (1995). Their model

discussed by Evans and Sullivan has five stages: 1. crisis phase; 2. skill building phase 3. education 4. integration; and 5. maintenance phase.

The Trauma model

Recovery, according to author Judith Herman in her book entitled *Trauma and Recovery* (1992) occurs when an individual has "...a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection" (p. 155)

Herman has outlined a treatment model for working with adult survivors of childhood sexual abuse. The model is described in five stages that Herman stresses are not in theory or practice meant to be understood as a linear process.

1. Healing relationship
2. Safety
3. Remembrance and mourning
4. Reconnection
5. Commonality

Herman discusses the complexity in healing from childhood trauma and stresses the need for providing an environment where women can have the experience of empowerment:

> ...The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections - in her renewed connections with other people the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience. These faculties include the basic capacities for trust, autonomy, initiative, competence, identity and intimacy (p. 133)

Herman describes the first phase of the model 'developing a healing relationship' - where individuals are encouraged to create safe supportive

relationships in their personal life and with a therapist. Issues within the therapeutic relationship are outlined by Herman, who stresses the need for careful attention to boundaries, transference, counter-transference, and supports for both the client and therapist. Developing a therapeutic contract is viewed as important using this model.

Safety is described by Herman to be the second phase. She discusses building a healing relationship as a pre-phase or as laying the groundwork for recovery. The developing safety phase is where the therapist begins an assessment of the client's situation and provides information to the client about the impact of trauma on ones life. This phase is marked by the therapist assisting the client in understanding how she understands safety and how to ground herself - breathing is stressed and the creation of a basic self care plan are essential. Issues of safety when a client is currently in an unsafe relationship are discussed by Herman, with suggestions of how to handle safety concerns.

Remembrance and mourning is the third phase and the time when the client shares her story of abuse / trauma. The hope of this phase is that the client "...reclaims her own history and feels renewed hope and energy for engagement with life" (p. 195). Herman argues that clients need not have complete or full memories to heal from the trauma. Mourning the associated losses from the abuse / trauma is an important component of this phase.

Reconnection is the fourth phase, although, and is marked by the client creating a future for herself apart from healing or surviving. Skill development in assertiveness, communication, understanding personal power, building a support system, and developing a sense of self, is encouraged.

Commonality is the fifth phase, although, as originally stated, these phases rarely occur in the stated order and are not intended to do so. Commonality involves the client understanding that she is not alone in her experience of trauma, which helps increase her sense of self and sense of safety in the process.

The Laurel Centre model

The clinical model for treatment at The Laurel Centre **(Appendix 1)** has been developed to work with women who have experienced child sexual abuse and have difficulties with compulsive coping behaviors. The model has been influenced heavily by the work of Judith Herman (1992) as previously discussed. An outline of the model is as follows:

1. Engaging and assessing
2. Creating safety
3. Intense debriefing
4. Integrating
5. Moving on

The model is presented in the form of a wheel, and, as Herman stressed, The Laurel Centre maintains that the phases are not linear, but rather as ongoing, repetitive, and cyclical. The Laurel Centre views healing as cyclical and often episodic. Episodic refers to coming to therapy and working through a particular issue or time period in their life and their feeling ready to move on without therapy. However, they often return to therapy to work through different issues or similar issues as the first episode - this time healing at a different level. The model acknowledges the potential link between childhood trauma and the adoption of compulsive coping behaviors and feels healing must address both issues in tandem. **(Appendix 2)**

The first stage is called Engaging and Assessing. The tasks of this phase are : establishing rapport, determining client goals, and negotiating a therapeutic contract. The therapist describes the therapeutic process and outlines the roles and boundaries within the relationship. Normalizing and validation for the client and her experience are an important component of the first phase.

Creating safety is the second phase of the clinical model. This (as with all phases) is ongoing - creating a safe therapeutic relationship where clients can feel trust and understand the boundaries and the confines of therapy is essential to healing. During this time, therapists work with clients in examining the ways in which they have coped and are currently coping in their lives, stressing the development new coping strategies and a strong support network. Information sharing about child sexual abuse and its impacts, coping, and the social construction of abuse begins within this phase of the therapeutic relationship.

Intense debriefing is the third phase of the model. This phase is marked by the client sharing her story of the abuse and trauma in her life, when she feels safe to do so. The impacts of the abuse are discussed and the consequences of the impacts and abuse are recognized. Grieving for losses due to the abuse is an important component to debriefing the abuse. Recognition and honoring of clients individual strengths is stressed.

The fourth phase, titled Integrating, outlines the process of assisting the client to work toward developing and creating balance in their lives. New coping skills are developed, understanding of feelings, thoughts and behaviors and how each influence one another in our lives and healing occurs. A social and political

analysis of child sexual abuse often accompanies this phase to assist the client in normalizing her experiences.

The final phase of The Laurel Centre's model is called moving on. This phase typically marks the end of therapy for clients. Therapists decrease their role in the client's lives and encourage clients to become their own support in healing. Celebrations of healing and accomplishment mark the end of a difficult journey and the loss of the therapeutic relationship is processed. (The Laurel Centre, 1999)

Group work

Disadvantages to group work

While there is a great deal of literature which supports the utilization of groups for treating survivors of child sexual abuse, literature also states disadvantages and cautions to group therapy and treatment. Corey and Corey (1982) outline six risks of participating in a group:

1. Individuals may make themselves overly vulnerable when opening up to other group members
2. Self-disclosure may be misused or misunderstood by group members or may become an end in itself rather than a means
3. Confidentiality may not always be maintained by all group members
4. The group may scapegoat one or more members of the group
5. The group leader may lack experience and competence
6. Group members sometimes experience significant disruption in their lives.

The benefits of group, as discussed earlier, may not be experienced by all group members; in fact, some members may experience further trauma from being part of a group. Individuals who experience a great deal of shame may be further shamed and thereby have their negative views of themselves validated

and further entrenched. Starhawk (1987) cautions therapists, stating that groups can enhance an individual's weaknesses as well as strengths. Starhawk states further caution saying that groups can be places of liberation or replications of oppression.

Kasl (1992) outlines eleven potentially limiting components of groups:

1. Groups can isolate members by discouraging outside involvement
2. Groups may discourage access to reading material and other forms of personal growth
3. Members can be punished or discouraged when they express dissension
4. Groups can become grandiose and see themselves as being the only route to healing
5. Group members can get locked into roles
6. Groups can foster an 'us against them' mentality, developing a paranoia regarding outsiders
7. Members can internalize group rhetoric at the expense of individuality
8. In-group jargon can predominate conversations
9. Groups may exert undue pressure on members to stay
10. Group members may use the group to meet sexual needs
11. The group may become unable to reflect on itself and may create an unquestioning ideology

Advantages to group work

Group work is one of the more common therapy models for working with survivors of child sexual abuse. Group work is recognized as being helpful in assisting with a wide variety of issues and is used by many helping professionals including: social workers, nurses, psychiatrists, psychologists, teachers, and clergy. (Toseland & Rivas, 1984; Donaldson & Cordes-Green, 1994). Sprie with Unger stated that "there are many benefits derived from a group setting that are rarely achieved as quickly or as thoroughly in an individual setting" (Sprie and Unger, 1986 pp. 3).

Herman and Schatzow (1984) argue that group work with survivors of child sexual abuse appears to be a particularly suitable intervention. Courtois (1988) states:

> The obvious rationale for group treatment is its potential for countering and alleviating the most insidious characteristics and effects of incest. The impaired interpersonal functioning and mistrust which result from this human-induced trauma are reworked in a context which requires interpersonal engagement. Group allows breaking of the secrecy, isolation, and stigma resulting from the abuse and fosters exploration and resolution of the trauma and its aftermath. The sharing and empathy derived from common experiences and reactions, as well as the analysis of the interaction between members, are of great therapeutic value. Together group members build an environment of safety and consistency within which to explore the effect incest has had on their lives and to help each other undo its damage by developing trust and by practicing new skills and behaviors. (Courtois, 1988, pp. 244).

Courtois makes the point that many authors state that group work helps to alleviate some of the secrecy, isolation, shame and stigma of childhood sexual abuse or incest. (Courtois, 1988; Donaldson & Cordes-Green, 1994; Gil, 1988; Herman, 1992; Jehu, 1988; Walker, 1995 & van der Kolk et al., 1996).

The group experience often allows members to experience close relationships, trust, and feelings of emotional intimacy.(Kasl, 1992) This bonding and connection to others within group is referred to as 'universality' by Yalom (1985). van der Kolk (1987) states:

> In a group patients can start re-experiencing themselves as being useful to other people. Ventilation and sharing of feelings and experiences in groups of people who have gone through similar experiences promotes the experience of being both a victim and a helper. Even a trusting and secure relationship with a therapist who serves a parental substitute does not necessarily enable the patient to assess his or her relationships with others accurately. In a group, the therapist can facilitate reempowerment by encouraging mutual support and by exploring the patient's resistance to taking an active role. (van der Kolk, 1987, pp. 163-164)

The advantages of group work outweigh the disadvantages in providing therapy for women survivors of childhood sexual abuse and group work is often the chosen therapeutic medium over individual work.

Group work is one of the earliest interventions known to social work practice. The origin of group work in social work can be traced back to the settlement houses in Great Britain and the United States in the early 1900's . (Johnson, 1986)

> The values of social work, the beliefs in the inherent worth and dignity of all human beings are integrated in the development of the 'anger in healing' group. The Canadian Association of Social Workers Code of Ethics (1994) states that: Social workers believe in the intrinsic worth and dignity of every human being and are committed to the values of acceptance, self-determination, and respect of individuality. They believe in the obligation of all people, individually and collectively to provide resources, services and opportunities for the overall benefit of humanity. (pp. 7)

Social worker as group leader

The student / clinician - social worker developing and delivering the 'Anger in Healing' group was aware of the multiple roles she was engaging in and the need to remain conscious of the needs of the clients or participants at all times. The role of social worker requires that the needs of the clients or those receiving services need to take precedence over any other needs. (Peterson, 1992, pp. 75) The fact that the groups were part of the completion of a Masters degree in Social Work implies that the social worker was invested in the outcome of the group and would benefit from the group. The group participants and potential participants need to be informed of the multiple roles of the social worker and to

understand what their involvement would mean before deciding to be part of the group.

Group facilitation

Although the literature discusses both single and co-facilitation of groups there does not appear to be any research to indicate one form of facilitation is superior to another. However, many authors discuss the advantages to co - facilitation as a preferred style due to the emotional intensity of the group experience. (Donaldson & Cordes-Green, 1994; Saxe, 1993; Glassman & Kates, 1990; Courtois, 1988). Courtois (1988) states that "...the intensity of the group process and emotional content places great demand on the therapist". She makes a case for using a co-facilitation model and advocates for both facilitators to be female (Courtois, 1988). Saxe (1988) also suggests that both facilitators be female. Deighton and McPeek (1985) support the use of a male / female co therapist team, believing that the presence of a male that presumably can be trusted can allow women to begin to be able to form or perceive of forming trusting relationships with men. The facilitation of the Anger in Healing groups will be done using a co-facilitation model where both therapists are female. In addition to the above state rationale The Laurel Centre only employs and accepted as female counselors or volunteers within the agency.

Group structure

The number of participants in each group is an important consideration. Dimock (1986) suggests that an optimal number of members for a therapy group is between five and ten members (pp. 20). McEvoy (1990) suggest a maximum

of eight members. The number of members for the Anger in Healing group was planned to be between five and eight.

The literature reports that groups for survivors have been noted to range in length from four to twenty sessions (Cole, 1985; Gil, 1988; Herman & Schatzow, 1984; Saxe, 1993). Several authors state that short term groups hold advantages over long term groups (Courtois, 1988; Gil, 1988; Herman, 1992; Oakley, 1996). Courtois (1988), in her survey of literature regarding duration of groups for sexual abuse survivors, found that authors recommend between ten and twenty sessions (pp. 249). Saxe (1993) outlines a twenty week model, and Sprie (1987) a ten week group process.

According to Courtois (1988), short term groups may "limit the level of anxiety experienced by a survivor considering joining a group" (pp. 250). Gil (1988) notes that clients "...may feel more able to make this short term commitment" (pp. 250). While the literature seems to support short term groups, some argue that although short term groups promote trust and bonding, true growth and lasting change may require a longer period of treatment time. According to Donaldson and Cordes-Green (1994), long term groups (more than twelve weeks) allow for continued growth and more time to process and integrate skills. There does not appear to be significant research or information available on the merits of the length of group treatment. The Anger in Healing group was twelve weeks in duration with one follow up session. The possibility for further follow up sessions or re-contracting a group format was to be discussed if there was a request by the members to do so, but this was not the case.

Screening for group participation

The screening interview is an opportunity for the social worker to assess the woman's readiness and suitability for group. (Courtois, 1988; Donaldson & Cordes-Green, 1994; Walker, 1995). The screening process is equally important for the prospective group member to gain information and ask questions about the group before making a decision to become involved. Cole and Barney (1987) discuss reasons for screening in the following manner:

> The screening interview includes a reciprocal exchange of information. Emphasis is placed on the fact that both therapist and potential group member must make a decision about the interviewee's participation in the group. Thus the survivor's ability to be a part of the decision making process and act on her own behalf is underscored, as is the therapist's responsibility to set limits and 'do no harm'. The prominent themes in a survivors life, taking care of oneself and appropriate (or inappropriate) exercise of responsibility by authority figures, are relevant even in this early context. (Cole and Barney, 1987 pp. 603)

The Anger in Healing group needed to be concerned about women with a history of violent behavior and past aggressive behavior. The group was not focused entirely upon anger or anger management per se, but rather upon the role of or experience of anger in the women's life past and present. Schadler (1992) cautions against including survivors who are suicidal or psychotic. Several authors agree that potential members must demonstrate the capacity to tolerate questions about their experiences as pre-requisite to group participation. (Courtois, 1988; Donaldson and Cordes-Green, 1994; Cole and Barney, 1987; Marziali, 1994; Schadler, 1992).

Participants in the Anger in Healing group will be referred and initially screened by their individual therapist within The Laurel Centre. During the intake process the group facilitators screened for emotional readiness and maturity. They also looked at the 'fit' between group members, to lessen the likelihood that women with a tendency to externalize anger and behave aggressively would be mixed with women who internalize anger in a group format.

Women's anger, and anger in healing from child sexual abuse

A specific literature search looking at anger, women, and child sexual abuse did not yield any sources looking at the three issues exclusively, although many sources dealing with women and child sexual abuse do look at anger in healing. Additionally, a search looking only at women's anger produced a small number of sources; however, the literature based on the general topic of 'women and anger' was not necessarily appropriate for inclusion in the literature review section of the practicum proposal. Women's anger is not a well researched subject, which, in part, is a reason to develop a group looking at women's anger in healing from child sexual abuse.

Nearly all the sources looking at women's anger both in a sexual abuse context and in a general context agree that women have been socialized in our society to not express anger. (Bass & Davis, 1983; Courtois, 1988; Frankel, 1992; Hougland & Nicholas, 1995; Jordan, et al, 1982; Kopper & Epperson, 1991; Lerner, 1985; Oliver & Wright, 1995; Rosellini & Worden, 1985; Tavris, 1989; Thomas & Jefferson, 1996) Many authors state that further research and writing is necessary in exploring women's anger.

Feminist authors such as Jean Baker Miller (1982) wrote about women's relative position as a subordinate to men in our patriarchal society:

> ...women have been led to believe that their identity, as women, is that *of* persons who should be almost totally without anger and without the *need* for anger. Therefore, anger feels like a threat to women's central sense of identity, which has been called *femininity*. (pp. 184)

Many authors describe the socialization of women to emphasize care giving of others and not of caring for themselves. Baker Miller (1982) states,

> From very early in life, women have been led to believe that their life activities should be for others and that their main task is to make and maintain relationships that serve others.
> ...to be angry can feel to women as if it will disrupt a relationship...
> ...because any anger is too much anger in women. Indeed, the risk of expressing anger can appear grave and disorganizing. (Baker Miller, 1982)

Baker Miller (1982) clearly outlines the negative spiral women often experience in expressing or, rather, not expressing anger. Repeated experiences of not expressing anger leads to repeated feelings of frustration and lack of action, which brings about feelings of weakness and lack of self esteem, thus increasing feelings of lack of worth and inferiority. This in turn causes more feelings of anger and the cycle repeats itself. (Baker Miller, 1982 pp. 185)

Several authors cite women's suppression of anger and the cycle above in different variations and state that if women do express anger it is often in a state of exasperation (Baker Miller, 1982; Courtois, 1988; Frankel, 1992; Lerner, 1985; Thomas & Jefferson, 1996) Women's anger "...can end in a kind of self-fulfilling prophecy," according to Baker Miller (1982). If anger is finally

expressed, it often appears in an exaggerated form, perhaps along with screaming and yelling.... then dismissed as 'hysterical'." (pp. 185)

Lerner (1985) states that when women do experience anger they begin to question themselves and block or invalidate their anger - producing feelings of guilt, depression and self doubt. Women's anger is linked to depression in many sources (Frankel, 1992; Hougland & Nicholas, 1995; Kopper & Epperson, 1991; Oliver & Wright, 1995; Tavris, 1989; Thomas & Jefferson, 1996).

Lois Frankel, in her book titled '*Women, anger and depression*' (1992) states, "Many women simply cannot distinguish between anger and other more socially acceptable emotions" (pp. 15). Frankel goes on to explain in detail her clinical experiences in working with women and men that lead her to believe that "...depression is the ultimate manifestation of turning anger inward ..." and that "...unexpressed anger is the single most significant block to a woman's empowerment. Until she confronts the anger in a healthy way she will feel stuck, unfulfilled, useless and act as if she has no other alternatives." (Frankel, 1992, pp. 39)

Self harming behavior or compulsive coping is discussed by Courtois (1988) as being employed by women as a way of expressing anger directed inward at themselves. The comparison of women directing anger inward in self harm, compulsive coping, and depression to men expressing anger outward in an aggressive manner is made by nearly every author previously cited as part of discussing the role of socialization in men and women's experiences with anger.

Carol Tavris' '*Anger: The Misunderstood Emotion*' outlines the role of anger in the women's movement in the United States in the 1960's and 1970's.

In her description of the experiences women had in lobbying for action and consciousness raising, comparisons can be drawn to the experiences women have in healing from child sexual abuse.

> Realizations are, at first, halting and then begin to hit you like a relentless sledge hammer, driving the anger deeper and deeper into your consciousness with every blow ... This is an uncomfortable period to live through. You are raw with an anger that seems to have a mind and will of its own. You yourself get tired of this anger-- it's exhausting to be furious all the time -- which won't even let you watch a movie or have a conversation in peace. (Tavris, 1989 pp. 270).

In healing from child sexual abuse, women often express feelings similar to those expressed in the above quotation, that feelings seem relentless. Tavris goes on to explain how the discomfort in experiencing feelings of anger can lead women to direct their feelings in another direction to avoid the pain or discomfort of the feelings of anger, stating "...it is safer, certainly, to feel guilty rather than angry."

Baker Miller (1982) states at the end of her article that "...anger can be seen as a potential source of mobilization for action - an available potential - but with many obstacles to confronting in the realities both within and outside family and within the construction of the mind" (pp. 195).

Relevance of Anger in Healing group to social work practice

The Anger in Healing group is relevant to social work practice as it is fitting with many of the basic tenets of social work. A strong emphasis on looking at women's experiences within their contexts and the myriad of outside systems which impact all areas of a survivors life were considered and discussed. The

group employed ecological approaches with the feminist and survivor models approaches. The cornerstone of social work, looking at the person within their environment, was a major influence in the development of the group. While a psychological approach might look at the issues from a more individualistic or micro level, social work looks at issues from a micro, mezzo and macro level and attempts to bring about change in each level. (Johnson, 1986)

Conclusion

This chapter has discussed feminist theory and therapy, narrative and solution focused theory and therapy, child sexual abuse, understanding effects of and treatment models for working with adult women, group work approaches to social work, women's anger and the way women's anger is socially constructed, and the need for and relevance of a therapeutic group dealing with women's anger and healing from child hood sexual abuse.

From the discussion within the literature review, the theoretical frameworks are used to compliment one another and were adapted to meet the needs of the specific client population of women survivors of child sexual abuse. The impacts of the abuse and varying models of treatment were considered and relied upon in developing and implementing the group. The literature and theory regarding women's anger and its social construction formed the basis of many of the exercises and information within the group. An understanding of the usefulness of group therapy in treating child sexual abuse survivors was woven into the group design, as is the relevance of such a group for the social work field.

CHAPTER THREE

PRACTICUM METHODOLOGY

Chapter three provides a description of the agency setting where the group intervention took place, a description of the practicum committee, discussion of the participant selection and intake process, a discussion of the facilitation using a co-facilitator model, and concludes with an outline of the group model, along with an overview of the group agendas with objectives and a session schedule.

The Setting

The setting for the Anger in Healing practicum was The Laurel Centre at 62 Sherbrook Street, Winnipeg, Manitoba. The Laurel Centre was established in 1985 as service for women who were survivors of childhood or adolescent sexual abuse and who had been affected by addictions.

The mission and philosophy statements of The Laurel Centre are as follows:

Mission

1. To enable the provision of counseling services for women who have experienced childhood or adolescent sexual victimization and want to resolve long term effects of the abuse. The agency recognizes addictions as one of the long-term consequences related to unresolved trauma.

2. To address the issue of societal denial - of the seriousness and relevance of the problem of childhood sexual abuse - and the detrimental long term effects (one of which is addiction). (The Laurel Centre, 1999)

Philosophy

The Board and staff of The Laurel Centre believe:

* that women have a right to social, political, and economic equality and power

* that childhood sexual abuse has a long-term damaging effect over one's well being (physical, emotional, social, spiritual, intellectual), and one of these effects is the adaptation of compulsive coping behaviors

* that problematic adaptation is a consequence of inadequate resources and supports, rather than a reflection of deficiencies within the woman

* that women have the right to choose the course of their own healing process

Given these beliefs, The Laurel Centre provides counseling which allows women to understand the context of their lives and to make the link between their compulsive coping behaviors and the trauma experienced in their childhood. This understanding empowers them to make life-affirming choices and to resolve the impact of trauma by integrating physical, emotional, social, spiritual, and intellectual aspects of self in context

(The Laurel Centre, 1999)

Clients of The Laurel Centre are either self referred or are referred through other community or social services agencies. The first point of contact for clients is a brief intake interview on the telephone to determine if the woman meets the mandated criteria of experiencing childhood or adolescent sexual abuse and impacted by compulsive coping behaviors. Following the intake, women are then placed on a wait list. The average length of time on the wait list is currently 14 - 18 months. Upon nearing the top of the wait list women may be offered to participate in the pre-counseling group or the parenting group within the agency. Women who do not wish to be involved in a group or who may not be suitable for a group begin individual therapy. The Laurel Centre staff have found that many clients have a long history of help seeking from addiction and

mental health services. (The Laurel Centre, 1999) The agency works with approximately 300 women per year, with the average length of service being 12 months (The Laurel Centre, 1999).

The Laurel Centre offers a variety of services to women: individual, group and couple counseling on an outpatient basis. Treatment and therapeutic plans are developed on an individual basis between the woman and the counselor. Several therapy and educational groups are offered each year at The Laurel Centre. The groups currently offered within the agency are as follows: Pre-counseling group; Regular sexual abuse group; Parenting program; Sexuality group; Positive coping group and the Anger in healing group. There are two other projects that The Laurel Centre is involved with. The first is a youth counseling program aimed at meeting the specific needs of younger women between the ages of 16 - 24 seeking counseling. The second is a Girls' Outreach Program, run in co-operation with Andrews Street Family Centre. The Girls' Outreach program is intended to provide supportive education to young girls ages 7 to16 in developing self-esteem and confidence, and gain information about issues of violence and abuse. The Laurel Centre provides workshops and training to other agencies funded by the Family Violence Prevention Branch (Department of Family Services, Manitoba) regarding childhood sexual abuse and its long term impact on survivors. The Laurel Centre is also involved in the Winnipeg Development Agreement and provides supervision to 5 satellite programs aimed at providing services to women who have experienced domestic violence and are impacted by compulsive coping behaviors. For a further

description of services see the Therapy Program Chart **(Appendix 1)** and The Laurel Centre Clinical Statement **(Appendix 2).**

The Practicum Committee

The practicum committee was comprised of: a main practicum advisor, an adjunct professor, and an external advisor. The main practicum advisor was Kathy Levine, MSW, of The University of Manitoba, Faculty of Social Work - Fort Gary Campus. Kathy Levine provided ongoing student supervision during the practicum process. The adjunct professor was Ellen Tabisz, MSW, former Executive Director of The Laurel Centre. She provided input and support during the practicum process on an as-needed basis. The external advisor was Lee Woytkiw, MSW, therapist at The Laurel Centre. Lee Woytkiw provided the on-site supervision.

Participant selection and intake

The Anger in Healing group was offered to clients who had received counseling with The Laurel Centre for a period of time and had reached a point in healing where they felt ready to look at the role and experience of anger in their lives and healing. The women who took part in the group had been in counseling within the centre for between one and more than five years, and all had taken part in previous groups. The group was not offered to new clients, as the content and structure of the group was intense and required participants to be in a place of willingness to look at their issues in a clear adult manner, taking responsibility for their role in their current life experiences. The group was presented to individual clients by their counselor before a referral to the group was made. This provided the first level of screening in the intake process. Also

noteworthy is that the group was offered to women who were on the student / clinician's regular caseload. This dynamic will be discussed further in the practicum report.

Two group sections were offered, one in the morning and one in the evening. This format allowed opportunities and flexibility for women's individual schedules to be considered. At the time of the intake, the intention was to have between six and eight group members in each section.

The intake process took place over a three week period and involved two scheduled meetings between the participant and the student / clinician. The intake interviews or meetings were not conducted with the co-facilitators as scheduling did not allow for their involvement.

The intake process was broken into three sections: first, a meeting to provide an overview of the group and the practicum; second, a one week waiting period allowing participants to consider if they wanted to take part in the group; and third, a second meeting to finalize group involvement. The initial intake meeting took approximately one hour and fifteen minutes. The student / clinician went over the group format and structure and outlined the practicum procedures, including the necessary weekly statistical questionnaires **(Appendix 3 & 4)** and permission issues around the use of video taping of the group sessions. The initial intake process was also allowed a brief assessment of participants including: their expectations they have for the group, goal areas, current expressions and experiences of anger, past group experiences, coping behaviors, and support systems. **(Appendix 5)**

The second component of the intake process occurred over the December holiday season and participants were asked to complete the two quantitative questionnaires and return them at the second intake meeting. Participants were encouraged to consider their potential involvement in the group with some knowledge of the amount of work and commitment the group was likely to demand.

The final component of the intake process involved a second meeting between the clinician and each participant individually. At this time, participants were given the opportunity to ask questions or raise concerns they might have about the group. The consent forms **(Appendix 6)** were completed during the second intake meeting and a finalized group schedule was set according to the specific needs of the participants.

The intake process was designed to provide information about the group and the practicum while preparing participants for the intense undertaking of the group. No participants were screened out during the intake process. However, the student / clinician did have concerns about the 'readiness' of three of the four participants who did eventually chose to withdraw from the group.

Composition of group members

The number of participants initially involved in the practicum was fifteen; seven in the morning group, and eight in the evening group. Two people chose to withdraw from each group. One woman withdrew after the first morning session stating that she did not feel she had the time or emotional energy available at that time to complete the group. One woman withdrew following the first evening group stating the same reason - that she did not feel she had the

emotional or physical strength to continue with the group. The third woman to withdraw was from the evening group. She withdrew following the third session, stating that she was feeling overwhelmed in the group and felt she would be more comfortable looking at her issues around anger with her individual therapist within the agency. The fourth woman to withdraw was from the morning group. She was ending therapy within the agency and did not feel that she would have the necessary supports in place to continue with the group. The clinical team within The Laurel Centre had discussed this woman's case previously and it had been determined, in conjunction with the client that after many years of therapy this individual would be asked to discontinue counseling within the agency and steps were taken to strengthen this woman's formal and informal support networks.

The remaining participants totaled eleven, with five in the morning group and six in the evening group. Attendance was regular with absences being primarily related to illness. The age range of the eleven participants was 26 to 50. Demographic information regarding participants is presented in tables 1 and 2 for each of the two groups.

Group co-facilitators

A co-facilitator model was used in implementing each of the two groups. One co-facilitator volunteered her time to be part of the practicum group and one was a clinician within The Laurel Centre.

Group model

The 'Anger in Healing' group was developed to provide a 12 week group

format designed for women who had been sexually abused as children. The objectives for the practicum were as follows:

1. To assist women who have survived childhood sexual abuse to acknowledge and to honor their experiences and expressions of anger in their healing from the abuse.

2. To examine these experiences using a cost / benefit perspective, and provide women the opportunity to choose whether to continue engaging in the same forms of expression of anger or to choose to try on different forms of expression in experiencing their anger.

3. To explore different ways of expressing and experiencing anger that fit with each individual woman's goals in relation to her healing from the child sexual abuse.

The group, as discussed previously, was developed in part due to a perceived need for a specific arena to deal with women's experiences and expressions of anger, as determined by the staff at The Laurel Centre.

Structure and format of group sessions

The group structure and format included the following activities: completion of necessary statistical forms, check -in and check-out, a breathing exercise, reading of inspirational sayings or poetry, large group discussions, 'brainstorming', individual writing exercise, creative exercises, and homework assignments.

1. Completion of forms

Each group met 15 minutes before the commencement of the actual group session. Group members spent approximately 15 minutes completing the 'Generalized Contentment Scale' and the 'Assertiveness Aggression Index'. The qualitative feedback **(Appendix 14)** form was completed following the group check out. The decision to incorporate the quantitative statistical scales and the

qualitative feedback forms into the body of the group was made at the urging of other social work students who had very poor return rates on measures because they were not completed in a structured environment. Group members were aware of this component and were all in acceptance of using time before and after the group to complete the forms.

2. Check-in and check-out

Following the completion of the scales as described above, each session began with a 'check-in'. The practice of a check-in to open the group involves a 'round' where each participant in turn has an opportunity to speak briefly about how she is feeling at the start of the group. A structured format asking each woman to respond to a specific question was often employed. Employing a 'speaking stone' was negotiated by each group in the first session. The speaking stone was held by the speaker and only the person with the stone was permitted to speak. This provided a clear respectful way to limit interruptions and allow each person to share. Each session was closed with a 'check-out' round where,

again each woman spoke in turn, sharing briefly about their experience of the group and whether they felt 'safe' in leaving the group.

3. Breathing exercises

Time was taken following check-in, to complete a breathing exercise. The format in the morning group involved the use of several breathing and relaxation visualizations, while the breathing exercise in the evening group remained unchanged each group session. The purpose of incorporating a breathing exercise was to allow the participants an opportunity to focus upon their breath,

their body and the current experience of the group. Participants in each group requested a breath exercise be used as a way to assist them to become centered and grounded before beginning the groups.

4. Reading

A brief reading of a poem, or excerpt from an inspirational book was read following the breathing exercise and a copy of the reading was given to each participant. The poems were chosen to fit with the theme or the objective of the group to provide a small piece of inspiration or validation.

5. Leftovers

Following the reading for the group, we had a discussion of 'leftovers' from the previous group. A 'round' format was used and each participant was given an opportunity to share their response to the previous session, their homework experience, or raise an issue that they felt needed to be discussed. The leftovers section of the group provided time for the facilitators to distribute any handouts (e.g. previous brainstorms) or discuss any administrative issues (e.g. scheduling).

6. Session activities

A group agenda was placed on flip chart paper at the beginning of each group session. This provided a detailed outline of the session activities and the time line for each activity. Following the leftovers section, the first activity of the group was completed. The first activity was often a brainstorm or open discussion of the session's topic. This was generally followed by an individual exercise which was usually more emotionally intense. This brought the group to

the half way point, at which time a 10 - 15 minute break for refreshments was taken. A round of sharing about the individual exercise followed break, and at this time participants could share an aspect or a response from their individual exercise. A second exercise which was either a group or individual exercise of a lesser emotional intensity took place before the introduction of the week's homework and the check- out.

7. Use of rounds

The use of rounds, including a speaking stone, was employed to diminish the possibility of one or more participants dominating the group session or discussion time. As was discussed in the intake section, nearly all the group participants noted from past groups their discomfort when not all group members participated and one or more members took a large amount of group time. Each participant was passed the speaking stone and time was loosely monitored by the facilitators. Participants could choose to pass; however, each was encouraged to share their experiences or input. In turn, participants could ask permission of the individual and then offer a personal response of feedback about what had been shared. The speaking stone did not disallow affirming nods or quiet agreement to what other members were sharing. The speaking stone was not used in brainstorm activities. These issues and practices were agreed upon by all group members in the development of the group agreement / group rules.

8. Homework activities

Prior to the check-out of each group, the student / clinician presented homework activities to be completed at home before the next group session. The

homework included: anger journals, articles or excerpts from relevant publications to read, journaling, and creative art exercises. The intent of the homework was to provide a different medium to present information and encourage growth and insight into the subject matter.

9. Sensory and self care baskets

As a component of the check-out, a basket of cards with invitations to complete a sensory exercise (e.g. eating an orange slowly while noticing the tastes and textures, or observing birds for 10 minutes in silence) was passed around. On other weeks a basket with inexpensive self care items (candles, bubble bath, stickers, small note paper) was passed around for participants to choose an item to assist them in honoring themselves and the work they are doing in their healing. Participants were asked to bring in self care items as they could afford to help restore the basket.

Group Outline

ANGER IN HEALING GROUP

UNDERSTANDING WOMEN'S' ANGER IN HEALING FROM CHILD SEXUAL ABUSE

SESSION 1	Introduction to group
SESSION 2	What is anger?
SESSION 3	Fears around anger and expressing anger
SESSION 4	What did we learn about anger as children & Goals for group
SESSION 5	Goals for group & Sources of anger
SESSION 6	Naming who and what we are angry at and about

SESSION 7	How we express anger - and how we can express anger more positively
SESSION 8	Present anger - recognizing and releasing
SESSION 9	Present anger - recognizing and releasing
SESSION 10	Awareness of personal safety around anger
SESSION 11	Anger in our healing - pulling together and looking forward
SESSION 12	Group celebration

Description of the intervention

The group consisted of three components: therapeutic, support and educational. The therapeutic component involved the content as well as the experiential aspects of being a part of the groups. Involvement in a therapeutic group where peer support and assistance is emphasized and the 'expert' role of the facilitators is downplayed is an important component of the group from a feminist perspective. The support component is more difficult to define as the exposure to other women and the peer support or rapport built in a group is often more therapeutic than the specific exercises or content of the group. The educational component is evident in the theory, the information and the exercises of the group.

Session by session overview

The Anger in Healing groups focused upon anger - internal experiences, familial experiences, societal experiences, as well as anger expression patterns.

Participants were invited to 'try on' new ways of considering and experiencing anger and new patterns of expressing anger.

The group outline, as presented above, shows the topic titles for each group. Session 1 provided an introduction into the group, the group format and an opportunity to negotiate the group agreement / rules as a group. Session 2 focused upon the definition of anger. Participants individually and collectively came up with a definition for anger and discussed the various meanings associated with the context and attribution of anger. Session 3 looked at fears of anger and its expression. Participants discussed present and historical fears of anger and came up with challenges to these fears. Session 4 looked at what participants learned as children about anger. Participants examined their individual and collective experiences as young people learning about anger. The structural or societal influences on how anger is learned about, experienced and expressed anger were discussed. The setting of personal goals for the group was introduced. Session 5 encouraged setting specific tangible personal goals for completing the Anger in Healing group. Sources of anger, particularly past anger, were discussed and participants completed exercises designed to identify where in their body they experience anger they hold it in their bodies. Session 6 focused on naming who and what they are angry at and about. Again, the focus was on past anger, and the exercises were designed to assist in releasing past anger. Session 7 dealt with how participants express anger currently and how they would like to express anger more effectively, with exercises and brainstorming ideas on how to release anger. Sessions 8 and 9 focused upon recognizing and releasing present anger. The use of an 'anger cycle' visual tool

helped to illustrate how anger is experienced and expressed. Participants were provided with opportunities to 'try on' new ways of experiencing and expressing anger through role plays with facilitators or other group members. Session 10's emphasis was on awareness of personal safety in anger. Participants looked at the issues of safety from a personal level as well as a societal level for women and completed a personal safety plan for anger. Time was spent doing an 'update or report card' on progress of personal goals in completing the Anger in Healing group. Session 11 looked at using anger in healing. The focus was on the self - self care and recognizing the impact of anger on one's self. Participants were each given time to express their feelings about the group, ask for feedback, revisit a topic area or simply speak and receive validation from the group about a specific personal issue. The final session was a celebration and a closing ceremony was held. The specific group agendas can be found in the appendix section **(Appendix 8)**

CHAPTER FOUR

GROUP PROCESS

Chapter four provides an overview and discussion of each session of the two Anger in Healing practicum groups. In total there were eleven group participants, five in the morning group and six in the evening group. Each of the groups consisted of twelve 3 hour sessions and the groups were run concurrently beginning January 13th, 2000 and ending March 30th, 2000. The group sessions were developed to co-ordinate with The Laurel Centre's clinical model (Appendix 2) The clinical model consists of four phases with the development of a safe healing relationship central to each phase. The Anger in Healing group was developed to work within the clinical model. Each phase of the clinical model will be introduced and briefly discussed prior to the discussion of the group process within each phase.

Phase one 'Engaging and Assessing' is incorporated into sessions one, two and three. The emphasis on the first phase is on introductions, and on building a safe and healing environment where trust is developed. Phase two 'Intense Debriefing' involves sessions: four, five, six. The emphasis is on personal sharing, recognizing patterns of anger, understanding sources of anger and sharing goals for healing. Phase three, 'Integrating', encompasses sessions: seven, eight, and nine. The emphasis is on integrating information from previous groups into participants current life experiences. Phase three involves participants taking information and working actively to integrate new patterns and behaviors related to anger into their current lives. Phase four, 'Moving on'

consists of sessions ten, eleven and twelve. The emphasis is on closure and celebrating accomplishments.

The description of group sessions which follows does not contain any identifying information and there are no direct quotations from participants. Chapter six will provide a more in depth discussion of the themes which presented themselves throughout the practicum process, and the learning process of the student / clinician. This chapter provides a discussion without analysis of what took place in each session. The writer is described as the student / clinician and the co-facilitators are noted as such. Participants are discussed both generally and specifically as participants. It should be noted that the academic form of writing in third person does not adequately capture the spirit in which the group was developed, facilitated or experienced. The language used throughout the practicum experience was intentionally inclusive and non hierarchal. In the interest of academic writing third person is employed within the practicum report.

Session by session discussion

Employing the clinical model in the development and implementation of the Anger in Healing group involves the 'Development of a safe healing relationship' at the centre of all action. The student clinician and the co-facilitators worked at providing safe and healing environments for the groups to develop in. This was primarily handled through the use of respectful and accepting language and by having each group work together to develop their specific group agreement. Coming from a strong feminist perspective, the

student / clinician and the co-facilitators described themselves as 'facilitating' the group and not as the 'experts' of the group. This acknowledgment was stated at the beginning and reiterated throughout the group process. It was stressed that all the women, facilitators and participants alike, had pieces to offer one another as teachers and pieces to take as learners. Contrasted with this philosophical position, remained the role of the facilitators in providing information and a structure with clear boundaries for the group. Messages of safety were conveyed in both pieces of information regarding the roles of the group facilitators. The facilitator's role is to provide, with the highest possible level of respect, an environment where participants can experience the group and 'try on' new behaviors or roles related to anger. As has been outlined in the literature review section, the clinical model of the Laurel Center is a representation of a is a dynamic cyclical experience of healing and is not meant to be experienced nor understood as a linear process.

Phase One - Engaging and Assessing

Phase one from the clinical model is entitled 'Engaging and Assessing'. This phase within the Anger in Healing group intervention involves introducing the group format, developing a group agreement, beginning to share and witness personal stories and experiences of other group members, validating and normalizing experiences, and affirming strengths of self and others in survival strategies. Sessions one, two and three of the Anger in healing group make up phase one.

Session one: Introduction to group

The objectives of the first session were: 1. To introduce the participants and the facilitators, and the group format; 2. To develop a group agreement; 3. To share hopes for the group; 4. To complete an emotional protection plan for the participants for the duration of the group.

The first session in each group was consumed with introductions and orientations to the group. This orientation included: the measurement scales; the group format; check in; check out; use of rounds and speaking stone; introduction of anger journals; breathing exercises; self care and sensory baskets; feedback forms and developing the group agreement.

Session two: What is anger?

The objectives of the second session were: 1. To normalize the difficulty in discussing and defining anger; 2. To begin to place anger in a social and political context which differs depending upon the sex of an individual; 3. To begin to look at anger as linked to other feelings and experiences rather than its own separate entity.

Session two involved following the group agreement and format (in each session as previously described). During the first exercise participants worked together using brainstorms to define anger, and to discuss past and present ways each participant expresses or has expressed anger. A discussion outside of current experiences of 'what do we need to release anger' allowed participants to begin considering their current reality and, in a sense consider what they would need to create in a preferred reality to release anger. This was a

beginning step towards goal setting and allowed participants to gently consider making changes without directly asking them to make changes.

The second exercise involved the facilitators providing information about anger and how anger in linked to other feelings and / or experiences. The use of Merrily Marchessault's (1996) 'Iceberg' and 'Anger never rides alone' car both illustrated the relationship of anger with other emotions or feelings and how anger does not and cannot exist in a vacuum. **(Appendix 9)** This exercise was designed to challenge the conventional and stereotypical understanding of anger as being separate from other emotions and being a 'bad' feeling that should be abolished etc. Following the second exercise, the group format and closing was observed. Homework related to session three, fears of anger was introduced.

Session three: Fears around expressing anger

The objectives for the third session were: 1. To validate and normalize fears associated with anger; 2. Express fears related to anger in a creative medium and imagine how their experience could be different with the absence of these fears.

Following the group agreement and format the first exercise for session three involved sharing in a round each participants homework about fears and anger. This sharing allowed each participant to be heard and validated by the group, while at the same time normalizing the fears other group members have about anger. The second exercise allowed participants to brainstorm fears related to anger. Some of these had been shared previously and many more shared for the first time. This exercise was designed to advance the feelings of normalcy and validation in participants' experiences of fear. The third exercise

involved the participants representing with a creative medium (paint, collage, marker) how their experience of fear would look 'if they could see their fears' on one side of a fairly large card and on the other side to illustrate what their life would 'look' like or be like without this fear influencing their experiences.

This was the first of many creative exercises within the Anger in Healing group. It provided a beginning step for understanding patterns related to anger and for considering making changes and setting goals related to anger in a non threatening or anxiety provoking manner.

By the end of session three many of the objectives of phase one had been met and the development of safety and trust were well on their way in each of the two groups.

Phase Two - Intense Debriefing

The second phase of the clinical model is titled 'Intense Debriefing' and the focus of this phase modified for use with the Anger in Healing group, is on recognizing the role of anger in the participant's lives and to address the impact that anger has had on their lives. A grieving process, with respect to the losses associated with the anger and the child sexual abuse was acknowledged, normalized and validated.

Session four: What did we learn about anger as children?

The objectives of the fourth session were: 1. To have participants witness each others, childhood experiences of learning about anger, thus providing validation and normalization of their individual and collective history as children; 2. To begin to set goals for self, particularly for women parenting about what

messages are given to children about anger; 3. To provide opportunities to release anger and memories about anger through using clay.

The first exercise following the sharing of homework was a series of three brainstorms where the participants looked at: 'what did we learn as children about anger?' 'what are children's needs?' and 'what do children need to learn about anger? Others and their own?' These three brainstorms took a graduated look at anger from a child's perspective and invited the participants to share their experiences. In the sharing of their experiences came acceptance validation, and self challenge to change their current life situations.

The second exercise invited participants to, create a clay symbol of what they learned as children about anger, or to create a symbol of their hopes in healing - integrating their experiences of anger. This exercise takes both a physical and an emotional approach to dealing with the experience of anger. The homework for session four was to complete a detailed goal statement for completing the Anger in Healing group. **(Appendix 10)**

Session five: Sources of anger

The objectives of session five were: 1. To have each participant share their goals for completing the group; 2. To identify past and current sources of anger and the physical impact of anger has on our bodies.

The first exercise was sharing their individual goal statements with the group. The timing of sharing goals for the group was intentionally placed in session five: at this time each of the groups had an opportunity to connect. The level of trust within each group was high in session five and participants were willing to risk sharing their individual goals. The second exercise was a

brainstorm on 'sources of anger' and 'where anger is held in our bodies'. The two brainstorms built upon one another to look at the connection between the emotional experience of anger and the physical experiences of anger. The third exercise built further upon the brainstorm by asking participants to identify where in their body they experience or express anger. This was represented with a creative medium on a body form drawn on a large sheet of paper. Participants were also asked to in a narrative form, describe the source of the anger which they had represented and to notice if different sources were held or experienced in particular areas of their body. This exercise connected the emotional and physical aspects of self and anger allowing participants to gain further insight into their past and present experiences. The homework for session six was to prepare an anger journal to present to the group in the following session.

Session six: Naming who and what we are angry at or about

The objectives for session six were: 1. To provide an opportunity for each participant to share a or the significant source of anger for them and to explore the impact that this person / event / experience has had upon their life; 2. To provide an opportunity for participants to begin to make the first steps toward resolving this significant experience.

The exercises in session six embodied the essence of the Intense Debriefing phase in the clinical model at The Laurel Centre. After a relaxation exercise, participants were asked to connect with a significant source of anger in their lives. They were then asked to expressly name the source of anger; after naming the source, they then described in detail what the impact of this person / event / experience has been upon their lives. Finally, they were asked to

describe in detail the consequences this has had on their current life experience. This three step exercise was designed to have the participant experience their significant source of anger as fully as possible and describe the repercussions this source has had for them.

Once participants described this experience in detail, the next exercise was designed to bring their awareness to the power they currently have to let go of this source and to reclaim their life without the often devastating impact of the source of anger for them. In a three step process participants were asked to connect with their bodies in order to identify what they need to reclaim the power that experience has had or currently occupies in their life. Participants were then asked to make a commitment to themselves to continue to reclaim their power by setting the first step, and the next step etc. These exercises challenge the very common belief that one does not have control over anger or sources of anger and allows participants to become empowered in making life changes specific to their situation.

Phase three - Integrating

The third phase of the clinical model is entitled 'Integrating'. This phase, when adapted for use in the Anger in Healing group, involved inviting the participants to actively integrate the new information and insight they have gained in the group. In this phase focus is placed on participants 'trying on' new ways of expressing and experiencing anger as well as other emotions in relationships both with self and others.

Session seven: How we express anger and how we can express anger more positively

The objectives for session seven were: 1. To identify what both individually and as a group participants have discovered about anger at this half way point in the group and to identify the areas participants feel are left to explore before the ending of the group; 2. To challenge current experiences or behaviors to make changes in the direction of goal areas for participants.

The exercises for session seven included first a brainstorm of 'what we have discovered about anger and ourselves so far'. This exercise was placed at this point in the group to provide positive feedback to the participants that they have already made many discoveries and changes. This brainstorm also allowed participants the opportunity to ask for what they needed in the remaining sessions to feel that the group has been successful. These exercises reenforced the positive changes participants had made and renewed their commitment to their goals and healing. The second exercise invited participants to review their anger journals and note looking back what they would have liked to have done or perceived differently, in a way more in line with their specific goal areas. This exercise both reenforced participant success and promoted progress in achieving goal areas. The co-facilitators had also planned to begin discussing communication styles in session 7, however the first two exercises generated a great deal of discussion and interest with the participants in both groups and it was decided to leave communication styles for a later group.

Session eight: Present anger recognizing and releasing

The objectives for session eight were: 1. Introduce concept and model of anger cycle; 2. Increase participants' understanding of personal anger cycles by using their own examples.

The first exercise in session eight was the introduction of the anger cycle, using examples from participants **(Appendix 11).** The cycle provided a concrete tool for participants to examine situations where anger was problematic in their lives. The anger cycle provides a format to look specifically at a situation and at the same time invites the participant to notice what else is going on outside of the anger situation or response. The second exercise was for participants to create reminder cards for ideas on releasing anger in ways that fit with their individual goal areas. The cards were designed to be kept with the participants in a location where they would often be seen and thereby serve as positive reminders to release anger in more positive ways.

Session 9: Present anger - releasing continued

The objectives of session nine were: 1. To continue to work through specific situations using the anger cycle; 2. To teach the technique of using the cycle to examine situations; 3. To describe and discuss communication styles (assertive, aggressive, passive aggressive).

Session nine's the exercises involved using examples from the participants and the anger cycle. Discussions of communication styles and the ways each communication style solves problems and deals with anger were discussed as well as how to improve communication.

Phase four - Moving on

The fourth phase of the clinical cycle is entitled 'Moving On'. When adapted for this group, it involves the participants weaning from the group experience in preparation for the groups completion. Sessions ten and eleven build to the final session and the closure of the Anger in Healing group

experience. The Moving On phase is concerned about pulling the entire group together in a meaningful way for the participants, evaluating the group experience and assisting participants in looking forward past the group experience.

Session ten: Awareness and personal safety around anger

The objectives for the tenth session were: 1. To reevaluate progress on specific goals for completing the Anger in Healing group; 2. To develop a personal safety plan for anger; 3. To create a symbol of safety.

The first exercise in session ten asked that participants reevaluate progress on their anger goals. This allowed the participants an opportunity to share their accomplishments and struggles with the group and receive validation and support. The second exercise asked participants to complete a safety plan for their anger (Appendix 12). The safety plan was designed to assist participants in maintaining gains made through the anger group. This exercise was developed in response to participants' statements of concerns about feeling safe with their anger once the group was over. The third exercise was a creative exercise where the participants created a symbol of safety which they could keep with their safety plan as a further reminder of safety.

Session eleven: Using anger in our healing - looking forward

The objectives of session eleven were: 1. To provide an opportunity for each participant to share with the group or ask the group for feedback or support on a specific issue; 2. To plan the final celebration group.

The first exercise allowed each participant 10 minutes to share whatever they felt was appropriate with the group as the group was coming to an end. This

was also an opportunity for individuals to seek feedback or support on a specific issue or simply to be validated in their experience(s). The second exercise involved a series of brainstorms which looked the questions: 'how will you maintain gains for yourself?', 'How will you know if you need to revisit some issues or feelings related to anger?'

Session twelve: Celebration

The objectives of session twelve were: 1. To acknowledge the accomplishments of each participant in completing the Anger in Healing group; 2. To celebrate the individual and collective spirit of women.

Session twelve consisted of a celebration meal and a series of closing rituals. The session opened with a round of sharing about celebration of self. The participants then shared with one another the messages they had written to each other. Following this, each participant lit a candle offering a hope for themselves - and when blowing the candle out were encouraged blow their hope into the universe. Each participant was presented with a certificate and a personal message from the facilitators, and the session closed with a final check out reflecting upon the final group.

CHAPTER FIVE

RESULTS AND IMPLICATIONS

The evaluation procedures for the Anger in Healing group were both quantitative and qualitative. Of the eleven group participants, ten completed the quantitative measures. Rossi & Freeman (1985) describe quantitative measures as those that "lend themselves readily to numerical representation" (p. 223).

Qualitative findings, as Heinonen (1995) states, can "best be described in words rather than numbers" (p. 10). Qualitative data is gathered in many different forms. The Anger in Healing group used questionnaires and open ended questions to gather information about each participants subjective experience(s) within the group. The qualitative questionnaires were more fitting within the feminist philosophy of the group intervention.

Design Plan

The A-B-A design was chosen as the research design for the practicum. The first A phase is the baseline phase which corresponds with the initial 3 week intake and assessment phase of the intervention. The data collected at this time included: The Bakker Assertiveness-Aggression Inventory; the Generalized Contentment Scale (GCS), and a participant intake **(Appendix 5)**. There were three baseline data points in this section.

The B phase is the intervention phase and consisted of twelve weeks of group sessions. The Bakker and GCS standardized measures were plotted weekly using the same frequency as the baseline phase. Also included in the

intervention phase were the twelve qualitative survey measures related to the weekly session topic.

The second A phase composed the follow up phase and was a four week period with no group contact with the student / clinician. During this time participants collected (through self administering at a specified date and time) the standardized measures; and the qualitative measures. It should be noted that while there was no group contact, the participants who saw the student / clinician for individual counseling maintained contact throughout the second A phase. Four weeks following the final intervention session, each group met for a follow up session and at that time all follow up measures were submitted.

Measurement Plan

Two weekly standardized measures were used to gather quantitative data. The Generalized Contentment Scale (GCS), and the Bakker Assertiveness - Aggressiveness Inventory (AS / AG). A weekly non standardized qualitative survey style measurement was used to gather participant feedback and experiential data. Both quantitative measures and qualitative measures were used in the final analysis of the practicum.

Finding appropriate standardized measures to measure anger for women survivors of childhood sexual abuse was a challenging endeavor, as most standardized measures related to anger are too narrowly focused on aggression or managing anger. A scale measuring aggression is too narrow and does not capture all of the experiences or expressions of anger from the population in the practicum group. Aggression is often not thought of as a female expression of anger. Aggression is not only a male form of expressing anger, but males are

more likely than females to externalize anger and express it in aggression. (Frankel, 1992; Rosellini and Worden, 1997; Thomas and Jefferson, 1996; Oliver and Wright, 1995) Assertiveness is often seen as a more healthy alternative to expressing displeasure than anger. Our society encourages both women and men to be assertive and not aggressive in expressing anger. A scale measuring only assertiveness did not fit with the practicum population group, again due to the narrow focus. Depression is often discussed as anger that has been internalized and is therefore another option for a standardized scale. (Frankel, 1992; Rosellini and Worden, 1997; Thomas and Jefferson, 1996; Oliver and Wright, 1995) However, a scale measuring only depression would hold the same limitations as an aggression or assertiveness anger scale, as not all women in the participant population experience depression as a result of internalizing anger. From a feminist perspective, the lack of measures fitting this population can be argued to be due to the 'male as norm' reality of our society. Many measures are developed using only male participants or too few female participants, to draw any relevant research conclusions. The complexities of the participant population and the target issue being anger make standardized measures particularly difficult to employ. That being stated, the student / clinician employed two standardized measures: The Generalized Contentment Scale; and the Bakker Assertiveness-Aggressiveness Inventory.

Quantitative Measures

Generalized Contentment Scale

The Generalized Contentment Scale (GCS) created by Walter Hudson **(Appendix 3)** is designed to measure non-psychotic depression. The student /

clinician chose the GCS in part due to the ease in which it is administered and scored. This scale also fits with the feminist theoretical perspective of the practicum focusing upon the strengths of the individual and the individuals unique context of their experiences.

> The GCS is a 25 - item scale that is designed to measure the degree, severity, or magnitude of non-psychotic depression. In contrast to many measures of depression, the GCS focuses largely on affective aspects of clinical depression, examining respondents' feelings about an number of behaviors, attitudes, and events associated with depression. (Corcoran and Fischer 1987, pp. 165-67)
>
> RELIABILITY: The GCS has a mean alpha of .92, indicating excellent internal consistency, and an excellent (low) S.E.M of 4.56. The GCS also has excellent stability with a two - hour test -re-test correlation of .94
>
> VALIDITY: The GCS has good concurrent validity, correlation in two studies .85 and .76 with the Beck Depression Inventory and .92 and .81 for the two samples using the Zung Depression Inventory. The GCS has excellent known -group validity, discriminating significantly between members of a group judged to be clinically depressed and those judged not to be clinically depressed. The GCS also has good construct validity, correlating poorly with a number of measures with which it should not correlate, and correlating at high levels with several measures with which it should, such as self-esteem, happiness, and sense of identity. (Corcoran and Fischer 1987, pp. 165-67)

Dr. Hudson has granted permission to use and reproduce the Generalized Contentment Scale in any quantity required provided the following stipulations are met: "the format and wording of each scale must not be altered, the copyright notation at the bottom of each scale must be retained and none of the scales may be reproduced for commercial purposes" (Bloom and Fisher, 1982, p. 162).

Bakker Assertiveness-Aggressiveness Inventory

The Bakker Assertiveness - Aggressiveness Inventory created by Cornelis B. Bakker, Marianne K. Bakker-Rabdau, and Saul Breit is designed to measure assertiveness and aggression.**(Appendix 4)** The student / clinician chose the AS AG inventory to use in the Anger in Healing group as it appears to have advantages over other anger scales due to the fact that both aggression and assertiveness are measured.

> This 36 - item inventory measures assertiveness in terms of two components necessary for social functioning: the ability to refuse unreasonable requests("assertiveness" AS), and the ability to take the initiative, make requests, or ask for favors. ("aggressiveness" AG) is different form hostility. It tends to relate more to being responsible and taking the initiative in social situations.
> (Corcoran and Fischer 1987, pp. 105-109)

The inventory fits well with the strengths oriented feminist theoretical perspective of the practicum. The inventory reports:

> RELIABILITY: These scales have been shown to be fairly reliable in terms of internal consistency and test - re-test reliability . Internal consistency was estimated from a split half procedure and was .73 for the AS scale and .80 for the AG scale. Test-re-test correlation were .75 for the AS and .88 for AG over a six week period.
>
> VALIDITY: Items analysis of all 36 items indicated that scores on each correlated highly with the score on the scale of which it is part. Research on known-groups validity indicated that both scales discriminated between a client and college sample. The scales are sensitive to measuring change as AS and AG scores changed subsequent to assertiveness training. (Corcoran and Fischer 1987, pp. 105-109)

The student / clinician contacted Dr. Bakker was contacted by telephone and discussed the Anger in Healing practicum group requesting permission to use the Assertiveness - Aggression Inventory as a standardized measure. Dr.

Bakker granted permission with similar conditions as Dr. Hudson imposed using the Generalized Contentment Scale. These conditions were stated as follows: the format and structure of scales could not be altered; the copyright notation must be retained on each scale; and the scales could not be used or reproduced for commercial purposes.

Both measures were administered beginning with the 3 week intake phase of the practicum and weekly thereafter. During the baseline phase the measures were completed by the participants, with the student / clinician during each of the 3 intake sessions. During the intervention phase they were completed prior to the beginning and at the end of each group session. Subsequent to the group, participants were asked to continue to fill out the inventory weekly in the four weeks following the group and submit their inventories in at the four week follow up sessions.

Limitations of the Measurement Plan

The fundamental limitation of the measurement plan was that the only source of measurement was the individual group participant. The concession to this is that much of the phenomena being measured are internal processes which are not readily or accurately observable by an outside source. The utilization of the standardized measures intends to aid in the methodological triangulation of the data. Standardized measures have previously been tested and found to be statistically reliable and valid in measuring the target of each scale or item. Therefore, should the student / clinician find similar results then a stronger statistical relationship may be drawn to the trend being observed in the data.

Qualitative Measures

During the initial contact with participants, as well as during the first and second intake sessions, qualitative data was gathered. Demographic information and expectations for the group were documented. Release documents were signed, allowing the student / clinician to use video taping within the sessions and to use the information gathered as part of a practicum report **(Appendix 6).** Participants were advised of the group structure, format and the outline of the content covered within the group.

The weekly non standardized qualitative survey style measure an example can be found in the appendix section **(Appendix 14)**, this was completed only during the intervention phase of the practicum. The measure was designed to gather data specific to the material covered in the individual sessions. Information about participant's expectations and experience was gathered as was feedback specific to the content of the sessions. This information forms the basis of the qualitative analysis of the practicum. Participants provided information about the quality and effectiveness of the facilitation / facilitator(s) as well as the content of the group. This information and feedback was assessed weekly by the student clinician and any changes requested were considered and, when appropriate incorporated into the remaining sessions of the group. The incorporation of feedback into the group is fitting with the feminist theoretical basis as well as the objectives of the intervention.

Group feedback forms developed by The Laurel Centre **(Appendix 15)** were completed at the final group session. The qualitative information gathered

will be discussed in a narrative format looking at the major themes and impressions of the participants in chapter six.

Butler and Wintram (1992) recommend the usefulness, in evaluating groups, using several different tools or formats to gather information or make assessments regarding participants. One may use for example: direct observations; self assessment scales; standardized measures; and personal statements from participants. Reinharz (1992) and Butler and Wintram (1992) advocate for the use of quantitative and qualitative research together to build the knowledge and research base of group work.

Demographic Participant Information
Table 4

	GROUP				ONE			
Participant	Age Category	TLC Group Experience	Other Group Experience	Length of therapy at TLC	Employ-ment Status	Relation-ship Status	Number of children	Identifica-tion of compulsive coping
B	50 - 54	yes	yes	< 1 year	working	single	1	past / alcohol
D	40 - 44	yes	yes	< 2 years	working	married	2	n/a

Table 5

	GROUP				TWO			
Participant	Age Category	TLC Group Experience	Other Group Experience	Length of therapy at TLC	Employ-ment Status	Relation-ship Status	Number of Children	Identifica-tion of Compulsive coping
G	35 - 39	yes	yes	< 2 years	working	married	2	marijuana
I	40 - 44	yes	no	< 2 years	working	married	0	self harming
K	30 - 34	yes	yes	< 2 years	disability	single	0	n/a

Quantitative Data Analysis

Generalized Contentment Scale

The findings with the Generalized Contentment Scale appear to indicate improvement in five of the ten participants. The GCS scale shows a clinical cut score of 30, a score above which indicates a clinical problem with depression. The scores for Participants B, C, E, F, and H see **(Charts 4,5,7,8 and 10)** show changes that seem to be consistent with what the student clinician was hoping to find in the results. The scores show a decreased pattern and move toward the clinical cut score of 30. Other graphs of participants for instance participants D and G **(Charts 6 and 9)** do not show any clinical problems with all the scores near or below the clinical cut score of 30. Participant A's scores are difficult to analyze as she did not complete measures for sessions 9-12 or any follow up measures. From the measures available she did not seem show a decrease in feelings of depression and there is some evidence from a visual analysis that her feelings of depression may have been increasing when looking at the chart **(see Chart 3)**. The feedback forms she completed as well as her verbal feedback indicate however, that she was finding the group to be a positive experience and assisting her in her anger. Participant I **(Chart 11)** did not seem to show any improvement with her GCS scores throughout the group intervention. Her feedback from the qualitative forms and her verbal responses indicate that she did find the group helpful in managing her feelings and meeting her goals related to anger. Participant J **(Chart 12)** did not complete the final group measure and did not complete any of the follow up measures; her scores are therefore difficult to assess. It does appear that she may have been moving in a downward motion

toward the cut off score, although it is difficult to determine as the data is not available.

While depression or 'generalized contentment' were not the focus of the practicum intervention in the Anger in Healing group, many authors link women's anger to depression and the results from the measures indicate some level of improvement in five of the ten participants', as well as some level of change in a positive direction for three others and no improvements in two of ten participants.

A full presentation of all participants scores including: means; standard deviations and t - statistics as well as c - statistics for the Generalized contentment scale can be found in **Tables 1a and 1b.**

Bakker Assertiveness Aggression Inventory

The Bakker Assertiveness Aggression Inventories are described as measuring "assertiveness in terms of two components necessary for social functioning: the ability to refuse unreasonable requests ("assertiveness" AS), and the ability to take the initiative, make request, or ask for favors ("aggressiveness" AG)" (Bakker, Bakker-Rabdua, Breit 1978 p. 105). Aggressiveness is described as being different from hostility and is related to taking initiative in social situations.

It is difficult to determine improvements as the scoring information does not outline how to interpret scores, only stating that lower scores indicate that the individual is likely to exhibit assertiveness or aggressiveness, and higher scores indicate the individual is more likely to exhibit assertiveness or aggressiveness.

The norms chosen for the tables are the scores for the individuals who were taking an assertiveness training program. The reason these norms were

chosen over the others who were college students was, that the ages of the participants more closely resembled the participants in the assertiveness training program. Additionally, the majority of women in the Anger in Healing group were looking to increase their assertiveness and to begin experiencing their anger rather than suppressing it, they would thereby more likely resemble the individuals who were taking the assertiveness training program.

A visual analysis of participants reveals that the Anger in Healing group scores tend to be close to or below the norms for the measures. Participants A, C, D, and G's scores **(Charts 3, 5, 6, 9)** for both the assertiveness AS scale and the aggressiveness AG scale are very close to the norm scores. Participants E, F H and I scores, were with only a few exceptions, below the norm scores **(Chart 7, 8, 10 and 11).**

Participant J's **(Chart 12)** scores for the AS scale were, with only one exception, all above the norm score which according to the author, indicates that she is more likely to exhibit assertive behavior. It is noteworthy that her scores are relatively stable across the intake and group phase in all three measures (GCS, AS, AG). Also noteworthy is that she did not complete any follow up measures which makes it difficult to draw any conclusions with her scores. However, given the stability of her scores it is hypothesized by the student / clinician that little change would have been present in the follow up phase. As was discussed in the generalized contentment measure analysis, participant J did report verbally and with her qualitative measures that she found the group helpful.

Participant B's scores **(Chart 4)** for the AS scale for the intake and the group phase were above or at the norm mark and for the follow up phase were below the norm mark. The AG scale with two exceptions scores for the intake and group phase are below the norm scores, and for the follow up phase are above the norm phase. The GCS scores for the intake and group phase were significantly above the cut score and in the follow up phase moved towards the cut score. It is difficult to determine with certainty any meaning in the changes.

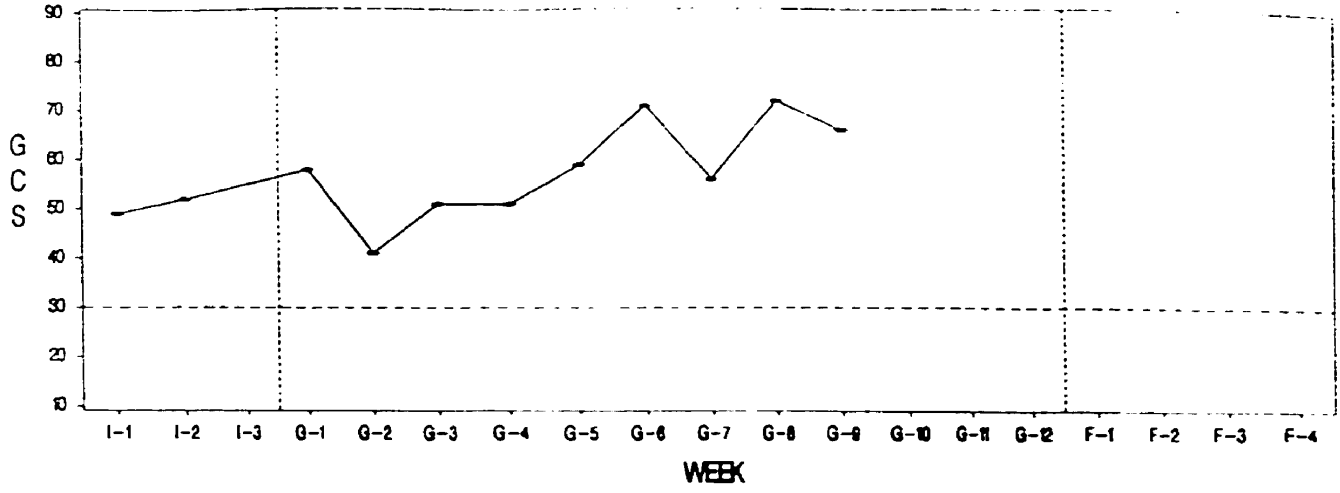
A full presentation of all participants scores including, means, standard deviations and t - statistics as well as c - statistics for the Assertiveness scale can be found in table 2a and 2b, and the Aggression scale in table 3a and 3b. Chart 11 displays a collapsed presentation of the group results for each of the three scales.

Single system research designs using quantitative measures with small samples, as is the case with the Anger in Healing practicum group can not yield data which can be generalized to a larger population. The 3 point intake phase does not allow for a solid baseline to be determined and when follow up measures are not complete as is the case with many of the participants scores for the group, it is difficult to make any conclusions about the intervention or the findings.

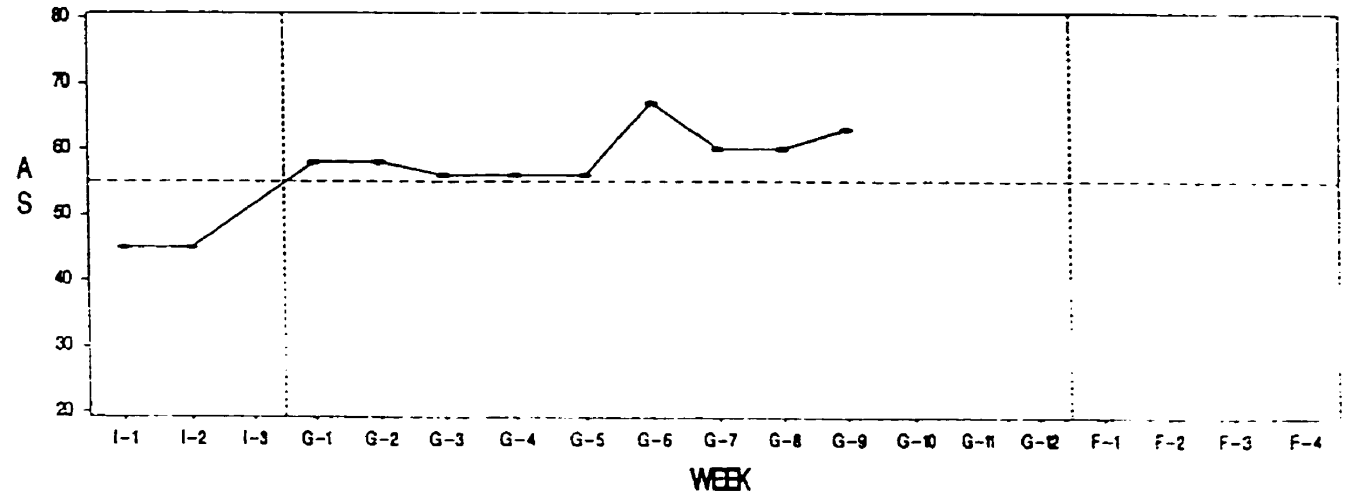
Quantitative Measures

Client A (Group 1)

GCS Scores



AS Scores



AG Scores

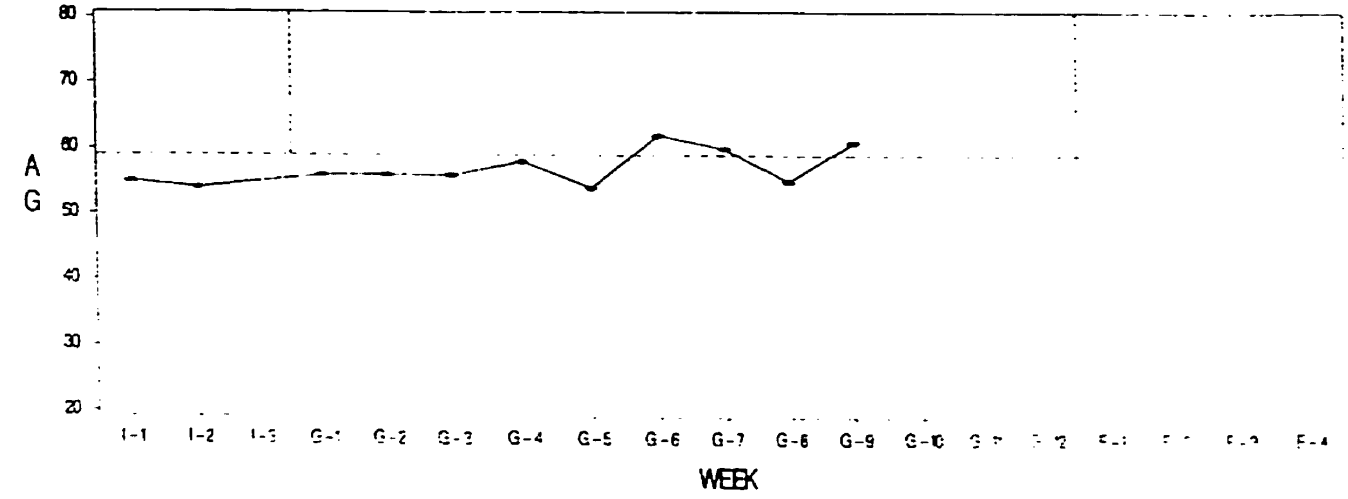
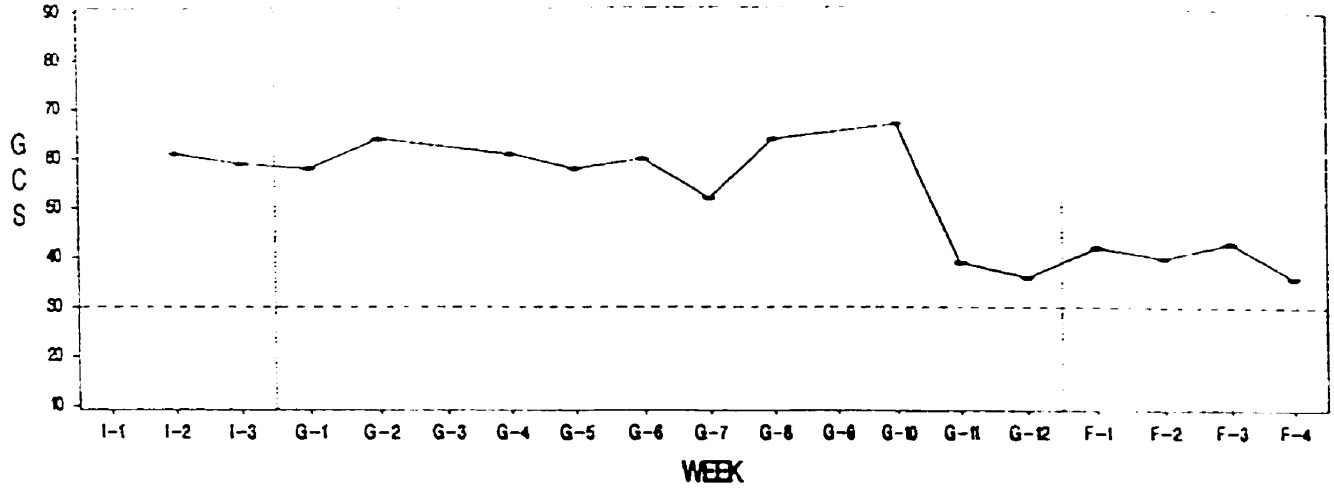


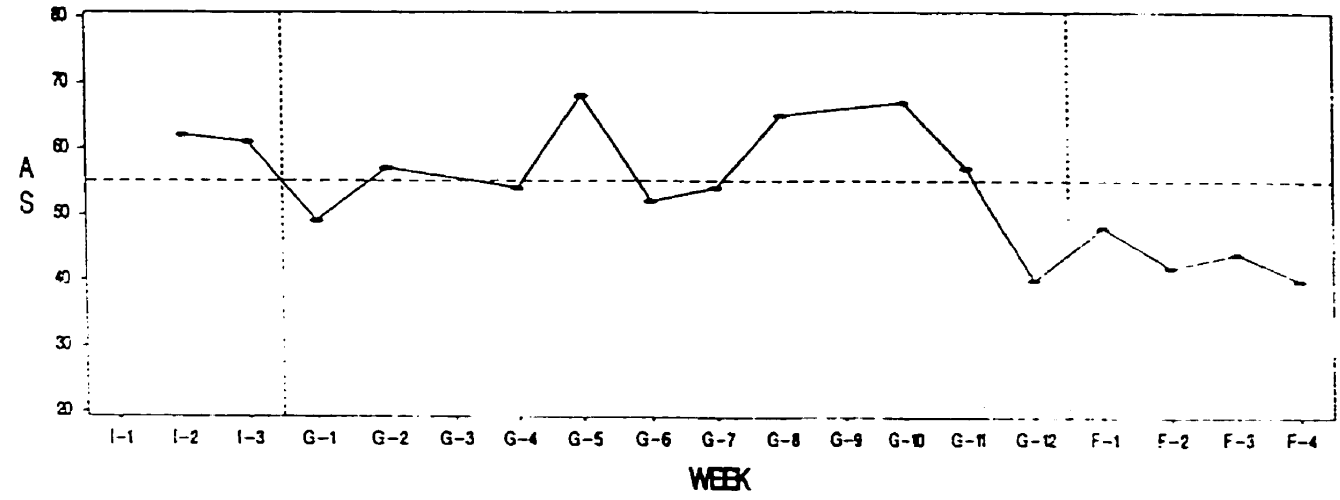
Chart 2

Client B (Group 1)

GCS Scores



AS Scores



AG Scores

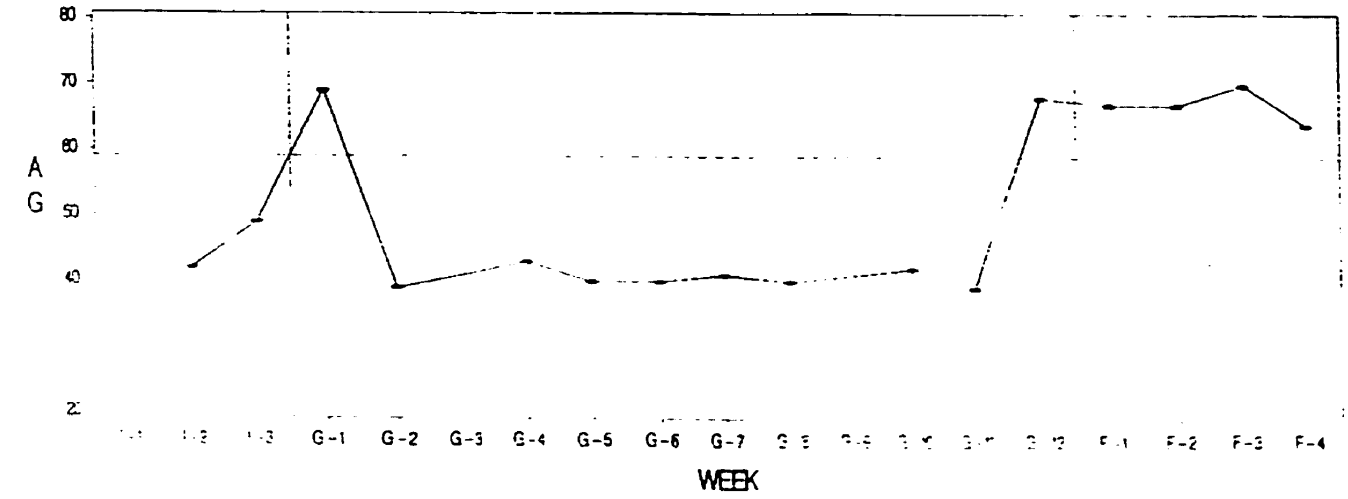
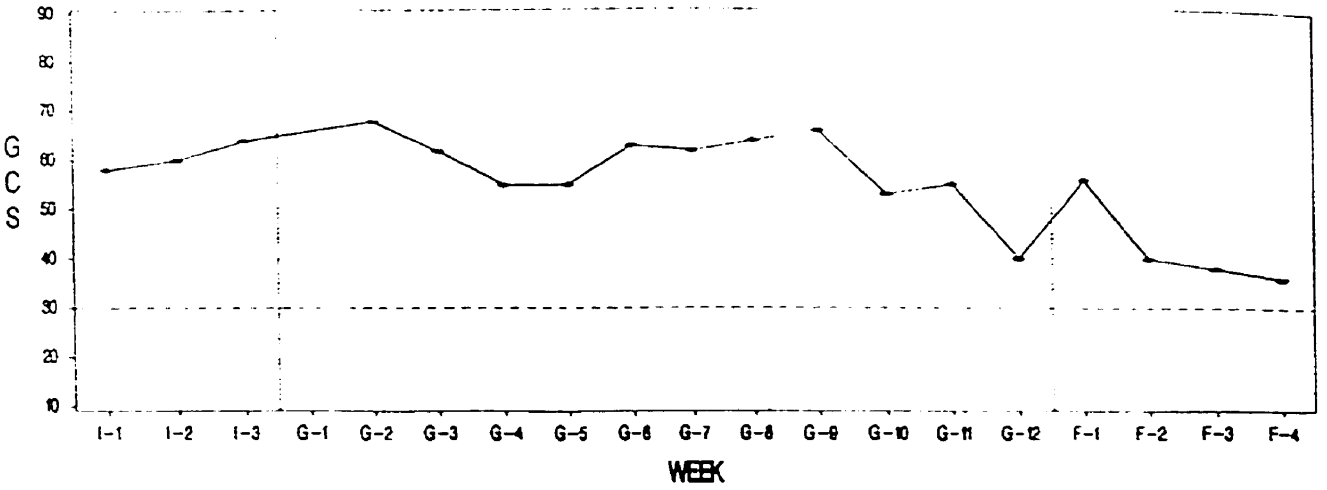


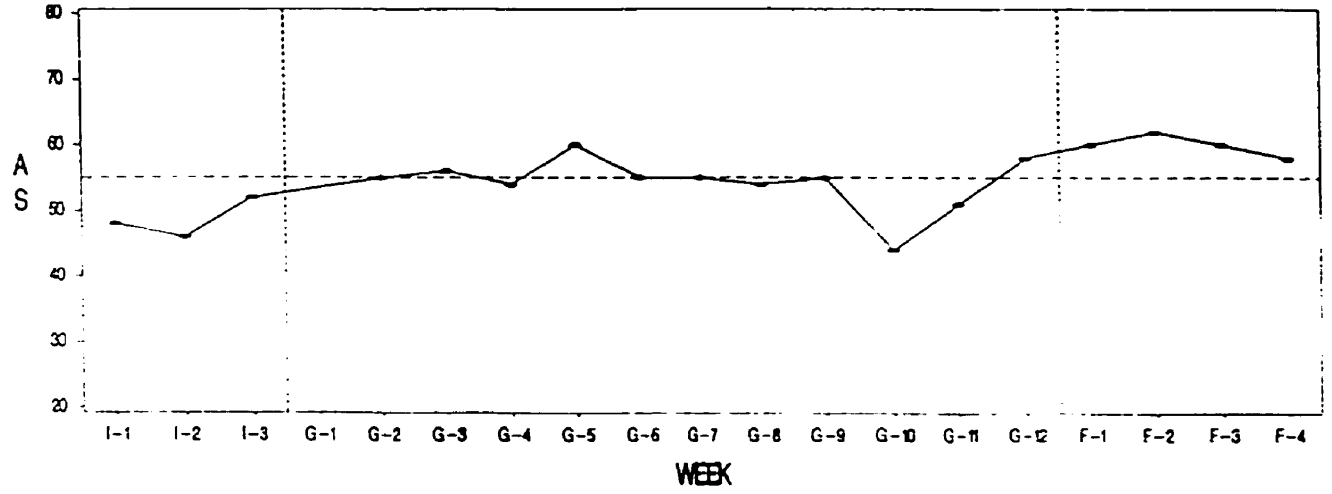
Chart 3

Client C (Group 1)

GCS Scores



AS Scores



AG Scores

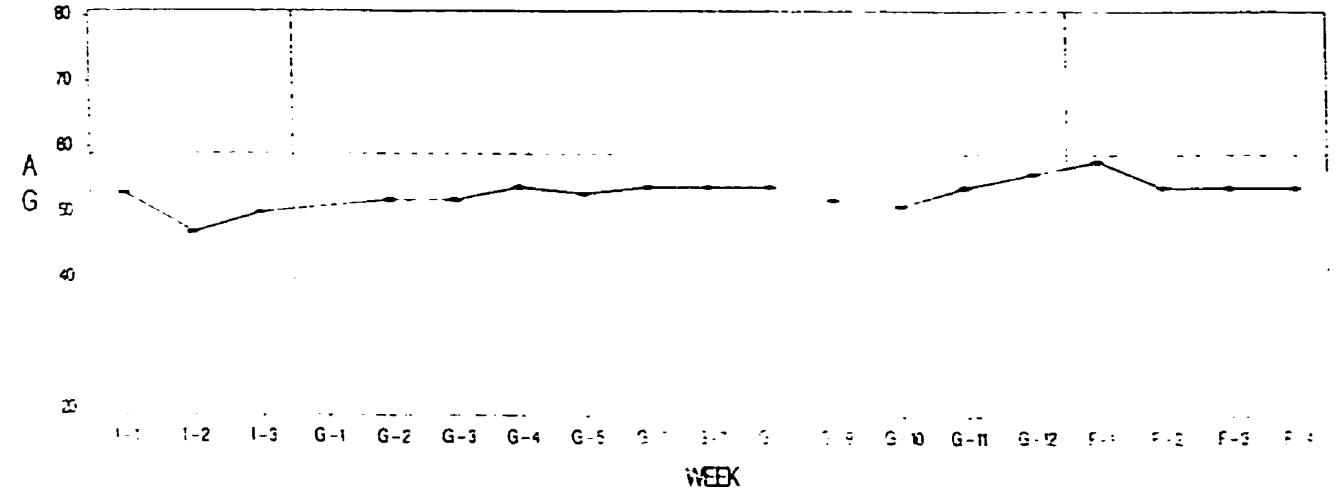
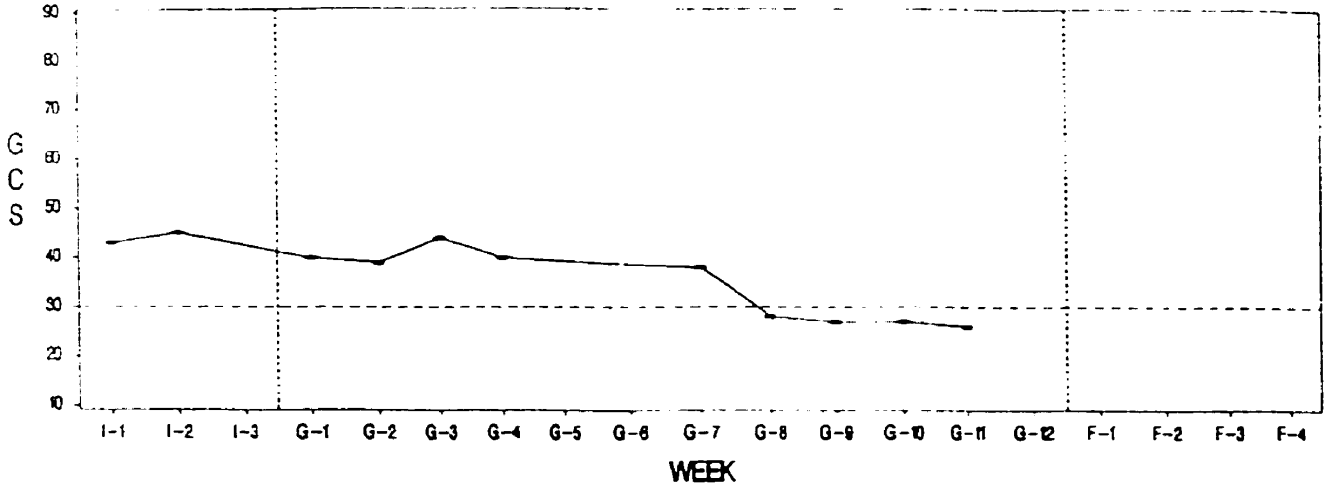


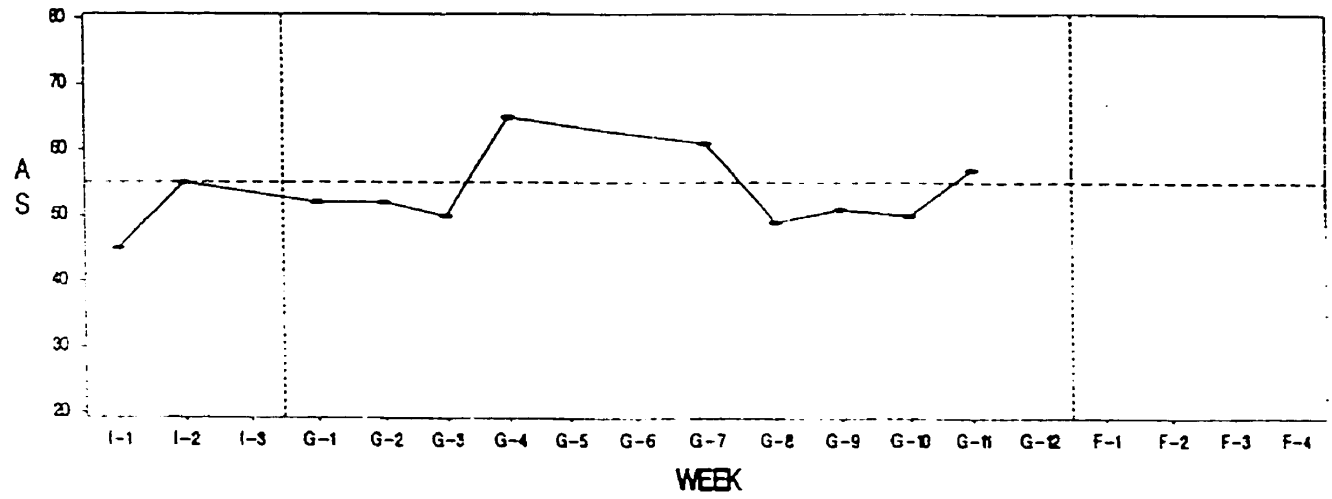
Chart 4

Client D (Group 1)

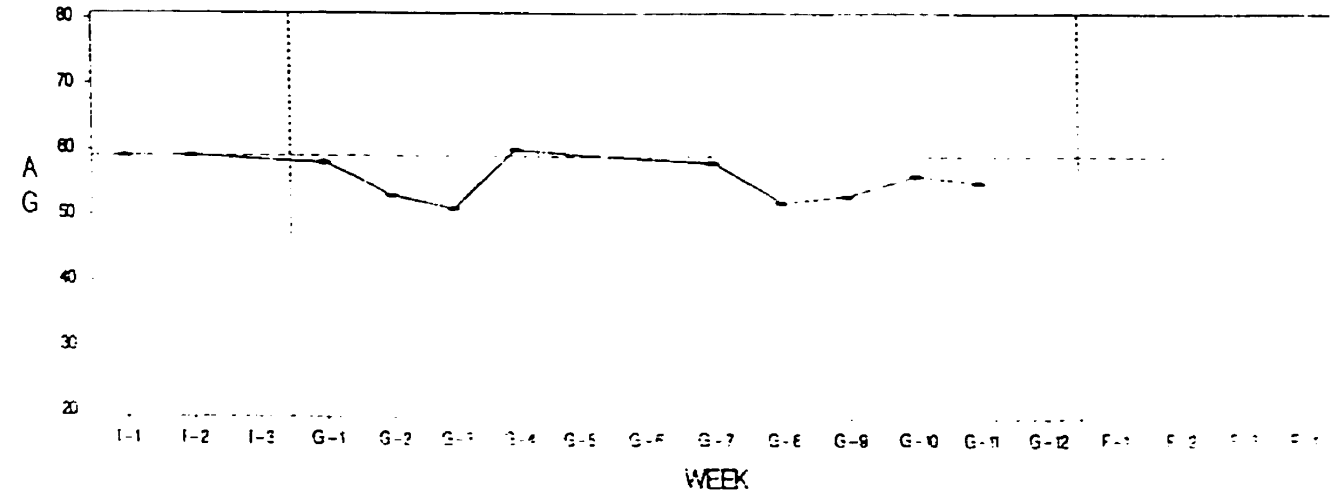
GCS Scores



AS Scores

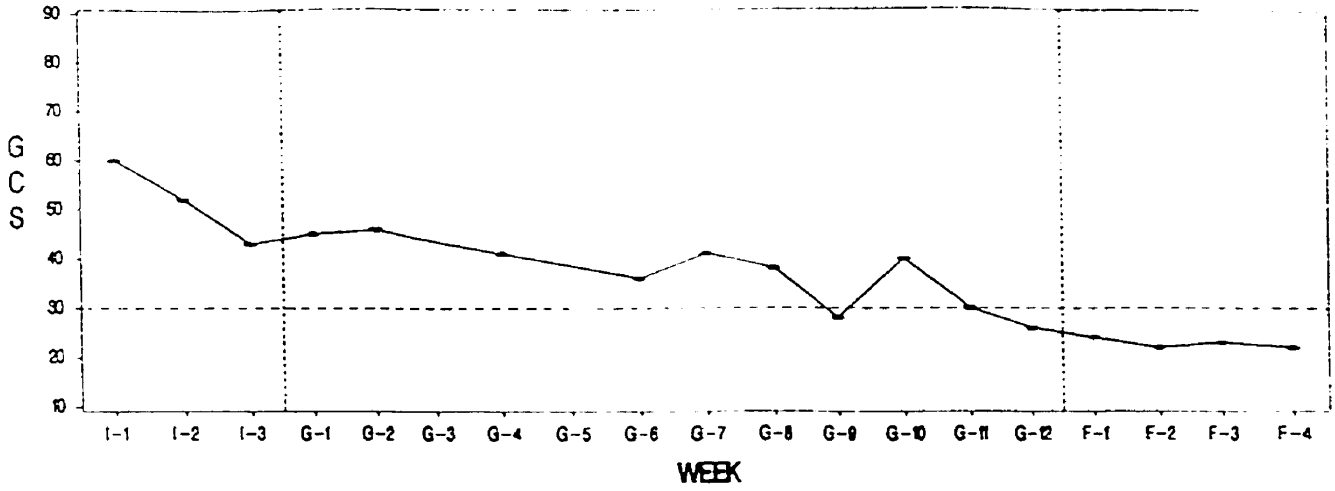


AG Scores

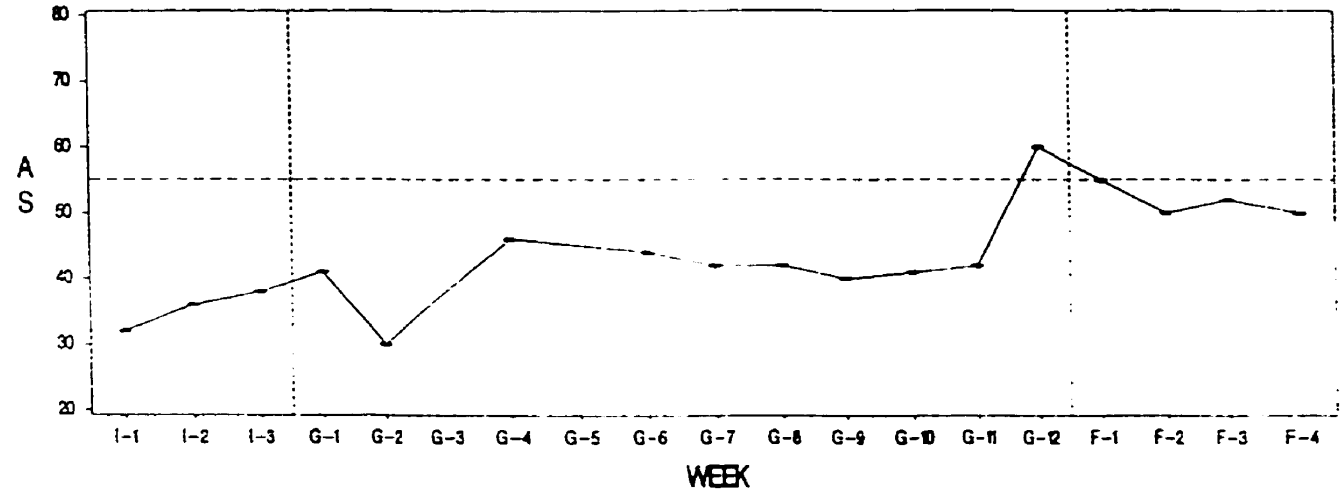


Client E (Group 1)

GCS Scores



AS Scores



AG Scores

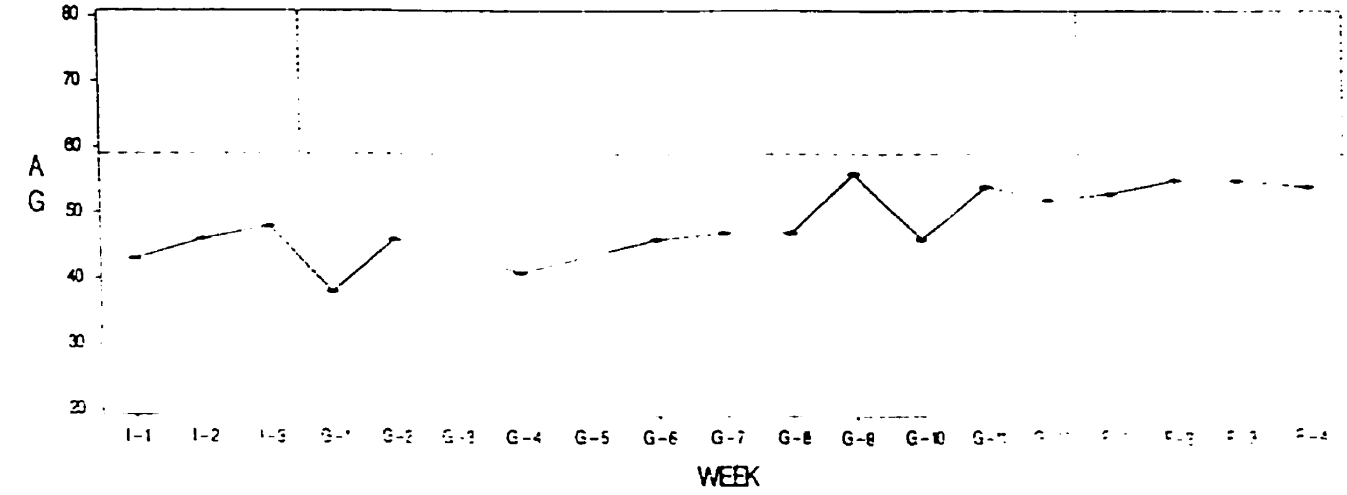
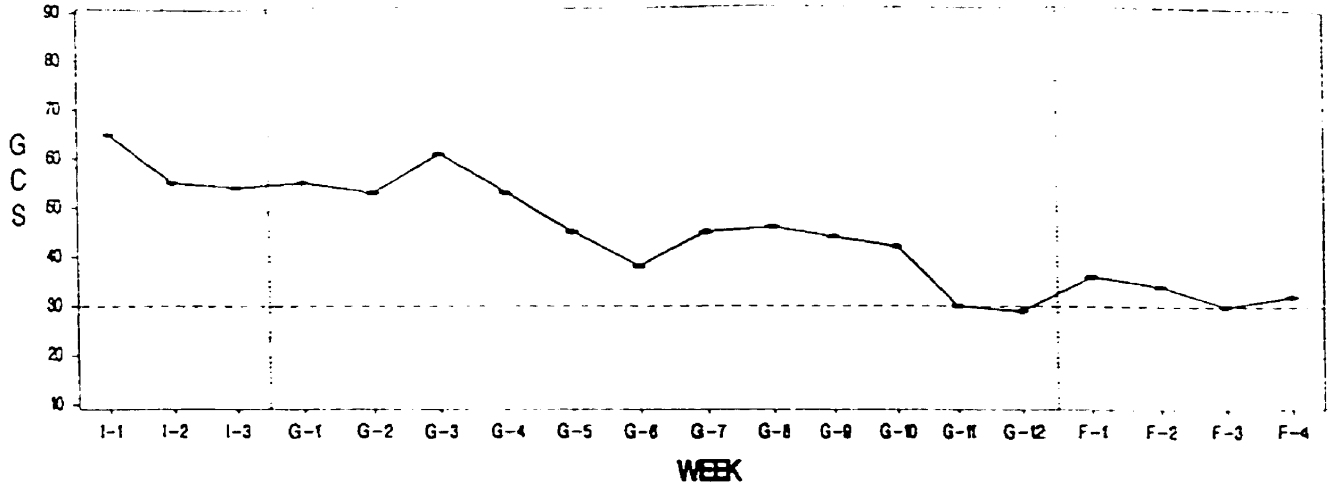


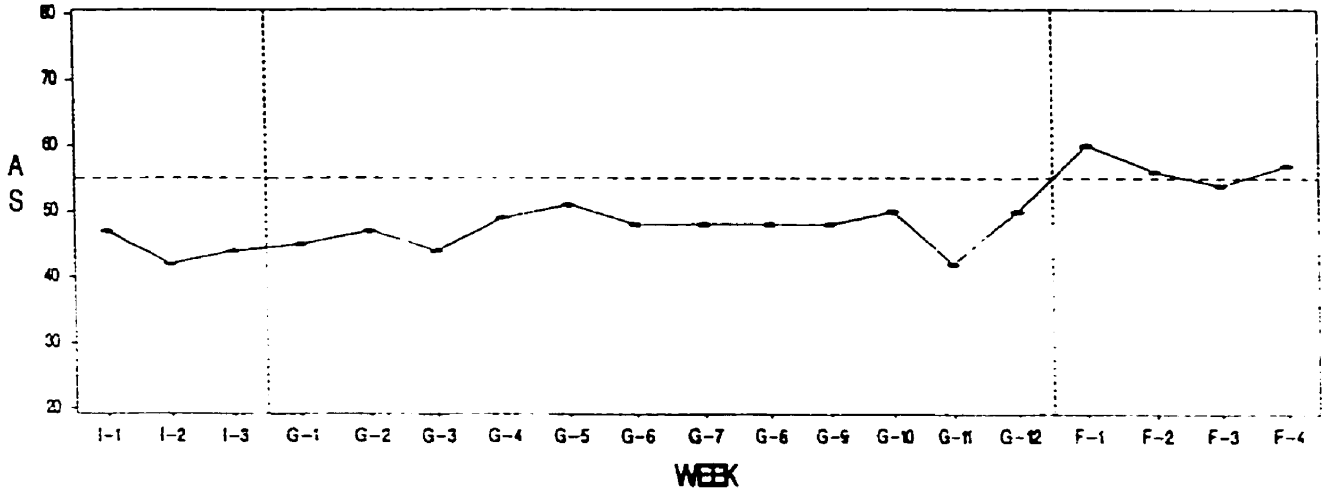
Chart 6

Client F (Group 2)

GCS Scores



AS Scores



AG Scores

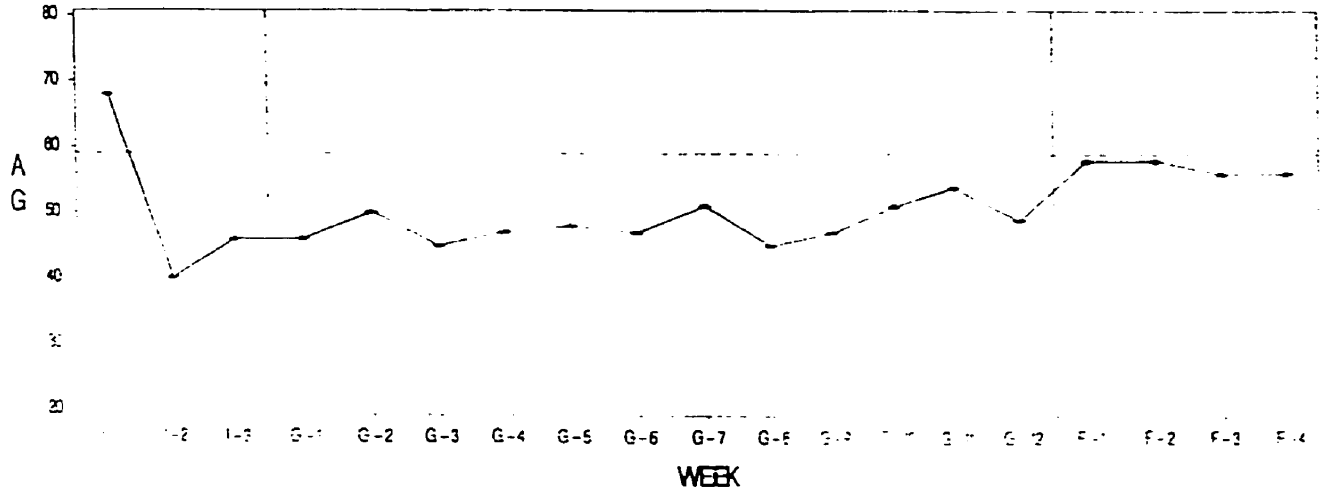
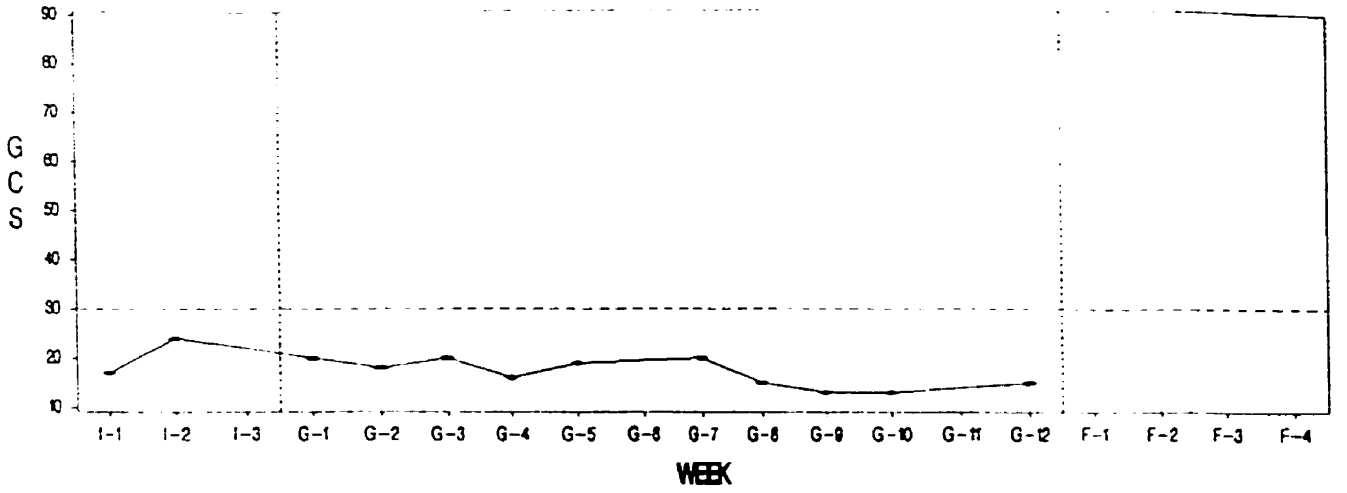


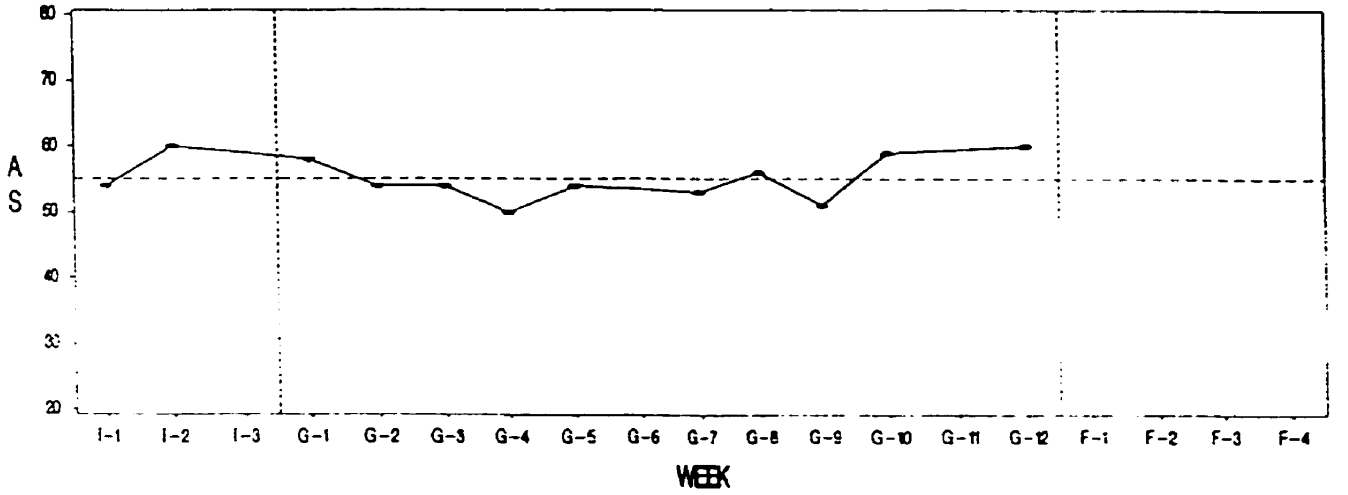
Chart 7

Client G (Group 2)

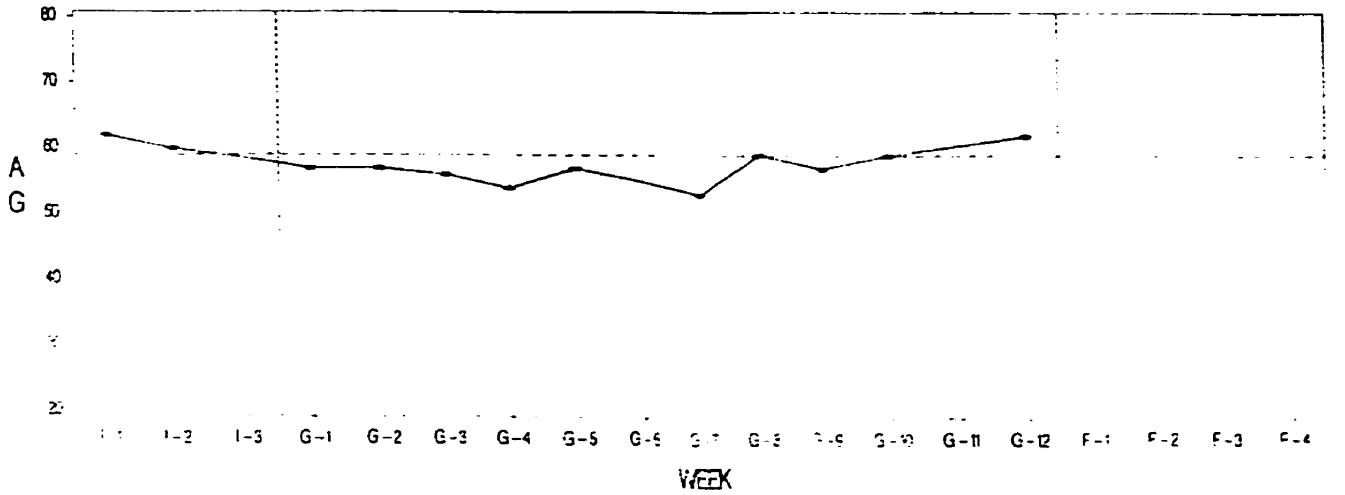
GCS Scores



AS Scores

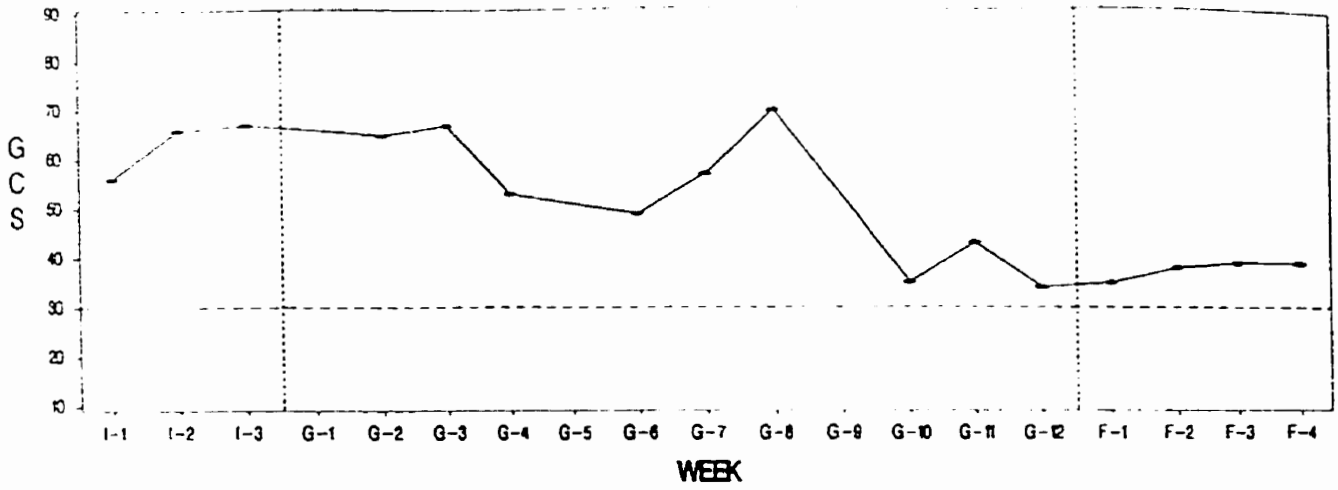


AG Scores

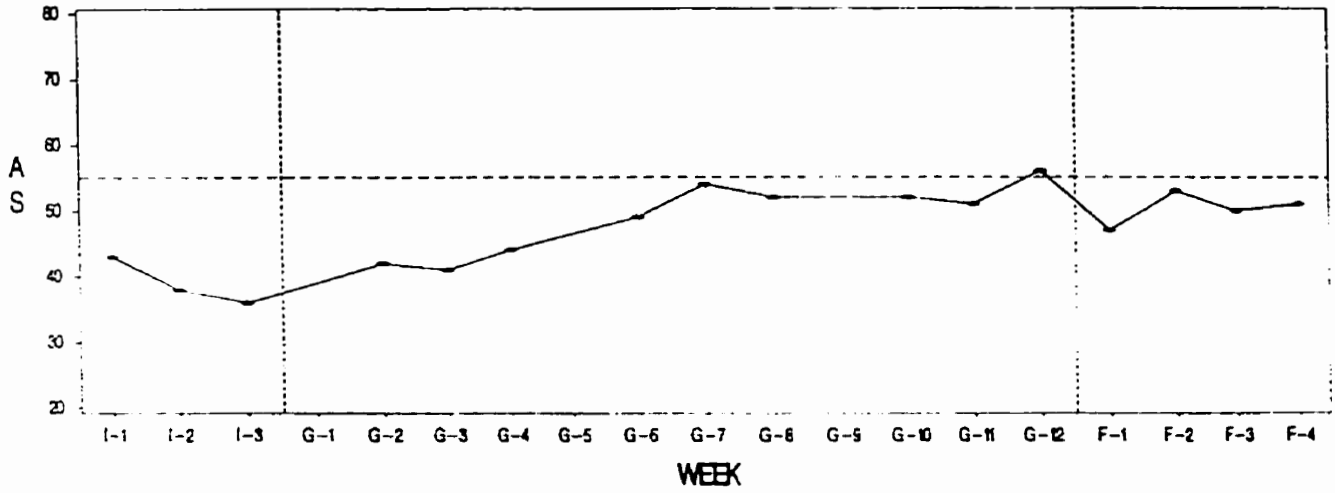


Client H (Group 2)

GCS Scores



AS Scores



AG Scores

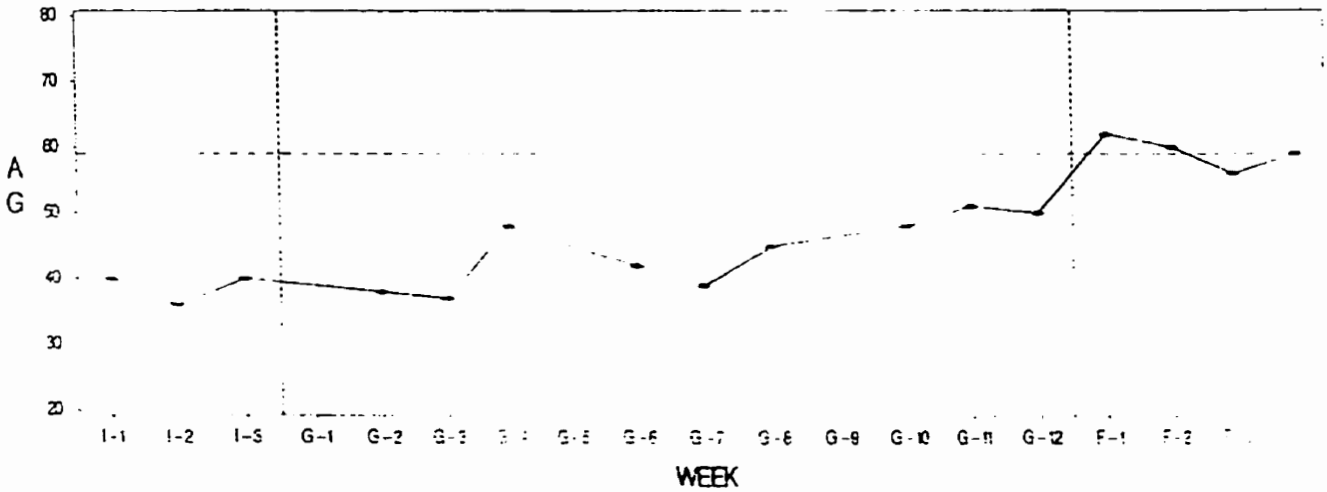
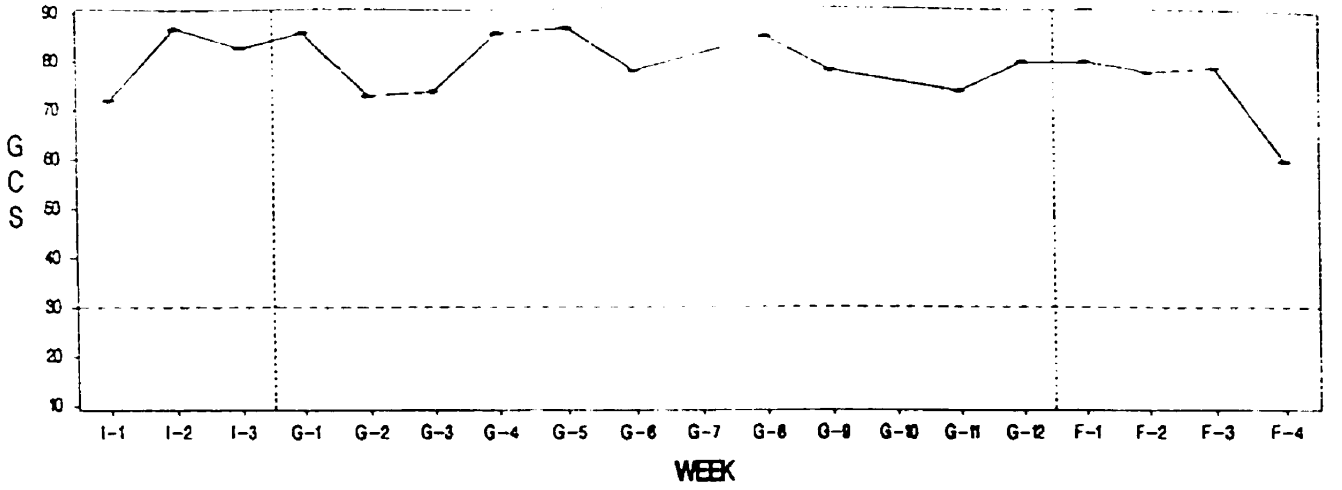


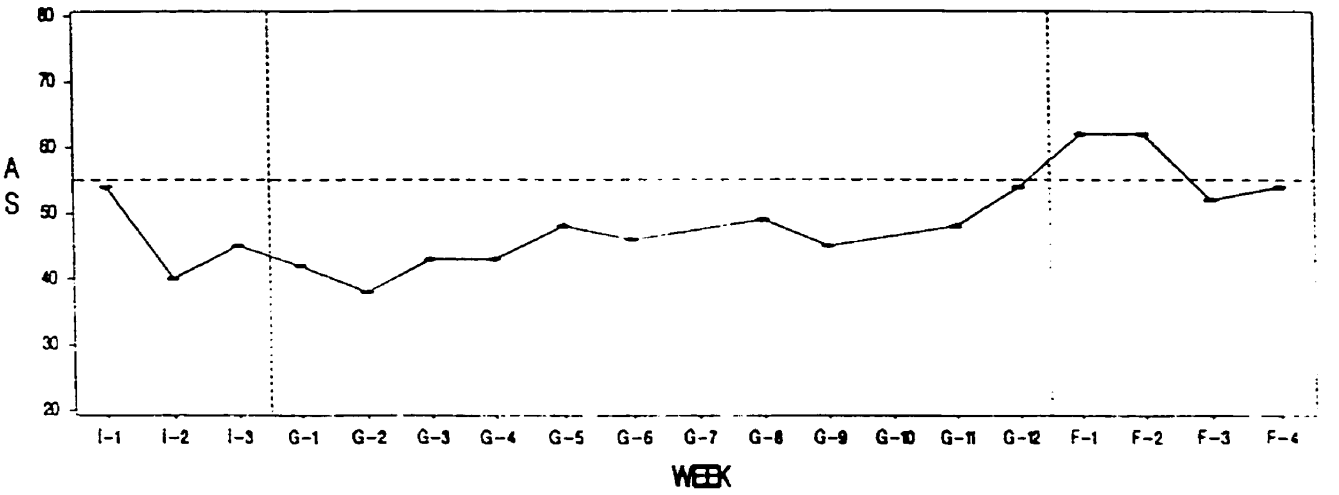
Chart 9

Client I (Group 2)

GCS Scores



AS Scores



AG Scores

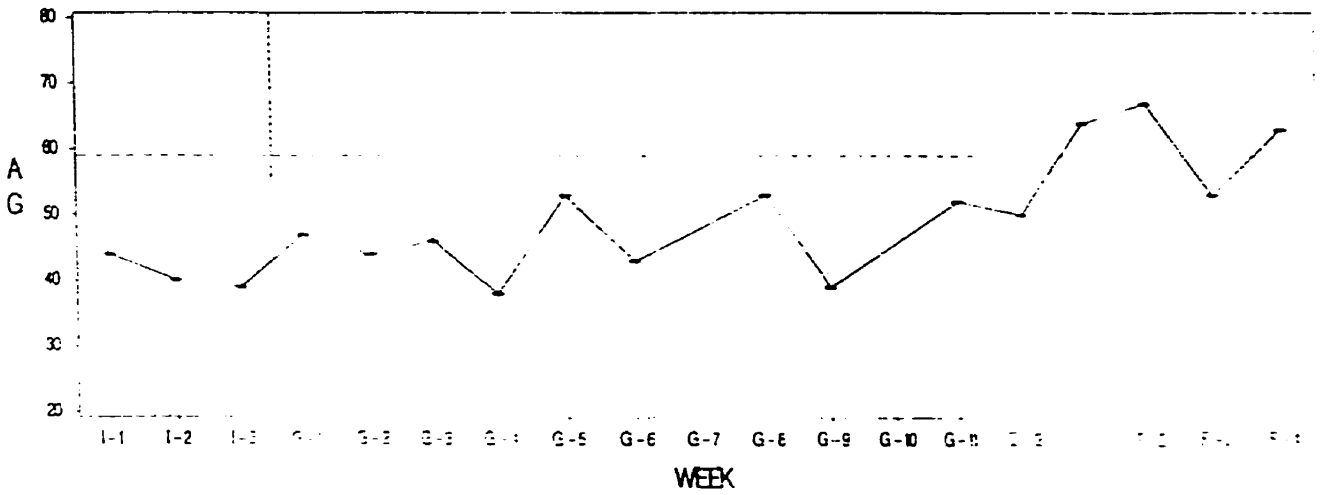
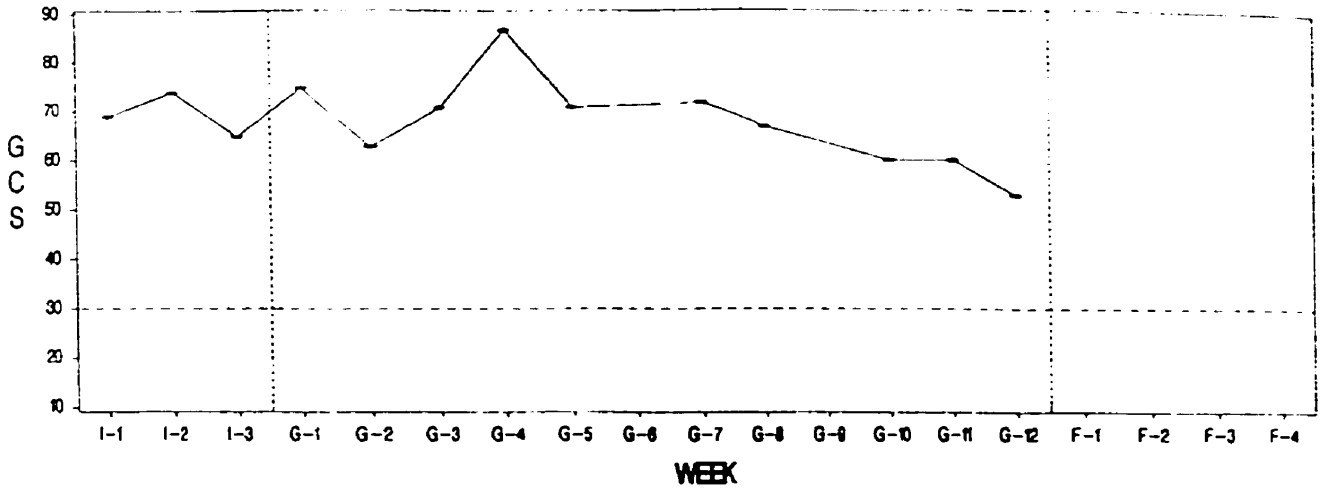


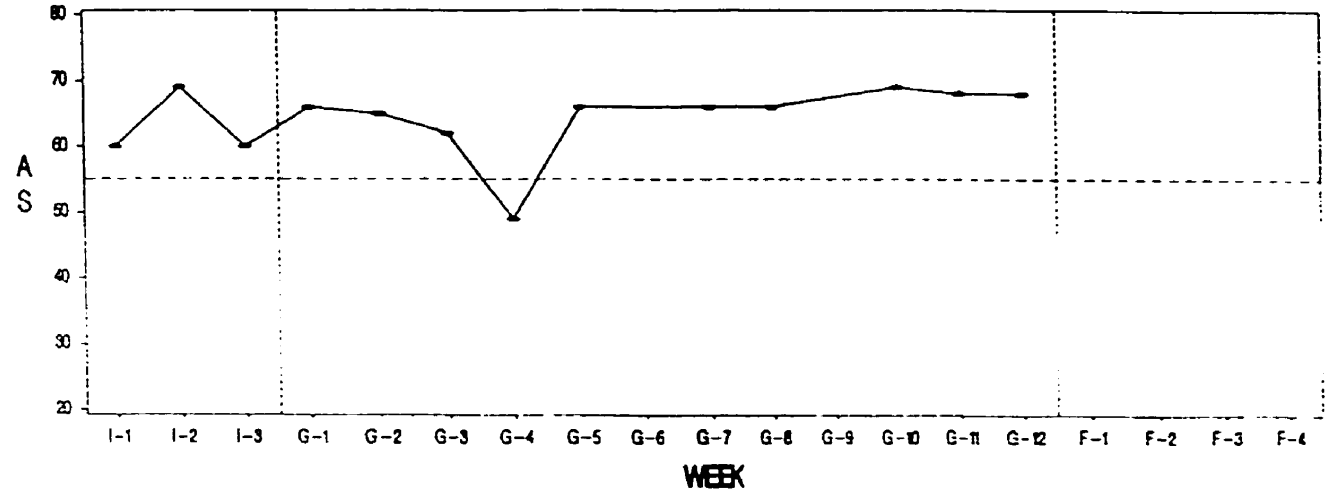
Chart 10

Client J (Group 2)

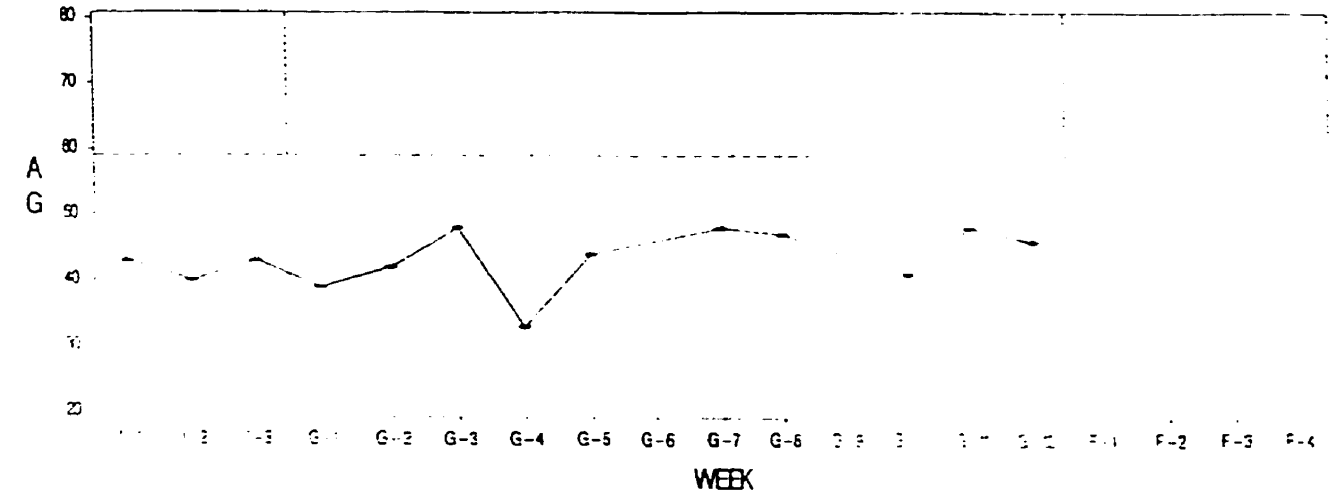
GCS Scores



AS Scores

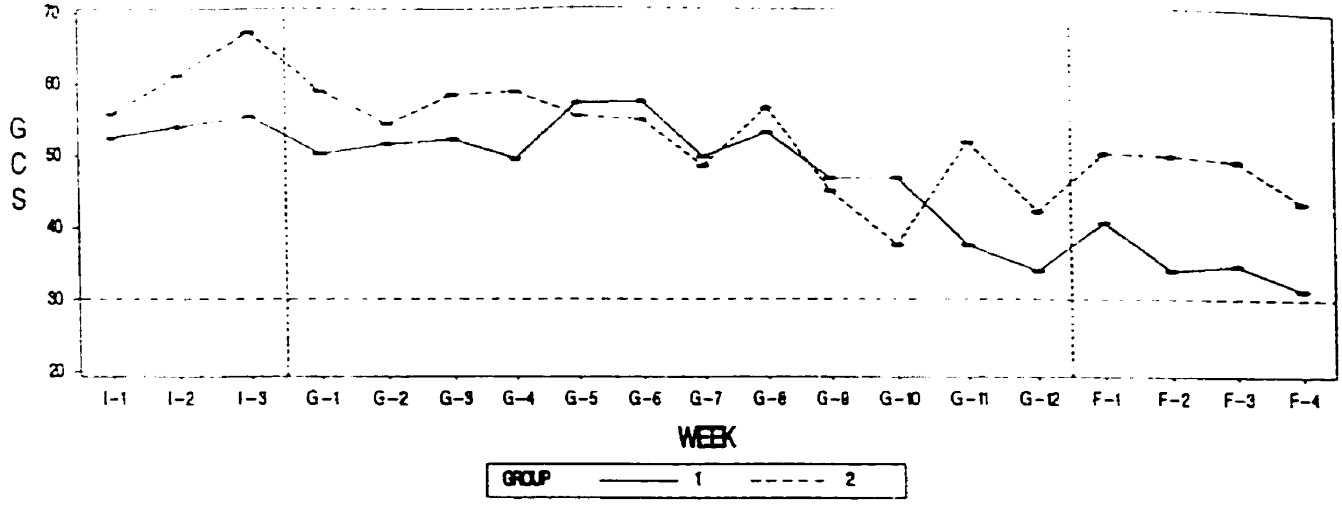


AG Scores

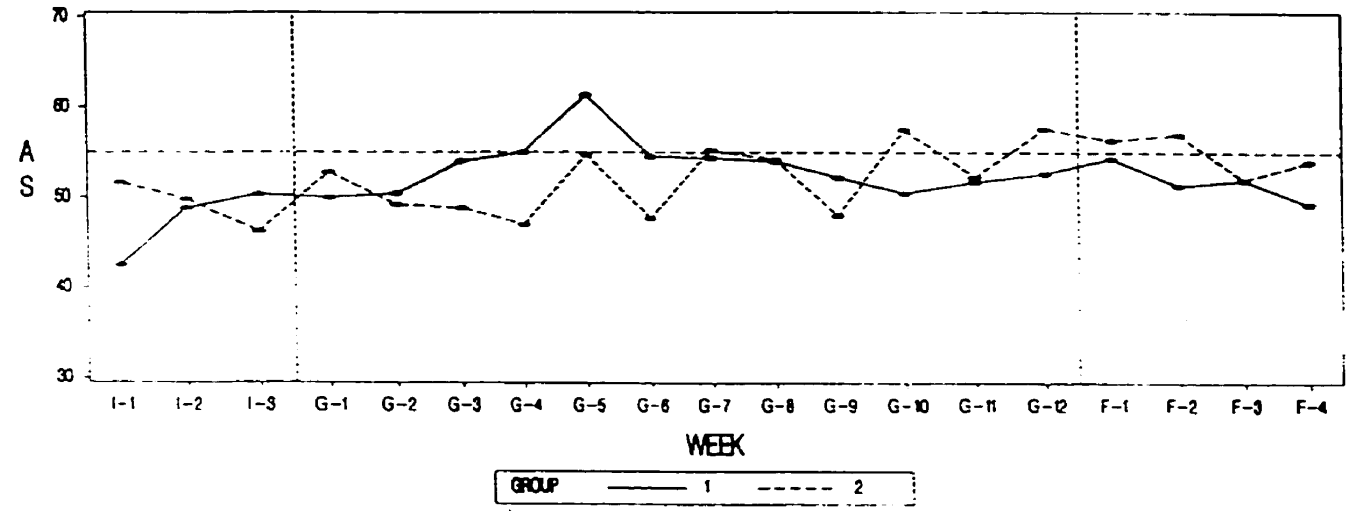


Comparing Group 1 and Group 2

GCS Scores



:S Scores



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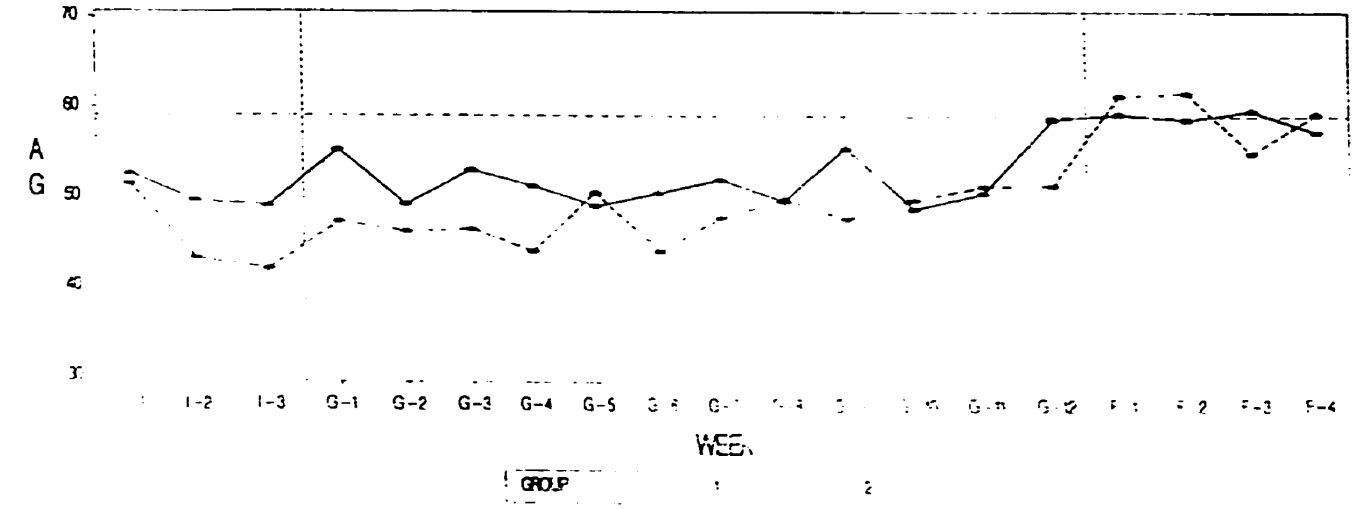

Table 1 a

TABLE 1a: Means, Standard Deviations, and t-statistics for GCS scores

	Phase I			Phase G			Phase F			Change (I to G)			Change (G to F)			Change (I to F)		
Client	n	m	sd	n	m	sd	n	m	sd	t	df	p	t	df	p	t	df	p
A	2	50.5	2.1	9	58.3	10.1	0	-	-	1.05	9	0.322	-	-	-	-	-	-
B	2	60.0	1.4	10	55.9	10.56	4	40.3	3.1	0.53	10	0.609	2.85	12	0.015	8.23	4	0.001
C	3	60.7	3.1	11	58.5	7.9	4	42.5	9.1	0.46	12	0.653	3.32	13	0.006	3.24	5	0.023
D	2	44.0	1.4	9	34.3	7.2	0	-	-	1.83	9	0.101	-	-	-	-	-	-
E	3	51.7	8.5	10	37.1	7.0	4	22.6	1.0	3.04	11	0.011	6.35	10	0.000	5.86	2	0.027
F	3	58.0	6.1	12	45.1	9.7	4	33.0	2.6	2.18	13	0.049	2.42	14	0.030	7.55	5	0.001
G	2	20.5	4.9	10	16.9	2.8	0	-	-	1.49	10	0.167	-	-	-	-	-	-
H	3	63.0	6.1	9	52.6	13.4	4	37.6	1.9	1.27	10	0.232	3.23	9	0.011	8.03	5	0.001
I	3	80.7	7.8	10	80.1	5.5	4	74.2	9.5	0.14	11	0.889	1.46	12	0.169	0.95	5	0.387
J	3	69.3	4.5	10	67.9	9.6	0	-	-	0.25	11	0.810	-	-	-	-	-	-
Group																		
1	3	53.9	1.4	12	48.9	7.1	4	35.2	3.9	1.20	13	0.250	3.65	14	0.003	7.73	5	0.001
2	3	61.4	5.7	12	51.9	7.1	4	48.3	3.1	2.13	13	0.053	0.96	14	0.354	3.93	5	0.011

Table 1 b

TABLE 1b: C-statistics testing for trend over various phases (GCS scores)

	Phase I			Phase G			Phase F			Phases I+G			Phases G+F			Phases I+G+F		
Client	C	z	p	C	z	p	C	z	p	C	z	p	C	z	p	C	z	p
A	0.00	0.00	0.500	0.32	0.86	0.194	-	-	-	0.37	1.13	0.128	-	-	-	-	-	-
B	0.00	0.00	0.500	0.47	1.34	0.090	-0.08	-0.12	0.549	0.48	1.54	0.062	0.66	2.32	0.010	0.69	2.58	0.005
C	0.46	0.59	0.279	0.56	1.70	0.045	0.47	0.75	0.227	0.55	1.93	0.027	0.67	2.43	0.008	0.68	2.74	0.003
D	0.00	0.00	0.500	0.82	2.21	0.014	-	-	-	0.84	2.56	0.005	-	-	-	-	-	-
E	0.50	0.63	0.264	0.49	1.42	0.078	-0.09	-0.14	0.557	0.72	2.42	0.008	0.78	2.72	0.003	0.85	3.32	0.000
F	0.32	0.40	0.344	0.78	2.50	0.006	0.40	0.63	0.263	0.82	2.96	0.002	0.82	3.10	0.001	0.86	3.55	0.000
G	0.00	0.00	0.500	0.54	1.55	0.060	-	-	-	0.45	1.42	0.077	-	-	-	-	-	-
H	0.32	0.40	0.344	0.37	1.00	0.159	0.53	0.85	0.200	0.45	1.45	0.073	0.56	1.86	0.031	0.64	2.41	0.008
I	0.01	0.01	0.499	0.01	0.02	0.492	0.33	0.52	0.301	-0.01	-0.01	0.506	0.29	1.02	0.153	0.25	0.99	0.162
J	-0.30	-0.38	0.649	0.49	1.40	0.081	-	-	-	0.40	1.32	0.093	-	-	-	-	-	-
Group																		
1	0.50	0.63	0.264	0.74	2.38	0.009	0.40	0.63	0.264	0.75	2.71	0.003	0.84	3.15	0.01	0.85	3.51	0.000
2	0.50	0.63	0.264	0.42	1.35	0.089	0.45	0.71	0.240	0.54	1.95	0.026	0.41	1.53	0.063	0.55	2.26	0.012

Table 2 a

TABLE 2a: Means, Standard Deviations, and t-statistics for AS scores

	Phase I			Phase G			Phase F			Change (I to G)			Change (G to F)			Change (I to F)		
Client	n	m	sd	n	m	sd	n	m	sd	t	df	p	t	df	p	t	df	p
A	2	45.0	0.0	9	59.3	3.7	0	-	-	5.24	9	0.001	-	-	-	-	-	-
B	2	61.5	0.7	10	56.3	8.7	4	43.5	3.4	0.82	10	0.433	2.81	12	0.016	6.98	4	0.002
C	3	48.7	3.1	11	54.3	4.1	4	60.0	1.6	2.18	12	0.050	2.66	13	0.020	6.43	5	0.002
D	2	50.0	7.1	9	54.1	5.6	0	-	-	0.91	9	0.388	-	-	-	-	-	-
E	3	35.3	3.1	10	42.8	7.4	4	51.8	2.4	1.67	11	0.123	2.33	12	0.038	8.08	5	0.001
F	3	44.3	2.5	12	47.5	2.6	4	56.8	2.5	1.87	13	0.085	6.13	14	0.000	6.49	5	0.001
G	2	57.0	4.2	10	54.9	3.3	0	-	-	0.79	10	0.446	-	-	-	-	-	-
H	3	39.0	3.6	9	49.0	5.4	4	50.3	2.5	2.94	10	0.015	0.43	11	0.673	4.92	5	0.004
I	3	46.3	7.1	10	45.6	4.5	4	57.5	5.3	0.22	11	0.829	4.31	12	0.001	2.41	5	0.061
J	3	63.0	5.2	10	64.5	5.8	0	-	-	0.40	11	0.696	-	-	-	-	-	-
Group																		
1	3	47.2	4.2	12	53.4	3.0	4	51.8	2.1	2.96	13	0.011	1.00	14	0.335	1.93	5	0.111
2	3	49.2	2.7	12	52.1	3.8	4	54.8	2.3	1.20	13	0.252	1.33	14	0.203	2.98	5	0.031

Table 2 b

TABLE 2b: C-statistics testing for trend over various phases (AS scores)

	Phase I			Phase G			Phase F			Phases I+G			Phases G+F			Phases I+G+F		
Client	C	z	p	C	z	p	C	z	p	C	z	p	C	z	p	C	z	p
A	-	-	-	0.17	0.45	0.325	-	-	-	0.61	1.84	0.033	-	-	-	-	-	-
B	0.00	0.00	0.500	0.23	0.66	0.256	0.20	0.32	0.376	0.18	0.57	0.286	0.51	1.77	0.038	0.50	1.89	0.029
C	-0.07	-0.09	0.536	0.15	0.45	0.328	0.25	0.40	0.346	0.36	1.24	0.107	0.44	1.61	0.054	0.58	2.33	0.010
D	0.00	0.00	0.500	0.12	0.33	0.369	-	-	-	0.17	0.50	0.308	-	-	-	-	-	-
E	0.46	0.59	0.279	0.27	0.77	0.222	0.01	0.02	0.491	0.41	1.39	0.083	0.47	1.65	0.049	0.60	2.33	0.010
F	-0.14	-0.18	0.573	0.56	2.10	0.018	0.27	0.36	0.360	0.06	0.23	0.409	0.56	2.10	0.018	0.61	2.53	0.006
G	0.00	0.00	0.500	0.25	0.72	0.235	-	-	-	0.26	0.83	0.203	-	-	-	-	-	-
H	0.44	0.56	0.288	0.81	2.18	0.015	-0.23	-0.36	0.640	0.84	2.69	0.004	0.58	1.93	0.027	0.74	2.79	0.003
I	-0.10	-0.12	0.549	0.61	1.75	0.040	0.37	0.59	0.277	0.34	1.14	0.128	0.77	2.68	0.004	0.66	2.56	0.005
J	-0.50	-0.63	0.736	0.20	0.59	0.278	-	-	-	0.06	0.20	0.420	-	-	-	-	-	-
Group																		
1	0.39	0.49	0.311	0.45	[illegible]	[illegible]	0.35	0.55	0.290	0.67	2.42	0.008	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
2	0.47	0.59	0.278	-0.13	-0.43	0.667	0.06	0.10	0.462	-0.08	-0.30	0.619	0.01	0.02	0.493	0.08	0.31	0.378

Table 3 a

TABLE 3a: Means, Standard Deviations, and t-statistics for AG scores

	Phase I			Phase G			Phase F			Change (I to G)			Change (G to F)			Change (I to F)		
Client	n	m	sd	n	m	sd	n	m	sd	t	df	p	t	df	p	t	df	p
A	2	54.5	0.7	9	57.6	2.8	0	-	-	1.46	9	0.179	-	-	-	-	-	-
B	2	45.5	4.9	10	46.1	11.9	4	67.0	2.4	0.09	10	0.947	3.41	12	0.005	7.62	4	0.002
C	3	50.0	3.0	11	53.3	1.4	4	55.0	2.0	2.82	12	0.016	1.88	13	0.083	2.67	5	0.044
D	2	59.0	0.0	9	55.1	3.1	0	-	-	1.70	9	0.123	-	-	-	-	-	-
E	3	45.7	2.5	10	47.3	5.5	4	54.3	1.0	0.49	11	0.637	3.84	10	0.003	6.40	5	0.001
F	3	51.3	14.7	12	48.3	2.7	4	57.0	1.2	0.35	2	0.759	6.03	14	0.000	0.66	2	0.575
G	2	61.0	1.4	10	57.1	2.6	0	-	-	2.04	10	0.069	-	-	-	-	-	-
H	3	38.7	2.3	9	44.2	5.4	4	59.3	2.5	1.69	10	0.121	5.24	11	0.000	11.11	5	0.000
I	3	41.0	2.6	10	46.5	5.5	4	61.8	6.1	1.63	11	0.131	4.55	12	0.001	5.44	5	0.003
J	3	42.0	1.7	10	43.6	4.9	0	-	-	0.54	11	0.601	-	-	-	-	-	-
Group																		
1	3	50.4	1.9	12	51.9	3.1	4	58.8	1.0	0.82	13	0.427	4.22	14	0.001	7.68	5	0.001
2	3	45.5	5.1	12	48.0	2.6	4	59.3	3.1	1.23	13	0.241	7.29	14	0.000	4.50	5	0.006

Table 3 b

TABLE 3b: C-statistics testing for trend over various phases (AG scores)

	Phase I			Phase G			Phase F			Phases I+G			Phases G+F			Phases I+G+F		
Client	C	z	p	C	z	p	C	z	p	C	z	p	C	z	p	C	z	p
A	0.00	0.00	0.500	-0.16	-0.43	0.667	-	-	-	0.04	0.11	0.455	-	-	-	-	-	-
B	0.00	0.00	0.500	0.30	0.86	0.196	-0.25	-0.40	0.654	0.14	0.44	0.329	0.64	2.23	0.013	0.57	2.14	0.016
C	-0.25	-0.32	0.624	0.41	1.23	0.109	0.33	0.53	0.299	0.42	1.48	0.069	0.46	1.68	0.047	0.50	2.03	0.021
D	-	-	-	-0.05	-0.13	0.550	-	-	-	0.20	0.62	0.269	-	-	-	-	-	-
E	0.49	0.62	0.269	0.34	0.97	0.167	0.09	0.14	0.443	0.19	0.62	0.267	0.55	1.93	0.027	0.47	1.85	0.032
F	0.06	0.07	0.471	0.07	0.24	0.406	0.50	0.79	0.215	0.10	0.35	0.362	0.62	2.33	0.010	0.29	1.21	0.112
G	0.00	0.00	0.500	0.30	0.85	0.198	-	-	-	0.44	1.42	0.078	-	-	-	-	-	-
H	-0.50	-0.63	0.736	0.52	1.40	0.080	0.23	0.36	0.360	0.59	1.87	0.031	0.77	2.59	0.005	0.81	3.05	0.001
I	0.39	0.50	0.310	-0.59	-1.68	0.954	-0.36	-0.60	0.724	-0.33	-1.10	0.864	0.35	1.21	0.113	0.44	1.72	0.042
J	-0.50	-0.63	0.736	-0.14	-0.40	0.654	-	-	-	-0.15	-0.51	0.695	-	-	-	-	-	-
Group																		
1	0.32	0.47	0.316	-0.03	-0.10	0.539	-0.08	-0.12	0.549	-0.13	[illegible]	[illegible]	[illegible]	[illegible]	0.029	0.52	[illegible]	[illegible]
2	0.34	0.44	0.332	0.17	0.56	0.288	-0.12	-0.19	0.577	0.23	0.82	0.207	0.71	2.67	0.004	0.69	2.85	0.002

Qualitative Data Analysis

The weekly qualitative non standardized measures were collected and considered in the ongoing assessment and planning for the remaining sessions. This element of allowing the participants' input into the group is in keeping with the feminist ideology, which encourages women to be authorities on themselves and their needs in healing. The weekly rating scales (1-5) were administered at the end of each session. The intention was to have the participants provide feedback regarding: the session, content-information presented and exercises. The participants' experience of the session refers to the participants feeling that the group was assisting them in their personal goals around anger in their healing. The participants were also given the opportunity to provide specific descriptive feedback.

The information gathered in these scales was intended to capture each individual participant's experience in the group. The qualitative feedback measures were perceived by the participants as being more useful indicating that the participants felt the qualitative measures had greater face validity. The findings from these measures will be discussed in chapter six as the results point to themes within the practicum experience for the participants. Following each group session the student clinician and the co-facilitator reviewed the feedback forms to see if any changes would be appropriate to better fit the needs or concerns of the group members. The responses to the feedback forms was nearly entirely positive. However it is questionable whether the participants would express less than positive feedback.

Implications

As previously discussed, it is difficult as was previously discussed to draw any conclusions about the group intervention or the findings in the Anger in Healing group as the findings from the group have not been replicated, nor strenuously tested for significance. A causal relationship is very difficult to draw in clinical populations where the intent of the group or program is not solely to develop research. What can be said however is that the women who took part in the Anger in Healing group found the group useful in meeting their individual goals related to anger. Further discussion of implications as well as recommendations are presented in chapter six.

CHAPTER SIX

DISCUSSION OF THEMES, THE EDUCATIONAL EXPERIENCE AND RECOMMENDATIONS

Chapter six presents the discussion of the practicum experience from the perspective of the student / clinician. First, the chapter discusses the themes which presented themselves throughout the group process and the qualitative feedback forms. The second focus is an analysis of the practicum: objectives, the student / clinician's learning related to goals, and a discussion of the experience as a facilitator. The conclusion of the chapter and the practicum report will be recommendations from the student / clinician regarding further group work and programing related to women, anger and child sexual abuse.

Themes

During the initial intake process, the first theme of the groups emerged. The first theme was the participants' labeling of anger as a negative and / or scary emotion; they also expressed a lack of understanding of their triggers for anger. The Literature available on women's anger concurs with this finding (Couttois, 1988; Frankel, 1992; Houghland & Nicholas, 1995; Jordan, et al, 1982; Tavris, 1989; Thomas & Jefferson, 1996). Thirteen of the fifteen women involved in the original intake felt that anger was a 'scary' emotion - feelings of fear for oneself and others accompanied experiencing their own anger, or witnessing others' anger. These women discussed how they associated anger with violence and aggression. Two women described anger as a shameful experience and did not want to associate with anger in any way. Seven women were aware or somewhat aware of what triggered their anger, while eight women stated they

were mostly unaware of their anger triggers. Lois Frankel (1992) describes what the participants appear to be expressing as confusion of the triggers of their anger stating, " many women simply cannot distinguish between anger and other more socially acceptable emotions." (pp. 15). Three of these eight women said they did not experience angry feelings at this point in their lives and wanted to become more aware of their anger and their triggers.

When asked what they would like to get out of the group, the majority of responses related to finding new ways to express anger that did not hurt others or oneself. Lerner (1985) concurs with this theme, in her book *The Dance of Anger* she discusses how when women experience anger they often begin to question themselves and block or invalidate their anger - producing feelings of guilt, depression and self doubt. Five women discussed finding new strategies to manage feelings, anger in particular, once it has already begun. Four women wanted to become aware of their anger and to make a positive connection with it.

All of the women involved in the groups had previous group experience and each stated that they were looking forward to the group knowing that they would have a safe place to connect with other women with similar backgrounds or experiences. When asked what they liked about past group experiences the common response was 'I didn't feel so alone, others felt like I do'. Many authors discuss the positive impact group work can have in healing from childhood sexual abuse (Toseland & Riva, 1984; Donaldson & Cordes-Green, 1994; Herman And Schatzow, 1984; Courtois, 1988; Gil, 1988; Kasl, 1992; Herman, 1992; Walker, 1995; and der Kolk et al., 1996 Also, building safe relationships

and sharing experiences were stated as positive aspects of group experiences. Courtois, (1988) states

> "...group allows breaking of the secrecy, isolation, and stigma resulting from the abuse and fosters exploration and resolution of the trauma and its aftermath. The sharing and empathy derived from common experiences and reaction, as well as the analysis of the interaction between group members build an environment of safety and consistency..." (pp. 224)

When asked about aspects of groups the women did not find helpful or that they disliked, the most common response was a variation of 'when certain group members talk too much or take over the group, not allowing sharing by all members'.

As the facilitator of the group, the student / clinician, outlined to each woman individually during the intake and screening interviews that the group, while supportive, would also be structured. Creating an atmosphere of safety was of paramount concern. In reviewing literature related to child sexual abuse and treatment for survivors the need to create a safe environment was stressed. (Herman, 1992; Walker, 1994; Courtois, 1988) Each woman understood before beginning the group that the facilitators were going to structure the group to ensure, to the best of their ability, that women were safe. This meant that should one or more women begin to experience or express anger in an unsafe manner, a facilitator would intervene. Interventions could include asking the woman to breathe deeply, take a few minutes to leave the group with or without a facilitator to collect herself and care for herself, and a reminder that the group norms/rules would be followed to ensure all members' well being. As has been previously discussed, the Anger in Healing groups employed a co-facilitator style

of leadership. (Donaldson & Cordes-Green, 1994; Saxe, 1993; Glassman & Kates, 1990; Courtois; 1988)

The student / clinician along with the co-facilitators, spent a great deal of time and energy working to create safety in the group experience for the women. Time was spent before each session to prepare the room to be as comfortable as possible for the participants. Cushions were placed on the floor for those women who preferred cushions over chairs. Extra side tables were place to allow each woman to have a place to put her beverage and personal items. There were objects (rocks, squeeze balls, small teddy bears, etc.) for the women to hold during the session if they wished. The room was assembled to be inviting, comfortable and predictable. Attention was paid to present the group agenda in a clear informative manner, while at the same time using color and illustrations to increase the feelings of warmth and comfort in the room and with the subject matter. Many women commented that they found the space to be warm and safe. Attention to detail and presentation in group while not formally discussed in the literature, has proven clinically to be a valuable component to group facilitation.

The student / clinician offered a healthy snack for each group and offered water, various teas and coffee to the participants. For the first four sessions the student / clinician baked homemade muffins and or scones for the sessions and served them with seasonal fruit. The fifth and subsequent sessions snacks were also provided, some were baked and others were purchased. The student / clinician felt strongly that providing 'comfort food' to the participants would assist in creating a caring atmosphere and model self care. Self care was stressed

during the breaks and the co-facilitators encouraged the participants to break from group and share informally with other members. Having a nourishing snack adds to the feelings of warmth and cohesion in a group. Again participants commented on how the snacks added to their group experience and allowed them to feel 'cared for'. While again not discussed in the available literature the clinical advantages and strengths found in attending to detail and providing concrete nurturing for participants paid a strong dividend in participants expressed experience of the groups.

Engaging and Assessing

The first phase of the group as described in chapter four is entitled the following The Laurel Centre's clinical model is the 'Engaging and Assessing' phase and comprised the first three sessions (The Laurel Centre, 1998). The second theme which emerged during this phase was that the participants conceptualized anger as a distinct experience, one that was not connected to other feelings or experience. Participants, both individually and collectively, did not recognize anger as being linked to other emotions or that other emotions could be linked to anger. This was evident in session two when the group looked at the "anger iceberg" and the "anger never rides alone car" **(Appendix 9)**. This theme is fitting with what Miller (1982) stated about women's beliefs about anger.

> From very early in life, women have been led to believe that their life activities should be for others and that their main task is is to make and maintain relationship that serves others.
> ... to be angry can feel to women as if it will disrupt a relationship...
> ... because any anger is too much anger in women. Indeed the risk of expressing anger can appear grave and disorganizing.

In both groups this topic generated much discussion and some resistance. For some of the women the notion that anger is a feeling not unlike other feelings, for example sadness or joy was very unsettling. Many of the women viewed anger as an entirely separate experience, not connected to other feelings or emotions. By the end of session two there was a beginning understanding that anger was a normal, legitimate feeling and was very much connected to other feelings. Tavris (1989) discussed women's anger as being "...a potential source of mobilization for action..." and goes on to describe how many obstacles need to be confronted before gains can be made. "...obstacles both within and outside family and within the construction of the mind." (pp. 195)

There was also a sense that women's experiences of and with their anger have social and political roots in their gender. The level of feeling attached to the seemingly 'new' information that anger was or could be linked to other feelings or emotions was high; higher than anticipated in both groups. It became apparent that for many of the women it did not feel 'safe' to consider anger as a normal, necessary and often times socially constructed aspect of their lives. Miller (1982) describes women's position in society as:

> "...women have been led to believe that their identity, as women, is that of persons who should be almost totally without anger and without the *need* for anger. Therefor, anger feels like a threat to women's central sense of identity, which has been called *femininty*. (pp. 184).

The student / clinician and co-facilitators spent more time than had been planed going over several different examples outlining how anger is a normal and interconnected emotion and experience.

The third theme was that many of the women found the creative exercises particularly helpful in accessing and expressing a different level of feeling. The first creative exercise occurred in session three when the facilitators invited the participants to express their fears related to anger through a creative collage. One half of the collage was to represent what their fears look like and the other half was what would things look like in the absence of fear related to anger. One participant's feedback form noted ***"I don't feel so afraid of anger (mine or anyone's) in doing the collage, I can see that I can make changes and not be controlled by my fears".*** Other comments included: ***"great exercise",*** and ***"creativity works for me".*** This exercise (as many exercises within the groups) was based upon narrative therapy techniques - outlining the 'current reality' developing a 'preferred reality' (Freedman & Coombs, 1996)

Intense Debriefing

The second phase of the group, entitled, "Intense Debriefing," (The Laurel Centre, 1998) encompassed sessions four, five and six. Literature related to effectiveness of group work in healing from childhood sexual abuse, as well as effectiveness of the Trauma Model (Herman, 1992) are drawn upon to support the findings of the Anger in Healing groups. Session four involved an exercise where participants expressed or released anger using clay. All but one participant in both groups valued the clay exercise in providing a tangible outlet for their anger and / or hopes for healing. Again, the use of a creative outlet was beneficial in assisting the participants to access feelings. One woman commented that ***"When I see this*** (clay representation of what I learned about anger as I child) ***I can see that I am able to take care of myself now, and I am***

not a victim anymore". The brainstorms in session four provided comprehensive lists of what the women collectively experienced and learned about anger as children, as well as what they believe children need to learn about anger. Women who were parenting, began to make connections for their children and all the women connected how, as adults, they could 're-parent' themselves and meet some of their own previous unmet needs. As was discussed in chapter four, the brainstorms allowed participants to begin to set goals for themselves related to anger. Sharing experiences and feeling throughout this phase of the group allowed the women to as Herman (1992) described "...reclaim her own history and feel renewed hope and energy for engagement with life" (pp. 195)

The facilitators began to increase their use of challenging within the group beginning in session four. Humor was used extensively. The student / clinician and the co-facilitators began to encourage in a gentle but assertive manner group members to take more risks in sharing and examining their issues. This was successful. As the women appeared to begin to require more of themselves in group, the group moved quickly into a 'working group' stage.

Session five presented the third theme of the group: the participants were able to identify specific goals related to their anger **(Appendix 9)**. Narrative therapeutic techniques of externalizing the problem, constructing or authoring a preferred reality, thickening and spreading the news are evident in the goal format (Durrant and Kowalski, 1990). This differed from the initial intake sessions when several women were unable to access or identify anger in their lives or were too frightened of anger to consider making goals outside of 'getting

rid of anger'. Each woman shared with the larger group an outline of her specific goals and her plan to achieve them. Session five was an ideal time to introduce goals as the participants now had a clear understanding of what anger meant to them and how it impacted on their lives. Had goals been suggested earlier, the necessary foundation would not have been present. If goals were not developed until later in the group, participants may have moved into a passive group mode and not been able to actively pursue their goals or the group material in an effective manner. The findings of the Anger in Healing group concur as was anticipated by the student / clinician with feminist principles holding women as the experts of their own experiences (Burstow, 1992; Herman, 1992; Levine, 1993; Jordan, 1995; Walker, 1998) and holding women as able, individually and collectively to make positive changes in their lives.

Session five also had each woman identify where in their body they felt or experienced anger and represent it figuratively on a body form. This proved to be a valuable exercise as it enhanced the previous theme of understanding anger as being linked to other feelings. This exercise allowed the women to recognize that anger feelings are linked to their bodies. Many women talked about how this exercise brought new awareness of their bodies, health and experiences (past and present) with anger. One woman said ***"I 'get' my headaches - I believe I am expressing anger at my partner within my body in the form of headaches".***

Session six marked the final session in the intense debriefing phase of the group. By this time there was a great deal of sharing among group members in both the morning and evening groups. The trust level in both groups was high

and the participants were well joined to each other and the group process. Session six embodied the student / clinician's understanding of 'Intense Debriefing'. Each participant completed an exercise which walked them through a process of naming either one, or the significant source of anger in their lives, outlining the costs and / or consequences of this individual / experience / event. Narrative and solution focused therapy principles and language informed the presentation of the exercise. Following this, they were asked to complete an exercise inviting them to reclaim their power in this situation and asking them to take action in moving past this experience. As was anticipated many participants found through the exercise(s) that they were able to make changes in their perception of 'the / a' significant source of anger in their lives. Solution focused (Molnar and de Shazer, 1987; de Shazer et al 1986; O'Hanlon and Weiner-Davis, 1989) beliefs that the possibility of change or rapid change can be viewed in these exercises.

These exercise provided a very concrete way of accessing deep emotional pain and healing both through affirmation and acceptance from the group and through personal tangible action or behaviors. Many women commented upon the power of the exercise in helping them to see that they are not powerless over past or present situations related to anger. ***"I didn't think I could change the way I felt, but... just by saying how I feel and telling myself I am allowed to feel that - its like the wind is out of the big balloon of my feelings - I feel almost ...free"*** Another woman said ***"This was the first time I said some of things out loud and to other people - first big step."***

The underlying premise of The Laurel Centre's Clinical Model of 'creating safety' can be noted in this section by the student / clinician and the co-facilitators encouraging the women to participate as fully as possible. The messages given by the facilitators centered around telling the women that they were worth the effort and energy it required to heal. It appeared that once the participants fully acknowledged 'a' or 'the' significant source of anger in their lives, and received validation in this experience, moving toward making positive change was not difficult. The group facilitators stressed that acknowledging and accepting feelings as they are, allows and often demands positive change within the individual. Each woman in the group was invited to practice using the following sentence to assist in acknowledging and accepting their feelings: ***"I feel _____. It is okay for me to feel _____, and I am going to take care of myself by _____."*** This simple sentence encapsulates the necessity of naming, acknowledging and accepting feelings. It goes a step further and invites one to commit to caring for oneself, and thereby initiates a change process.

The statements made by participants in the groups indicate that they at then end of the sixth group were beginning to make more positive steps in their healing and begin to take their personal power back. Walker (1995) states the following when discussing impacts of child sexual abuse on survivors, and personality disorders.

> Many of their symptoms disappear after supportive therapy that take a feminist and trauma focus, suggesting that these disorders were actually learned coping strategies and not integrated within victims' personalities. (pp. 35)

The response and findings of the Anger in Healing practicum groups concur with Walker that individuals symptoms do disappear after supportive therapy. Many participants stated informally that they were able to identify their feelings of powerlessness, fear, and anger related to their childhood sexual abuse. Several women discussed how they were now able to track their feelings of fear, anger and powerlessness back to the childhood trauma and through their lives as teens, young adults and currently.

Integrating

The third phase of the group entitled "Integrating" (The Laurel Centre, 1998) presented the fourth theme which was that participants were recognizing patterns related to anger. Session seven marked the beginning of the second half of the Anger in Healing group. Each group began with a brainstorm of 'what have we learned so far about anger?' and a second brainstorm of 'what else do we need to feel that this group has been beneficial?' The response to the first brainstorm of what had been learned so far was overwhelmingly positive (see the lists from each group in **Appendix 15)**. One woman responded in her feedback form **"I didn't know how far I had come until I looked back. Thank you".** Another woman said ***"I'm finding a difference between being in my head & in my heart. So it doesn't feel like my awareness is just in my head, it's like the head and heart are making steps together."*** A third woman stated in her feedback form ***"I am learning, learning, learning. I have a renewed hopefulness in my life".***

The student / clinician and co-facilitators had intended to begin using the anger cycle and communication styles in session seven. However, given the

success of the brainstorms it was decided to leave the other material for sessions eight and nine. Not pushing forward with the group agenda and providing time and opportunity to reflect upon the learning of the group is fitting with the feminist theoretical underpinnings of the group. Allowing the group to move in the direction that members collectively want to go, and honoring the women's experiences by not using the power of the group leadership role to overrun the will of the group experience also fit with feminist theory (Burstow, 1992; Herman, 1992; Levine, 1993; Jordan, 1995; Walker, 1998).

The comments made formally as noted above and informally indicate that the women participating in the groups were making linkages between what they were experiencing in the group and their personal lives outside the group regarding their healing. One woman stated ***" I feel like I am finally healing, this group and being with these women have helped me see that the abuse can not hurt me anymore."*** This statement is a clear example of how Herman describes the healing process for survivors of childhood sexual abuse:

> ..The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections - in her renewed connections with other people the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience. These faculties include the basic capacities for trust, autonomy, initiative, competence, identity and intimacy (p. 133)

Participants in the groups were able to make linkages to the origins of some of their feelings (particularly anger and fear) back to their experiences of childhood sexual abuse. Many expressed feeling 'ready' to make changes and not allow the abuse to impact their current or future lives.

Sessions eight and nine were comprised of working with an anger cycle model **(Appendix 10)** developed by the student / clinician within the practicum to assist women in identifying their triggers responses and behaviors related to anger. Of the eleven participants, 7 volunteered to be involved in a group roleplay or representation of a personal anger situation using the cycle. Each woman expressed a new understanding of their anger and, more importantly from the student /clinician's perspective, a beginning awareness that their experiences of anger are more related to their sense of self than to anything else. In nearly every example, when the facilitators asked the participant "so what is that about? what is under that feeling?" the woman's response referred to her sense of self or self concept. This led to a detailed discussion of the essential need for self care both in healing and in living. One woman said ***"More and more I am able to take my space in this group and my life in general. It's a wonderful feeling to have asleep parts of me come alive again."***

Using the anger cycle allowed the facilitators opportunity to work more on an individual basis with participants, while at the same time the group provided support and validation for the women sharing their experiences. The student / clinician and co-facilitators challenged the women sharing their experiences to take full responsibility for 'their part' in the situation they were explaining. The cycle sessions were, from the facilitators point of view an extremely beneficial way to encourage participants to integrate their new knowledge and understanding of anger.

Moving on

The final phase of the group 'Moving on,' encompassed sessions ten, eleven and twelve. The fifth theme which emerged in session ten, was that the participants remarked achieving success towards their goals. This theme came as a surprise to most participants who, upon the initial intake, often did not recognize their anger and were surprised to be able to set goals. Each woman in session ten provided a self 'report card' on their progress with their goals (see examples of goal statements and progress reports in **(Appendix 17)**. The second exercise involved developing a 'Safety Plan' using a specified format **(Appendix 11)** and creating a safety symbol using a creative medium (collage, paints, drawing).

The majority of women were well on their way to achieving success and made revisions to their goal statements to fit with their new understanding and awareness of their anger. One woman commented enthusiastically on her feedback form ***"I did it! Who knew?!!"*** Another woman said, ***"This group has aided me in putting a lot into perspective in my life, I feel a new zest for life and I have a renewed sense of my reality. Thank god for this place and I mean that with all my heart."*** A third woman said ***"It was great to have an opportunity to put everything together and see that I AM doing better ... Thanks!"***

Session eleven's focus was looking forward. Each participant was given the opportunity to share something of their choosing with the group, or to ask the group for feedback or support. The brainstorms provided valuable information for participants in preparing to end the group. A diagram entitled 'The Pit,' a

figurative diagram of how not caring for one's self and not acknowledging feelings can have a profound negative impact **(Appendix 12),** was developed by the student / clinician within the morning group and distributed to both groups. This diagram illustrates how caring for oneself can go a long way to not getting stuck in negative patterns, such as problematic ways of expressing or experiencing anger.

Some of the women responded to the group, saying: ***"The group provided me the safe place I needed to talk, what I shared for the few minutes, has opened one more door for me to explore in my healing".*** Another said ***"This group has not missed a beat, without the sharing exercise there would have been loose ends, closure was very important."*** A third woman wrote ***"This group helped me to find my real words my words, that stand up for me, that are there to protect me, also the group helped me to know that I have the right to feel hurt, the right to feel used, and not to feel it only for a second then store it away, but to feel it, know it, and speak against it in respectful way."***

The final group was a celebration, a lunch at a restaurant for the morning group and a potluck meal for the evening group. The final groups allowed time for each group member to present a personal message to their fellow participants and to share their experiences in the group in both formal intended and informal fashions. The celebration groups encouraged individuals to share their feelings of accomplishment. The student / clinician and the co-facilitators presented each woman with a certificate, a personal message, a flower and a

candle to recognize their accomplishments, their strengths, their spirit and inner light.

Each woman remarked in the final session on how they felt they worked hard and achieved success in healing further from their experiences of childhood sexual abuse. Each of the areas listed as long term effects of childhood sexual abuse: low self esteem, depression, guilt, shame, anxiety, chemical dependency, relational difficulties, lack of assertiveness and self destructive behavior (Bass and Davis, 1983; Binder, McNeil and Goldstone, 1996; Briere, 1996; Chew, 1998; Courtois, 1988; Evans and Sullivan, 1995; Gil, 1988; Herman, 1992; Mines, 1996; & Walker, 1995).

Each of the women in the groups shared personal stories and examples of how they were feeling: better about themselves, feeling less depressed or down. Nearly all the women remarked feeling much less shame and guilt in their lives. Several women proudly shared how they were less anxious in social and personal situations. The two women who identified as using alcohol and marijuana to cope during the intake now stated they had reduced their use. Seven women shared stories of how their personal relationships had improved and how they were more able to be assertive. One woman who identified using self harming behaviors to cope stated she had not harmed herself in the last six group sessions, the other woman who identified as using self harm behaviors did not discuss or comment as to her self harm behaviors.

The Anger in Healing group provided some new information about women's anger in healing from childhood sexual abuse. The group model

presented in this report indicates some apparent success of using a group model with a strong feminist philosophy, narrative and solution focused informed exercises, within a trauma based clinical model addressing anger issues working with women who have experienced childhood sexual abuse.

Feedback from the final session is included in the body of this chapter as the quotations provide valuable insight into the experiences of the Anger in Healing group from the participants perspective. The qualitative feedback form follows the structure of previous weeks in asking about the specific exercises and the facilitation of the group.

Feedback from final session

Each woman commented on their experiences in this group some of the comments were as follows:

1. Do you feel the celebration was a meaningful way to end the Anger in Healing group?

> ***"During most of my life, anger has been a vehicle of separation and disconnection. It was nice to end the group with an expression of connectedness."***
>
> ***"I felt as if I had every right to celebrate because I had worked as hard as I possibly could and I learned."***
>
> ***"Yes I think it was a wonderful, fun idea planned very well. I really liked to celebrate my own accomplishments as well as the other group members. It felt good to share my feelings, I left feeling great. Thanks"***
>
> ***"YAY!"***
>
> ***"Yes, yes, yes lots of closure, lots of sharing, lots of physical reminders."***
>
> ***"It was excellent."***

"Yes because you can close the door properly."

"I was sick, so it was difficult to be as present as I would have liked, very calm joyous time."

"Yes it was a perfect way to celebrate closure!"

2. Do you feel the group was facilitated in a manner which encouraged celebration in a respectful manner?

"Yes - oh yes."

"Definitely, feels very special with the (messages, candles, flowers etc)"

"I feel lucky to be here, felt very respected by the facilitators"

"Sharing was helpful"

"Yes I think so, I felt writing myself a card was helpful in allowing myself to acknowledge my own worth and strengths. Gradually through therapy, etc. I am liking myself."

3. Do you feel that the Anger in Healing group assisted you in setting and fulfilling goals for yourself related to your anger? How?

"My feelings were validated and I could identify the source of my anger and then the age I feel – then deal with it as my adult self."

"The group; and particularly sharing of experiences with anger and fear of anger - have been a catalyst to seeing anger as a healthy reaction to events in my own growth and have given me the courage to re-examine some of the sources and responses to my anger and make them feel more healthy and manageable."

" 1 triggers; 2 feeling valuable; 3 taking up space. How I was destructive and gave me new tools to cope."

"In such a gentle fashion we brain stormed and discussed ways of living with our anger in healthy ways. Because of such gentle safe space provided around our issues I was able to assimilate , absorb and digest peacefully."

"Yes, it helped to find my voice and challenged my catastrophic thinking . It provided me with insight as well as tools."

"I have better goals to follow than before, before I had nothing to go on."

"Yes, I read the information, filled out the anger logs, and was very aware of my anger in different situations. I have found that in incidents which normally could cause me to react in anger, I am much more calm and I don't feel the anger for hours. I have learned that reacting in anger does me no good in some situations. In matters which are more personal, I am working on assertiveness and 'talking / listening."

"The group has shown me, what convincing never could, that how I feel angry is okay. It wont kill anyone, it protects me, and it is respectful not only to me, but to the other person to be able to say 'what you're doing is not okay.' I have the right to not like the people who have hurt me or are trying to hurt me. Those people do not worry about my feelings while they are hurting me."

4. What changes or improvements would you suggest for future groups?

"There are no changes, that I could suggest, the group was run with respect to others and equality within. The facilitators moved the group without owning it, that was the best part."

"I can't think of anything to change."

"More brain storming and sharing time - the creative exercises were helpful but I got the most benefit from discussions."

"Get rid of the forms!"

"I don't know if it is possible but an Anger group II would be helpful."

Practicum Analysis

For the remainder of the practicum report the student / clinician will depart from third person writing in favor of first person. The student clinician will now be referred to as I, me, my etc. This section of the report allows the writer to discuss

the intimate details of the practicum experience from a personal perspective, and to do so in the more personal style of first person feels more respectful to the student / clinician', the co-facilitators and to the wonderful women who took part in the Anger in Healing practicum groups.

As awkward as it felt to write about the 'student clinician' over 100 pages previously, it feels uneasy to switch, and write about 'my' experiences as 'mine'. What I want to express to the reader at this point is my passion for this topic and my commitment to the work we do at The Laurel Centre.

Purpose and Objectives of Practicum

The purpose of the practicum was to develop, implement and evaluate a 12 week group for women survivors of childhood sexual abuse who have issues with compulsive coping behaviors. The objectives for the practicum were threefold:

1. To assist women who have survived childhood sexual abuse to acknowledge and to honor their experiences and expressions of anger in their healing from the abuse.

2. To examine these experiences using a cost / benefit perspective, and provide women the opportunity to choose whether to continue engaging in the same forms of expression of anger or to choose to try on different forms of expression in experiencing their anger.

3. To explore different ways of expressing and experiencing anger that fit with each individual woman's goals in relation to her healing from the child sexual abuse.

Looking at the objectives within the clinical model, the first objective fits in the first phase 'Engaging and Assessing'. Chapter five of the practicum report

outlines how in the first three sessions participants began to acknowledge, accept and honor their experiences and / or expressions of anger.

The second objective is met in the second phase of the clinical model 'Intense Debriefing' in sessions four, five and six. Participants examined experiences, identified patterns, set goals, and began to challenge themselves about their experiences / expression of anger.

The third objective is completed in the third phase of the clinical mode, 'Integrating'. Sessions seven, eight and nine provided opportunities for participants to develop and practice using new skills to communicate feelings particularly anger and to implement their personal goals.

The fourth phase, was not developed into an objective. The intention was not to omit the 'Moving On' phase from the objectives of the practicum, but rather to leave the final phase unpredicted. I did not feel it was appropriate to anticipate the outcome of the group(s) into a formal objective of the practicum.

The objectives of the practicum were satisfied to a higher degree than I had expected. Working with two remarkably skilled co-facilitators, I believe we provided high quality therapeutic group looking at anger in healing from childhood sexual abuse.

Questions to be considered

The main question to be considered in the practicum process was whether the Anger in Healing group assists in helping women to feel that they have met their goals as they define them related to their experiences and / or expressions of anger.

The feedback as presented in chapter five indicates that the Anger in Healing group did help the women involved to meet their personal goals dealing with anger. The women set, evaluated and for the most part achieved the goals they set for themselves and at the end of the group renewed their goals and made commitments to themselves to continue in their healing journey related to anger in healing from childhood sexual abuse.

Learning Goals

The student clinicians personal goals for completing the practicum were as follows:

1. To learn how to implement feminist theory within a group intervention on anger in healing for women survivors of child sexual abuse who are impacted by compulsive coping behaviors.

My confidence in the utility and strength of applying feminist theory (along with other theories, primarily postmodern) to group work has substantially increased. The success of the Anger in Healing groups is in part due to the strength and resolution of the feminist foundation of the group and The Laurel Centre.

I have a stronger grasp of how theory, particularly feminist, can fit with group work and my commitment in applying feminist principles to group work has been held steady, while my confidence to do so has vastly improved. I have added quotations from the participants to support my analysis of the goals.

> ***"I have started to believe I am no longer someone else's mat. That I have every right to exist, and to express myself, even if my words are not someone else's words."***

"The most valuable aspect for me was my own acceptance and respect of other people's differences. Every one of us women are beautiful and we all deserve the best."

"I most valued sharing and experiencing with other women."

2. To develop new and enhance existing skills in group facilitation with a co-therapist, focusing upon balancing structure and flexibility to best meet the needs of the participants.

To say that using a co-therapist model to facilitate the Anger in Healing groups was helpful in my learning, would be a gross understatement. I believe my educational and practical experience in facilitating the groups was immensely improved due to the two highly skilled women I had the good fortune to work with in this process. It is in this area that I believe I had the most learning and it is difficult to articulate the numerous levels of my learning.

My skills in facilitating groups have grown exponentially. I have learned to take a leadership role in a way that does not leave the other facilitator feeling 'led'. I have had the opportunity to negotiate leadership with peers and found that I will more often than not take the 'lead'. I have learned that I am able to seek and provide constructive feedback from / with co-facilitators in the interest of improving the group.

I have developed skills in assessing the needs of individuals within a group and needs of the larger group and made decisions which are honoring of all parties needs. My awareness of group dynamics and roles within groups has improved.

I have learned that I am inclined to both structure and flexibility in my preferred style of facilitation. I had the experience of working with one co-facilitator who is far more comfortable with flexibility than I am, and one who is

more comfortable with structure. I learned to negotiate the group agendas and individual needs with both facilitators, and increased my tolerance with both structure and flexibility.

I am a strong advocate for doing groups with a peer co-facilitator. I believe I learned a great deal more from my co-facilitators than I am able to express at this point and I believe I will continue to reflect upon this experience throughout my career.

I have again added quotations from participants to anchor my discussion of the benefits of using a co-facilitator model

> ***"I liked so much about this group, I'd have to say I liked everything about it, the facilitators were absolutely wonderful and the group was very well done."***

3. To increase understanding of the usefulness of group therapy with adult survivors of child sexual abuse.

My experience in completing the practicum process has renewed my belief in the power and impact that group work can have upon the lives of the individuals involved. Over and over again participants shared that they had been able to make changes, that for periods of at times years they were unable to make in individual therapy. Participants comments and feedback allow me to feel validated in my resolve of the usefulness of group therapy.

Participants offered the following feedback which is appropriate in understanding the usefulness of group therapy with adult survivors of child sexual abuse.

> ***"The group in general helped me immensely, discovering who I am at a deeper level and looking at the person I am discovering inside."***
>
> ***"The group gave me a lot of strength to keep going and keep healing."***

"Being in group increased my understanding and awareness to what I need for me - acceptance, gentleness and kindness to treasure who and what I am - to honor where I came from and where I am going."

4. To increase understanding of the role of anger in healing for women survivors of child sexual abuse.

The group has opened the eyes of the participants as well as facilitators to the role that anger plays in the lives of survivors of childhood sexual abuse. Child sexual abuse, anger and self concept are linked. Recognizing and valuing feelings including anger, sources or anger and coping strategies are all steps toward healing.

Many participants commented informally on the benefits of the group in understanding the role of anger in their lives, following are two formal quotations taken from the qualitative feedback forms.

"Before group, even in the beginning of group, I hated anger, I didn't want to deal with it. I wanted to pretend it didn't exist. Now I believe I have every right to my anger, which I now know is just a part of my feelings."

"The group helped me to realize some of my anger was at myself I am now able to begin to let it go. In letting go of this anger and acknowledging my other anger issues I can treat myself better, and with more care - I am worth it!"

5. How to gather and analyze research data.

I have a better understanding of how to gather and analyze research data. I have a new commitment to completing statistical feedback tests and completing survey forms, and view such activities as more important than I would have prior to completing my practicum. As a clinician, and not a researcher, my skills lie in implementing, rather than evaluating programming. I

am however passionately committed to providing the highest quality service possible to clients and I feel that social work clinicians have a responsibility to evaluate their practice and the only way to do so is through conducting some form of research.

6. How to implement a single system research design into clinical practice.

My learning of how to apply single system research designs to clinical practice has increased. However, I am not confident in my ability to successfully carry out further research without the assistance of an authority on research or data analysis.

7. How to blend quantitative and qualitative research methods and designs.

While my understanding of how to blend quantitative and qualitative research methods has improved, further experience in conducting research formally or informally will increase my comfort and skill in applying research methods to clinical case work.

Personal Impact

The practicum objectives and goals were met. However, the greatest learning for me in this practicum has been mirrored in many of the participants. I have learned that I am able to challenge myself beyond what I had perceived to be my limitations, that I am stronger than I ever knew, and I am worthy of respect, care and acceptance. My long held passionate belief that ***'there is always a way!'*** has been recharged.

Bearing witness to the sharing and growth of the eleven wonderful women involved in the Anger in Healing group, has been an honor. I feel so fortunate

that I am able to hold their stories in the memory of my heart, and the summation of this collective experience (this report) in my hands. I will be forever touched by the strength, tenacity and perseverance against overwhelming odds, displayed by the courageous women involved in the Anger in Healing groups.

Recommendations

My recommendations are presented to address micro, mezzo and macro concerns related to the Anger in Healing group and to the issues of women's anger and child sexual abuse.

From a micro level, I would recommend the following for clinicians wishing to implement this group format:

- Allow for three full hours for each group session
- Require participants to complete homework, journals and readings between group sessions
- Encourage participants to commit to themselves and their healing by not involving themselves in other group work or emotionally challenging experiences during the group process
- Insist that group members practice self care and develop support networks

I would recommend decreasing the use of standardized measures in group sessions, the only negative feedback we received in the practicum was regarding the weekly standardized measures. This however, is difficult to recommend as there is a great need for research on women's issues and anger in particular. I intentionally reframed the standardized measures stating that their involvement in this practicum may at some point lead to further programming for women. I discussed with the women the fact that for so many years women

have been under represented in statistical research and urged them to avail themselves to researchers when possible to help to adjust the 'male as norm' bias of our current experience.

On a mezzo level I recommend that agencies such as The Laurel Centre and other service providers to women impacted by child sexual abuse work together and provide awareness training regarding prevention of abuse of children. I would recommend that teaching and modeling about feelings, emotions, relationships and personal safety be at the core of curriculum focus throughout the education process beginning in pre-school and extending to post graduate levels of education.

I would recommend that all levels of government work to address issues of family violence and abuse of children with proactive programing aimed at increasing the level of safety and well being for all members of societies. Funding for programs such as The Laurel Centre providing counseling for women impacted by sexual abuse should be increased to allow staffing to meet the need in each community.

On a macro level we need, as a society, to examine and struggle against the social and political structures which create and maintain the current realities where children and women do not have equal access to power, creating environments which allow continued abuse(s).

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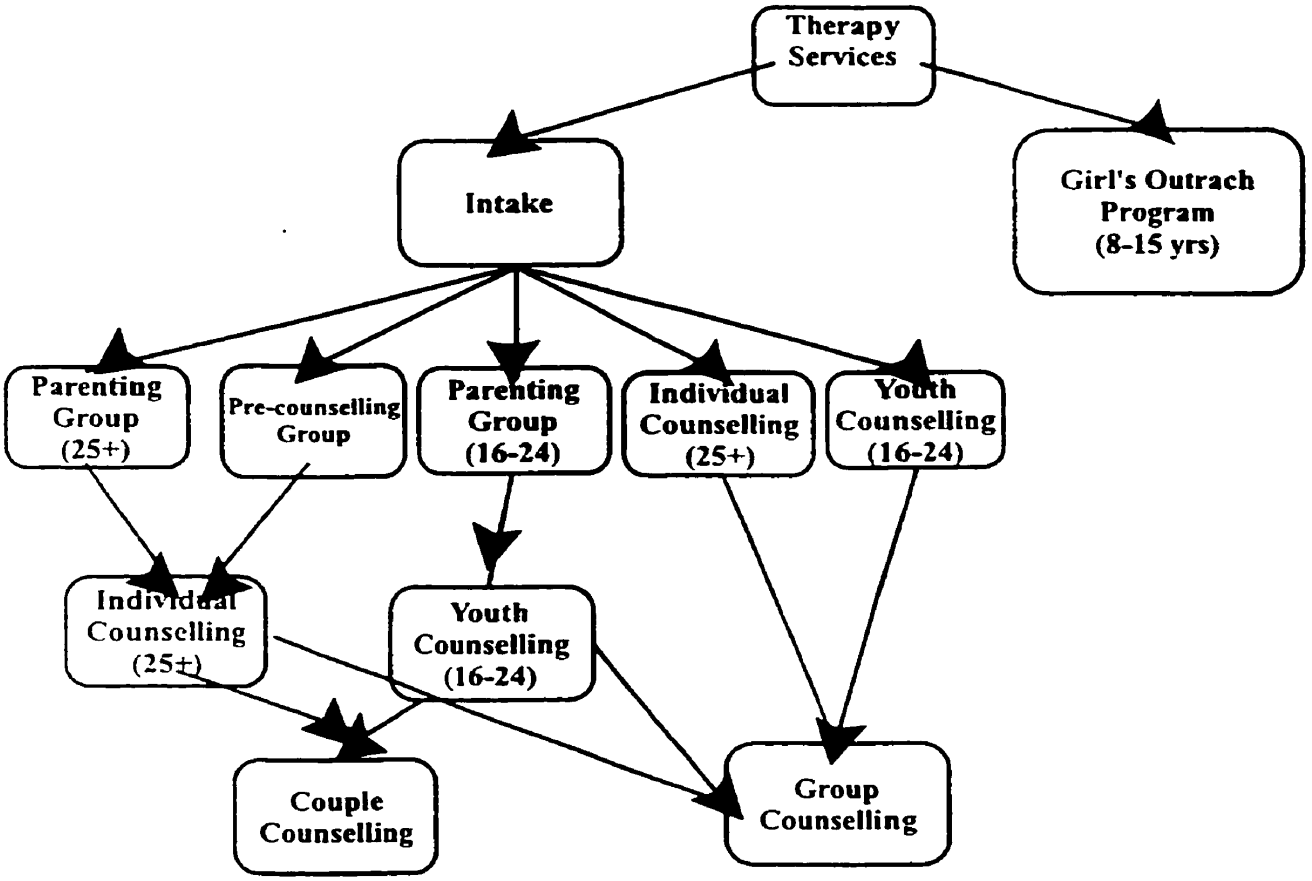
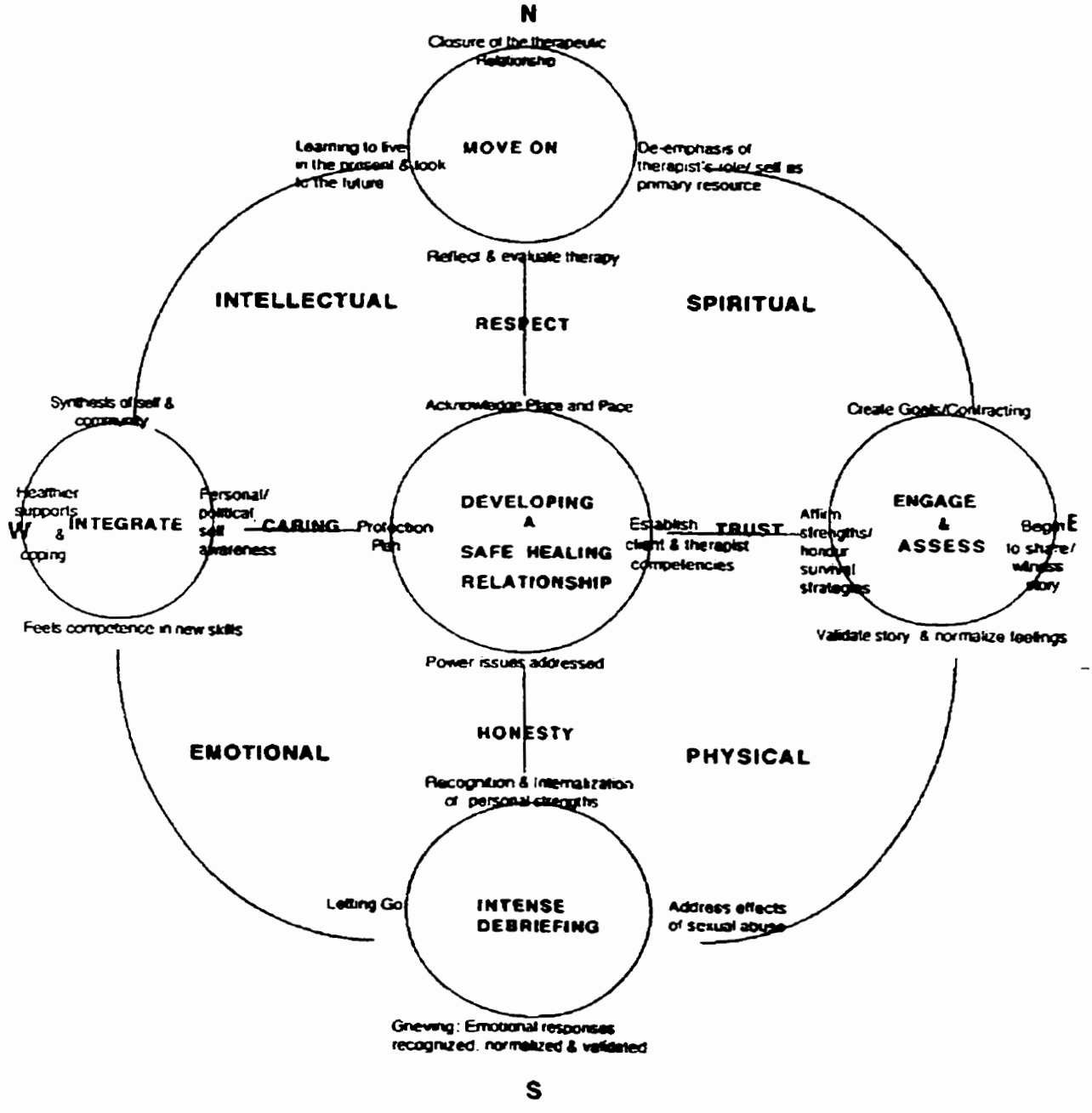
THERAPY PROGRAM CHART



THE LAUREL CENTRE CLINICAL STATEMENT



GENERALIZED CONTENTMENT SCALE (GCS)

AUTHOR: Walter Hudson

PURPOSE: To measure nonpsychotic depression.

DESCRIPTION: The GCS is a 25-item scale that is designed to measure the degree, severity, or magnitude of nonpsychotic depression. In contrast to many measures of depression, the GCS focuses largely on affective aspects of clinical depression, examining respondents' feelings about a number of behaviors, attitudes, and events associated with depression. A particular advantage of the GCS is a cutting score of 30 (± 5), with scores above 30 indicating that the respondent has a clinically significant problem and scores below 30 indicating the individual has no such problem. Another advantage of the GCS is that it is one of nine scales of the Clinical Measurement Package (Hudson, 1982) reproduced here, all of which are administered and scored the same way.

NORMS: This scale was developed with 2140 respondents, including single and married individuals, clinical and nonclinical populations, high school and college students and nonstudents. Respondents were primarily Caucasian, but also included Japanese and Chinese Americans, and a smaller number of members of other ethnic groups. The GCS is not recommended for use with children under the age of 12.

SCORING: The GCS is scored by first reverse-scoring the items listed at the bottom of the scale (5, 8, 9, 11, 12, 13, 15, 16, 21, 22, 23, 24), totaling these and the other item scores, and subtracting 25. This gives a range of 0 to 100 with higher scores indicating more depression. For scoring questionnaires with missing items, see Hudson (1982) or instructions for scoring the Index of Family Relations in this book.

RELIABILITY: The GCS has a mean alpha of .92, indicating excellent internal consistency, and an excellent (low) S.E.M. of 4.56. The GCS also has excellent stability with a two-hour test-retest correlation of .94.

VALIDITY: The GCS has good concurrent validity, correlating in two studies .85 and .76 with the Beck Depression Inventory and .92 and .81 for two samples using the Zung Depression Inventory. The GCS has excellent known-groups validity, discriminating significantly between members of a group judged to be clinically depressed and those judged not to be depressed. The GCS also has good construct validity, correlating poorly with a number of measures with which it should not correlate, and correlating at high levels with several measures with which it should, such as self-esteem, happiness, and sense of identity.

PRIMARY REFERENCE: Hudson, W. W. (1982). *The Clinical Measurement Package: A Field Manual*. Chicago: Dorsey. Instrument reproduced with permission of Walter W. Hudson and the Dorsey Press.

AVAILABILITY: The Dorsey Press, 242 South Michigan Avenue, Suite 440, Chicago, IL 60604.

GCS

This questionnaire is designed to measure the degree of 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
2 = A little of the time
3 = Some of the time
4 = Good part of the time
5 = Most or all 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 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.
___ 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.

5,8,9,11,12,13,15,16,21,22,23,24

BAKKER ASSERTIVENESS–AGGRESSIVENESS INVENTORY (AS–AGI)

AUTHORS: Cornelis B. Bakker, Marianne K. Bakker-Rabdau, and Saul Breit

PURPOSE: To measure two dimensions of assertion.

DESCRIPTION: This 36-item inventory measures assertiveness in terms of two components necessary for social functioning: the ability to refuse unreasonable requests ("assertiveness" AS), and the ability to take the initiative, make requests, or ask for favors ("aggressiveness" AG). Aggressiveness is different from hostility. It tends to relate more to being responsible and taking the initiative in social situations. The two instruments can also be used separately as 18-item measures.

NORMS: Normative data are available from seven different samples. From a sample of 250 college students, males had average AS and AG scores of 48.83 and 51.07, respectively, while female scores were 47.69 for the AS and 52.37 for the AG. A sample of 17 male city employee supervisors, with an average age of 40.1 with a standard deviation of 6.3 years, had AS scores of 43.85 and 47.88 for the AG. From a sample of students seeking assertiveness training the average AS and AG scores were 55.0 and 58.67 respectively, for males and 54.85 and 58.60 for females; the average ages of these males and females were 39.0 and 43.4, respectively. Additional normative data on nurses, X-Ray technicians and employees of a city water department are reported in the primary reference.

SCORING: Each item is rated on a 5-point scale from "almost always" to "almost never" according to the likelihood the respondent would behave in the specified manner. Each scale is scored separately. Those items with a plus sign before the alternative are reverse-scored as follows: 1 becomes 5, 2 becomes 4, 4 becomes 2, and 5 becomes 1. The item responses for each scale are summed with a range from 18 to 90. Higher scores indicate that the individual is [redacted] likely to exhibit assertiveness or aggressiveness. more

RELIABILITY: These scales have been shown to be fairly reliable in terms of internal consistency and test-retest reliability. Internal consistency was estimated from a split-half procedure and was .73 for the AS scale and .80 for AG scale. Test-retest correlations were .75 for the AS and .88 for AG over a six-week period.

VALIDITY: Items analysis of all 36 items indicated that scores on each correlated highly with the score on the scale of which it is a part. Research on known-groups validity indicated that both scales discriminated between a client and college sample. The scales are sensitive to measuring change as AS and AG scores changed subsequent to assertiveness training.

PRIMARY REFERENCE: Bakker, C. B., Bakker-Rabdau, M. K., and Breit, S. (1978). The measurement of assertiveness and aggressiveness. *Journal of Personality Assessment* 42, 277–284. Instrument reproduced with permission of C. B. Bakker and the *Journal of Personality Assessment*.

AVAILABILITY: C. B. Bakker, M.D., Department of Psychiatry, Adult Development Program, Sacred Heart Medical Center, West 101 Eight Avenue, Spokane, WA 99220.

AS-AGI

Below are several different situations. Each is followed by one way of responding. Your task is to read each question and indicate how likely you are to respond in that way, according to the following scale:

1 = Almost always
2 = Frequently
3 = Occasionally
4 = Sometimes
5 = Almost never

Record your answers in the space to the left of each item.

AS Items

___ 1. You have set aside the evening to get some necessary work done. Just as you get started some friends drop over for a social visit.
- You welcome them in and postpone what you had planned to do.

___ 2. You are standing in line when someone pushes ahead of you.
+ You tell the person to get back in line behind you.

___ 3. A friend or relative asks to borrow your car or other valuable property but you would prefer not to lend it to them.
- You lend it to them anyway.

___ 4. A person who has kept you waiting before is late again for an appointment.
- You ignore it and act as if nothing has happened.

___ 5. Someone has, in your opinion, treated you unfairly or incorrectly.
+ You confront the person directly concerning this.

___ 6. Friends or neighbors fail to return some items they have borrowed from you.
+ You keep after them until they return them.

___ 7. Others put pressure on you to drink, smoke pot, take drugs, or eat too much.
+ You refuse to yield to their pressure.

___ 8. Another person interrupts you while you are speaking.
- You wait until the other is finished speaking before you go on with your story.

___ 9. You are asked to carry out a task that you do not feel like doing.
+ You tell the other that you don't want to do it.

___ 10. Your sexual partner has done something that you do not like.
- You act as if nothing bothersome has happened.

___ 11. A salesperson has spent a great deal of time showing you merchandise but none of it is exactly what you want.
- You buy something anyway.

___ 12. You are invited to a party or other social event, which you would rather not attend.
- You accept the invitation.

___ 13. In a concert or a movie theater a couple next to you distracts you with their conversation.
+ You ask them to be quiet or move somewhere else.

___ 14. In a restaurant you receive food that is poorly prepared.
+ You ask the waiter or waitress to replace it.

___ 15. You receive incorrect or damaged merchandise from a store.
+ You return the merchandise.

___ 16. A person who seems a lot worse-off than you asks you for something you could easily do without but you don't like to.
- You give the person what he/she asks for.

___ 17. Someone gives you -- unasked for -- a negative appraisal of your behavior.
+ You tell the other you are not interested.

___ 18. Friends or parents try to get information from you that you consider personal.
- You give them the information they want.

AG Items

___ 19. You have been appointed to a newly formed committee.
+ You take a leadership role.

___ 20. You are in a bus or plane sitting next to a person you have never met.
+ You strike up a conversation.

___ 21. You are a guest in a home of a new acquaintance. The dinner was so good you would like a second helping.
+ You go ahead and take a second helping.

___ 22. You are being interviewed for a job you really want to get.
- You undersell yourself.

___ 23. You are meeting or greeting several people.
+ You make physical contact with each other in turn either by hugging, putting an arm around their shoulders, or slapping their backs.

___ 24. You have observed that someone has done an excellent job at something.
- You don't tell that person about it.

___ 25. In a store or restaurant the personnel are very busy and many customers seem to be waiting a long time for service.
+ You manage to get service ahead of other customers.

___ 26. You observe someone behave in a suspicious manner.
- You don't do anything because it is none of your business.

___ 27. You have parked your car but notice that you do not have the correct change for the parking meter.
+ You ask a passer-by for the change.

___ 28. Someone has done or said something that arouses your curiosity.
- You refrain from asking questions.

29. You have observed certain behaviors of a friend or acquaintance that you think need to be changed.
    + You tell the other person about this as soon as possible.
30. You would like to get a raise but your boss has said nothing about it.
    - You wait for your boss to bring the matter up.
31. During a social visit with a group of friends everyone participates actively in the conversation
    + You dominate the conversation most of the time.
32. During a discussion you believe that you have something worthwhile to contribute.
    + You don't bother to state it unless the others ask you to give your opinion.
33. You have an opportunity to participate in a lively, no-holds barred debate.
    - You remain a listener rather than participate.
34. You want a favor done by a person you do not know too well.
    - You prefer to do without rather than ask that person.
35. You have moved into a new neighborhood or started a new job and you would like to make social contacts.
    - You prefer to do without rather than ask that person.
36. You see an opportunity to get ahead but know it will take a great deal of energy.
    + You take the opportunity and forge ahead.

ANGER AND HEALING GROUP

UNDERSTANDING WOMEN'S ANGER IN HEALING FROM CHILDHOOD SEXUAL ABUSE

Intake Form

1. What does anger mean to you?

2. How do you cope with your anger once you have begun to experience it? Have you changed or attempted to change the way that you cope with your anger in the past? If so, how did you experience the change?

3. How do you express your anger?

4. Are you aware of what triggers your anger?

5. What would you like to get from this group? What feelings do you have coming in to the group (apprehension, excitement, fear)? Is there anything we can do as facilitators to make beginning the group more comfortable for you?

6. Have you had previous group experiences?

    a. What was that like for you?
    b. What did you like / not like about the experience(s)?
    c. How did you act in the group - talkative, quiet ?

7. How will you feel about being in a diverse group in which people may be very different from you (age, race, class, sexual orientation, etc)?

8. What types of things might get in the way of you coming to group or completing group? (health issues, child care, transportation, other)

9. Do you have any questions or concerns that you would like to discuss?

ANGER IN HEALING GROUP

CONSENT FOR RECORDING GROUP SESSIONS

I _____, give permission to _____
(Client's Name) (Counselor's Name)

of the Laurel Centre to video the group sessions including the intake sessions of the 'Anger in Healing' group.

I understand that the 'Anger in Healing' group is the practicum component of one of the co-facilitators Sheila Sauteur's Masters of Social Work degree.

I understand that my participation and statistical information from the group will be used in the final written practicum report.

I understand that I will not be identified by name in the practicum report and that any identifying information will be modified to protect my confidentiality.

I understand that the video tapes will be evaluated only for the facilitators effectiveness and learning goals related to group facilitation.

I understand that the group session tapes may be evaluated by the facilitators of the group and or the 3 member practicum committee and will be erased at the end of the 12 week group.

Signed _____

Date _____

Witness _____

Feel free to contact Professor Kathy Levine at the University of Manitoba Faculty of Social Work 474 7050 should you have any questions or concerns about being involved in the group and or practicum experience.

Group #1 Outline

Welcome! forms please

Introduction of facilitators

review of group outline

hand out information

Check-In and introductions
- Please share something about yourself
- and/or your hopes for the group

Discussion of group format
- Safety and structure
- Establish group norms/rules

BREAK

Breathing exercise - muscle awareness and breathing

Introduce Anger Journals
- Complete Anger Study forms

Discussion of self-care
- Emotional Protection Plan

*Sharing

Check-out
- Discuss self-care and sensory baskets

Feedback forms

Group #2 Outline (morning)

Welcome! forms please

Check-in - share your name and
what you are bringing to group today

Breathing exercise and reading - just for today

Left overs

Brain storm - discussion
- What is anger?
- How are we releasing anger?
- What do we need to release anger?

BREAK

Energizer - bubble blowing

Handouts and discussion
Feeling that go with anger
(Ice berg and car)

*Sharing

Homework for next week
- Fear of anger
- Sensual experience
- Anger journals

Check-out
- What are you taking from group today?
- Are you safe?

Feedback forms

Group #2 Outline (evening)

Welcome! Forms please

Check-in - share your name and
what you are bringing to group today

Breathing exercise and Reading just for today

Left overs

Brain storm - discussion
- What is anger?
- How are we releasing anger?
- What do we need to release anger?

BREAK

Energizer

Handouts and discussion
Feeling that go with anger
(Ice berg and car)

Exercise - create your own image that
reflects how you experience your anger
and what feelings go along with it.

*Sharing

Homework for next week
- Fear of anger
- Sensual experience
- Anger journals

Check-out
- What are you taking from group today?
- Are you safe?

Feedback forms

Group #3 outline

Welcome! Forms please

Check-in
- What are you bringing to group today?

Breathing exercise - centering
- Reading - just for today variation

Left overs (not homework)

Round
- Sharing on 'fears about anger' homework

Brainstorm
- What are our fears about anger or expressing anger

Break

Energizer

Handouts and brief discussion about fears

Creative exercise
- express on one side of particle board what your fears of anger look like and on the other side express what it would look like without the fears

*Sharing

Homework

Breathing

Check-out
- What are you taking from group today?
- Are you safe?

Feedback forms

Group #4 outline

Welcome! Forms please

Check-in

How are you feeling about your participation in the group?

Breathing exercise/ Reading

Left overs (not homework)

Round - homework

Brainstorm

What did we learn as children about anger?
What are children's needs?
What do children need to learn about anger - others and there own?

Break

Energizer

Creative exercise - clay experience

a- Representation of what you learned about/from anger as a child
b- Representation of hopes for yourself and healing - integrating anger?

*Sharing

Homework

Breathing / Check-out

- What are you taking from group today?
- Are you safe?

Feedback forms

Group #5 outline

Welcome! Forms please

Check-in

Take a moment to go inside your body - listen and bring your awareness to what it may want to communicate.

Breathing exercise/ Reading

Left overs and homework- re: goals

10 min. Opportunity to complete homework if needed.

Round - homework

Brainstorm

- Sources of anger
- Where do we hold anger in our bodies?

Break

Energizer

Creative exercise

Identify on the body form how you experience/express anger within your body - Are there locations for fear? Family anger?
(Try to identify if the source influences body experience)

*Sharing

Homework - prepare an anger journal (new or one from before) and present to the group next day

Check-out

How will you honor your bodies (how they experience/express anger)
Are you safe?

Feedback forms

Group # 6 outline

Welcome! Forms Please

Check in - What are you bringing to group tonight

Breathing and Reading

Left overs - Present Anger Journals

Writing exercise

- Spend a few moments connecting with a significant source of anger for you. Express in words (picture if you wish) Naming the source - Who or what you are angry at. Carefully note the impact of the source on you - What has that (person/event/experience) meant to you - What have the consequences been for you.

Sharing

Breathing

Break

Energizer - re-focus

Exercise

Spend a few moments checking in with yourself - What do you need to make the first step towards not allowing the person/event/experience you discussed to hold so much power in your life? What is a step today? What is the next step?

*Sharing

Homework

Check-out

- Are you safe?
- How can you gently close the painful experiences/memories opened today to re-enter your life?
- How will you care for yourself today/tonight

Feedback forms

Group #7 outline

Welcome! Forms please

Check in -

Breathing / Reading - perseverance

Leftovers - Review what we have discovered about our anger and ourselves?

Presentation and Discussion of different styles of anger
Aggressive - Passive(often misdirected) - Passive Aggressive - Assertive

BREAK

Energizer

Written exercise:

Review your journals and your experience(s) re: anger

1. How are you expressing anger
2. Review your goals
3. How would you like things to be different?

Take a few minutes to re write or author your experience of anger so that it fits with your goals for your expression or experience of anger

* Note the ways you are moving toward your re-written scenario

Sharing

Discussion of what participants feel they need or would like to have in the coming sessions so that the group feels like a success or a more helpful experience for them

Homework -- stress journals - focus upon goals and self care -- readings releasing anger

Check out - What are you taking from tonights group with regard to your goals and expressing anger? Are you safe?

Feedback forms

Group #8 outline

Welcome! Forms please

Check in - Briefly describe yourself as an animal

Breathing / Reading - 10 rules for being human

Leftovers
- Brainstorm "what do we need from the remainder of group?"
- Homework - Positive releases of anger
- Brainstorm ideas for final group

Discussion of present anger and linkages to past experiences
- Anger cycles
- Using examples from group members

BREAK

Energizer

Creative Exercise
- Using index cards create reminders of ways you are already releasing anger and ways you can start to release anger - personalize and decorate the cards.
- ex. "BREATH"
  "What is this really about?"
  "I feel_____, it's okay to feel_____.

Sharing

Homework
- Reading on assertiveness and communication
- Be watchful for patterns
- Journals and growth toward goals

Check out -
What are you taking from tonights group?
Are you safe?

Feedback forms

Group #9 outline

Welcome! Forms please

Check in - Briefly describe yourself as an Appliance and why?

Breathing / Reading -

Leftovers
- Homework - assertive communication

Discussion of communication styles (assertive, passive, aggressive, passive-aggressive)
- How do we identify are primary communication style?
- Is it different depending on who we are talking to?

BREAK

Energizer

Role Plays

- Role plays on how to handle an anger trigger using the communication style you would like to use

Sharing

Homework

- Review goals and consider progress

Check out
- What are you taking from tonights group?
  Are you safe?

Feedback forms

Group #10 Outline

Welcome! Forms please

Check-In

If you had to describe yourself as a super hero who would you be? Why?

Breathing/ Reading

Left Overs

Plan session 12

Share progress on goals - 10 minute opportunity to complete goal homework if needed

Exercise

Complete 'Safety Plan' for your anger

- make as concrete/real as possible - incorporate goals and affirmations.
- Outline step by step plan: Intellectual; Physical; Emotional; Spiritual

Sharing 'Safety Plan'

Break

Energizer

Creative Exercise

- Create a symbol for yourself that represents safety - represent that symbol using paint, clay, collaging, or creating a music safety plan.
- Keep the symbol and the 'Safety Plan' together

Sharing

Homework

Plan for yourself how you would like to spend your sharing time
(role plays, anger expression, naming sources of anger, asking for feedback)

Check Out

Are you safe to leave?

How will you care for yourself this coming week?

Feedback forms

Group # 11 Outline

Welcome! Forms please

Check in

Create a name for yourself that expresses your very favorite part of yourself

Breathing exercise / Reading

Leftovers

Round on sharing insights that have come up over past few days related to safety for you

AM - Share creative symbol

10 minute opportunity to gather thoughts on what each participant would like to share with or ask for from the group as a way of pulling the group experience together

Sharing

Break

Energizer

Looking Ahead

Brainstorm: What to do on Thursdays now that group is ending?
How will you maintain gains made for yourself

How will you know if you need to revisit some issues or feelings related to anger? How will you do that?

Future Self Visualization

Homework

Finalize celebration plans
Schedule follow up group
** Remember messages to other group members homework **
** Prepare to present or discuss a symbol or a detailed plan for 'self celebration' to share with the group **

Check out

Forms

CELEBRATION !!!!

Group # 12 Outline

Welcome! **Forms Please**

Check in

Feast Time

Round Sharing Self Celebration

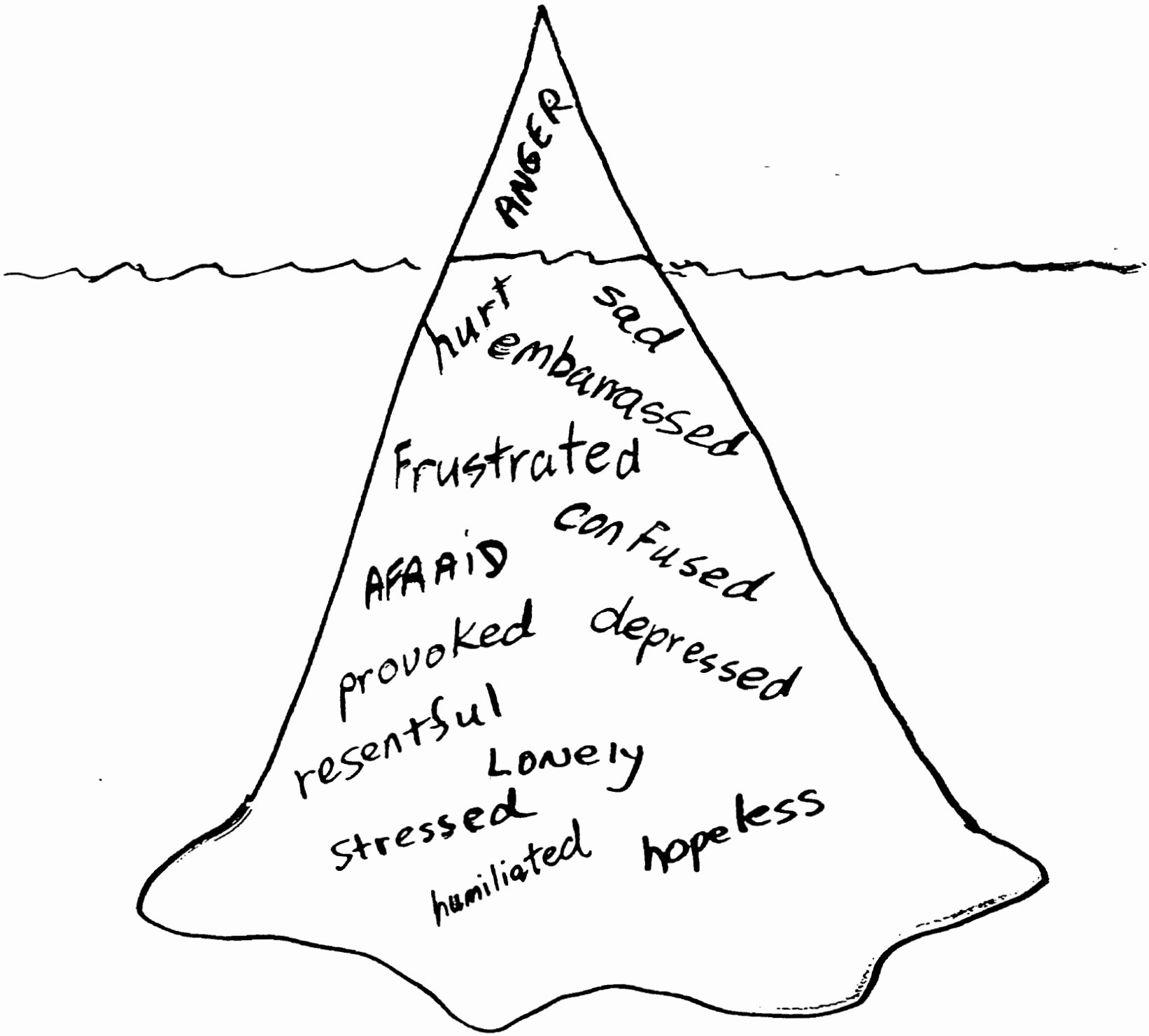
Break

Present Messages to group members

Candle ritual - light a candle and share a hope for yourself

> Take the candle and each day or evening light the candle and share a wish with yourself as you blow it out imagine the energy entering the universe for you

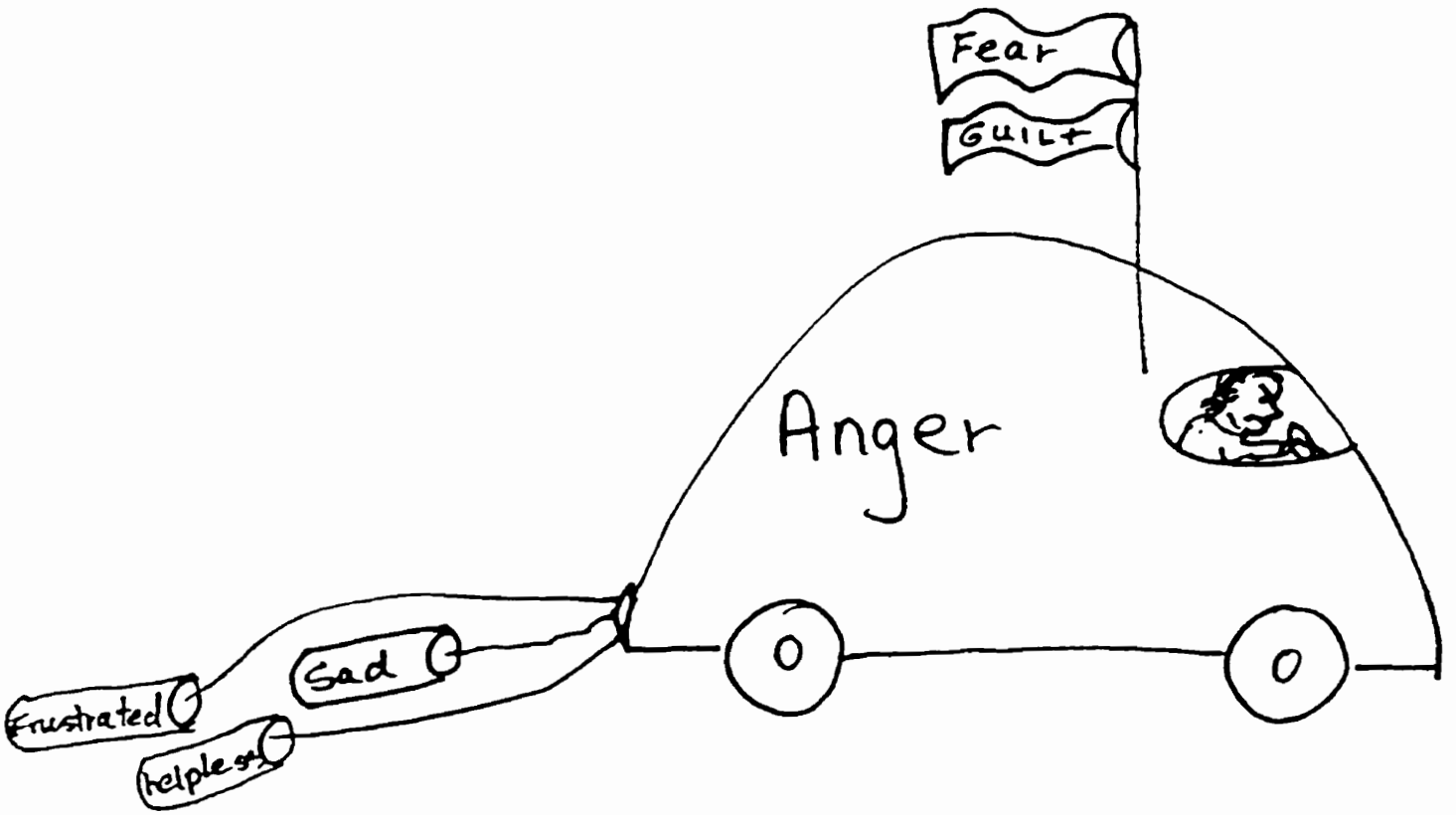
Present Certificates and hopes from the group facilitators



ICEBERG

ɛmily Marchessault M S W . R S W
ɾger Management Program

Anger Never Rides Alone



Merrily Marchessault M.S.W., R S W
Anger Management Program

Goals for the Anger in Healing Group

My Personal Goal(s) for completing the Anger in Healing group is / are:

I intend to work at achieving this / these goal(s) by:

I will know I am on my way to achieving this / these goals when:

Other people will notice when:

I intend to hold myself accountable to working at this / these goals by:

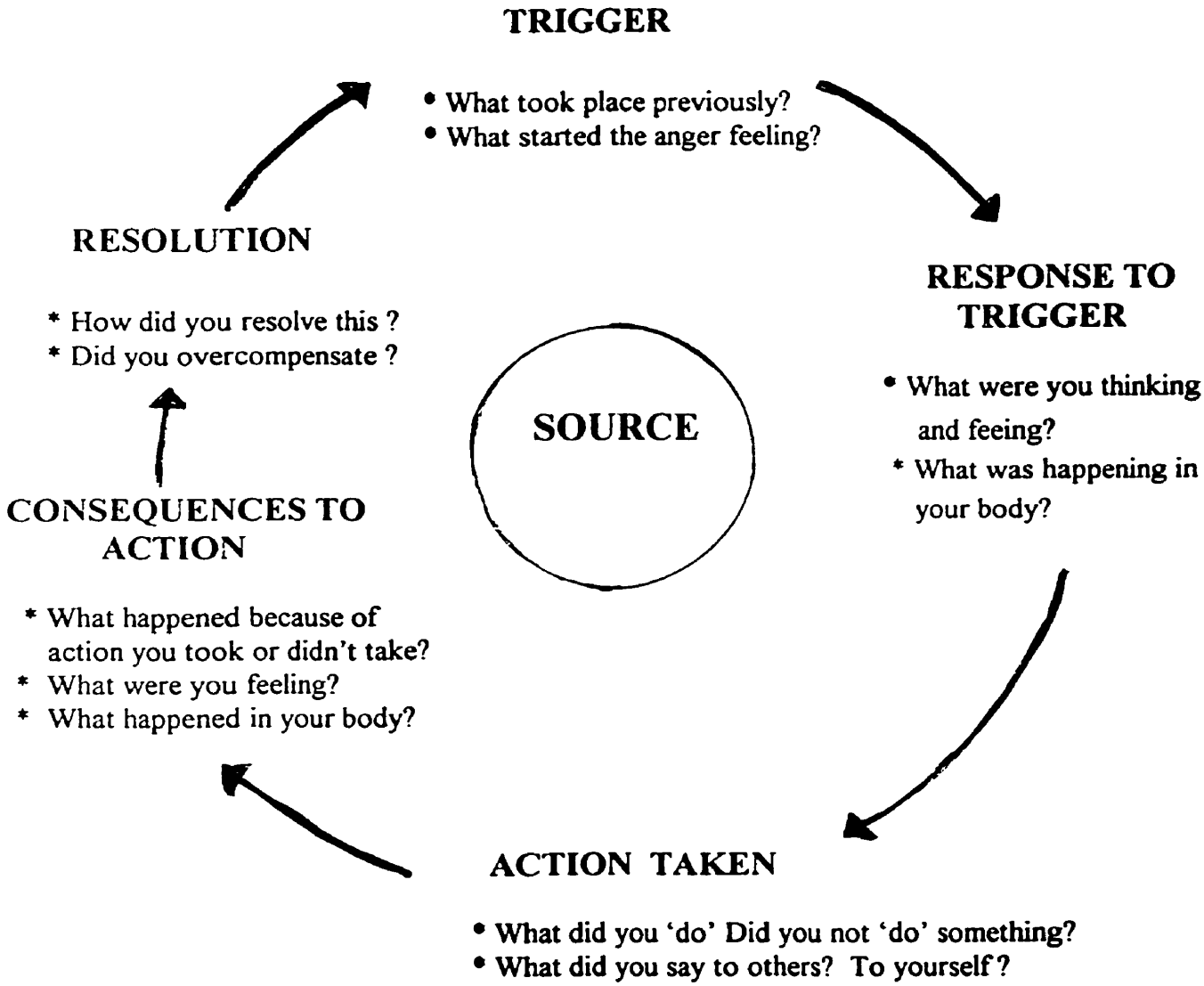
I will celebrate my efforts and my success (as I define it for myself) by:

I am worthy of the effort to work at and achieve my goals in this and all areas of my life!!

YAY FOR ME !!!

Signed _____

ANGER CYCLE



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EXPLORE THE SOURCE OF YOUR ANGER?

* Beyond the 'trigger' can you identify the underlying source?
* What is this really about it?
* What can you do differently? What is a 'choice / change' point? How would the cycle change if you made a change in one point of the cycle?
* HOW IS THIS PATTERN WORKING FOR ME?

Sheila Sauteur, (2000)

SAFETY PLAN FOR ANGER

Please complete as fully and concretely as possible - it is important that you make the steps clear in order to enable yourself to follow the plan and stay 'safe'

WHAT DOES SAFETY MEAN TO ME?

PHYSICALLY...

EMOTIONALLY...

INTELLECTUALLY...

SPIRITUALLY...

1. What do I need in order to feel some level of safety in my anger?

2. How can I meet this need for myself in a pro active way (before feeling anger or fear of anger)?

3. What can I do *specifically* to regain a feeling of safety or relative safety once I have began to feel anger or fear related to feeling anger or being exposed to anger?

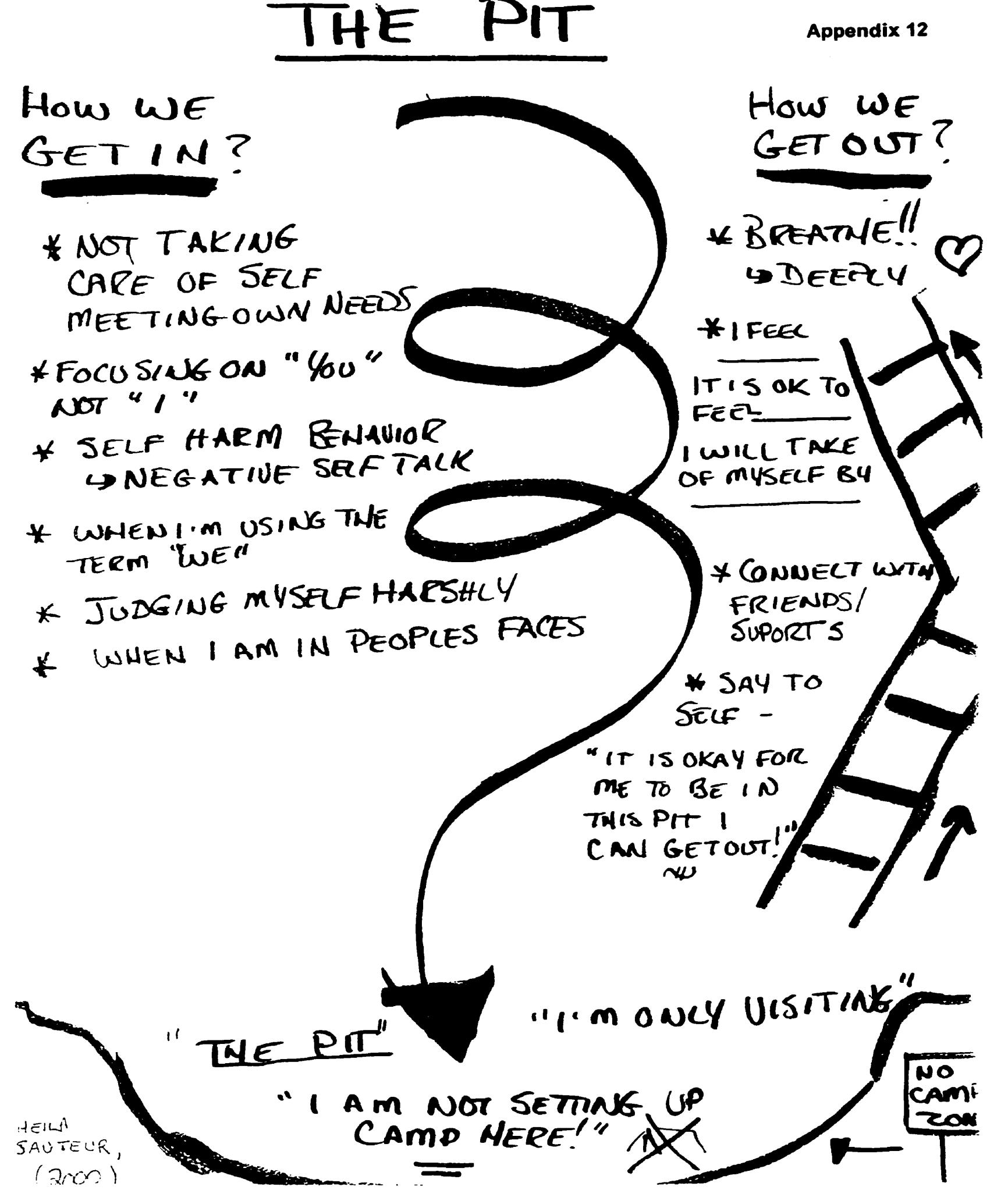
4. What small changes can I make to adapt my current situation and create more safety in my life - particularly related to my anger? What is the order of the small changes?

5. How will this 'Safety Plan' assist me in my life?

6. How will I implement the 'Safety Plan'?

DATE _____ SIGNATURE _____

THE PIT


How WE GET IN?
* NOT TAKING CARE OF SELF MEETING OWN NEEDS
* FOCUSING ON "YOU" NOT "I"
* SELF HARM BEHAVIOR
↳ NEGATIVE SELF TALK
* WHEN I'M USING THE TERM "WE"
* JUDGING MYSELF HARSHLY
* WHEN I AM IN PEOPLES FACES
How WE GET OUT?
* BREATHE!! ♡
↳ DEEPLY
* I FEEL _____
IT IS OK TO FEEL _____
I WILL TAKE OF MYSELF BY _____
* CONNECT WITH FRIENDS/ SUPORTS
* SAY TO SELF -
"IT IS OKAY FOR ME TO BE IN THIS PIT I CAN GET OUT!"
"I'M ONLY VISITING"
"THE PIT"
"I AM NOT SETTING UP CAMP HERE!"
NO CAMP ZON
HEIDI SAUTEUR, (2000)

Anger in Healing Group

FEEDBACK AND EVALUATION
SESSION 11

Please complete and return to the group facilitator before leaving the group
Using a scale of 1- 5 (1 definitely no, 5 absolutely yes)
Please rate the following:

1. Did you feel the group facilitated a discussion and environement which supported you in exploring and expressing feelings about **pulling the group together and looking ahead** as group is ending?

1 2 3 4 5

Comments _____
_____

2. Do you feel the **'Sharing opportunity'** was a helpful exercise in drawing the group to a close? Please comment on your answer

1 2 3 4 5

Comments _____
_____

3. On a scale of 1-5 how would you rate the group in helping you draw the group to a close and look ahead in your life and healing. Please comment

1 2 3 4 5

Comments _____
_____

4. Do you have any further comments or questions?

_____
_____

Anger in Healing Group

FEEDBACK AND EVALUATION OF SESSION 6

Please complete and return to the group facilitator before leaving the group

Using a scale of 1- 5 (1 definitely no, 5 absolutely yes)
Please rate the following:

1. Did you feel the group facilitated a discussion and environement which supported you in exploring and expressing - naming who and what you are angry with

1 2 3 4 5

Comments _____
_____

2. Are you comfortable with, the style and format in which the group was presented?

1 2 3 4 5

Comments _____
_____

3. Do you feel the creative exercise(s) are helpful in assisting you to express yourself or enhance your experience in the group? Please comment

1 2 3 4 5

Comments _____
_____

4. Do you have any further comments or questions?

_____
_____
_____

Group Feed Back Form - The Laurel Centre

Date _____.

1. Did you attend group? ☐Yes ☐No

(If yes please complete the following) Circle the number that is most true for you.

	Not at all				somewhat					Very
2. Overall, how useful was the group to you?	1	2	3	4	5	6	7	8	9	10
3. Were your expectations met?	1	2	3	4	5	6	7	8	9	10
4. Did you feel safe in group?	1	2	3	4	5	6	7	8	9	10

5. Did you feel a sense of group unity - members working together towards a common goal? ☐Yes ☐No
6. The length of sessions was satisfactory ☐Yes ☐No
7. The number of sessions was adequate ☐Yes ☐No
8. Were the handout materials helpful/useful? ☐Yes ☐No
9. Did the group experience help you to attain a better understanding of yourself, your needs, and values? Explain_____

_____

_____

_____

_____

10. What aspect or experience was the most valuable to you?_____

_____

_____

_____

11. I liked_____

_____

_____

_____

12. I did not like_____

_____

_____

_____

13. Have things changed for you since you started group? If so, how?_____

_____

_____

_____

_____

14. What, if anything, would you suggest we add, subtract, or change in future groups?_____

_____

_____

What have we discovered so far about our anger?

Am group 7

We can stay away from those who make us angry

Power **We can only change our selves** * *"In my changing I'm noticing other people changing too"*

"I'm getting happier" *"Anger in an OK feeling"* **(and some people don't)**

Acknowledging worth of self and others *"Letting it drop- Let go"*

"I have a right to voice my concern(s)" ***"I want to have fun"***

"I can voice my concern and deal with it in a constructive way"

"I'm not the only person with anger problems"

"Keeping anger in is not a good thing - but how we release it we must deal with - the consequences"

"I'm tired/exhausted" ***"Coming to terms with myself is hard"***

"I'm more aware of the origins of my anger"

"I'm starting to deal with it - when it comes up - not waiting or stuffing"

Limit setting -what is yours and what is mine "I want to become more active"

"I don't feel as stuck - I feel more in control" *"I've been angry for a long time"*

"I'm finding I am teary eyed more - more able stay with the sadness than mask it with anger"

"I'm more able to express feelings and ask questions"

"I'm mourning what could have been if I learned about this in kindergarten"

"Our anger ... *"I use my anger in a more constructive way"*

"Feeling off balance - insecure"

What have we discovered so far about our anger? Pm Group 7

I only have control over myself and my response I have to power to change

I can be angry without being violent of hurtful

Be gentle with myself Breath Anger never rides alone

I don't have to get even anymore "I'm stuck in some patterns"

Anger can cause depression There are patterns to triggers and responses

Deep rooted/learned from family Anger can be scary for some of us

How we deal with anger is generational, it's what we were taught "It is possible"

Can't bullshit myself anymore There's nothing that can't be healed

I have to express in the moment - if I wait I might get angry at something else

We hold anger in our bodies Name and acknowledge feelings

Feelings of loss and grieving for past Discovering others resist change in ourselves

The world doesn't end when we get angry Holding it in doesn't work

Realization and acceptance that I have to let go - too tiring Can unlearn

Stating my truth and expressing anger is the only way to go

Getting angry at myself for XYZ does not help - Serves no purpose

Natural reaction to something being wrong Not always engaging 'biting'

My personal goals for completing the anger in healing group are:

- Learning better ways to express anger and channel that energy
- Learning to recoignize anger before it becomes rage
- Learning where to interrupt the thought process to regain control
- Recognizing that anger is healthy and normal and okay and allowed
- Learning that anger does not have to lead to violence
- Learning to differentiate between present and past anger
- Learning not to fear anger - it's only a feeling
- Learning not to direct anger inward to hurt me

I intend to work at achieving these goals by:

- Posting group handouts visibly to remind me of important points
- Attending group and learning what works and what doesn't
- Working on recognizing my anger for what it is - a feeling
- Learning when I'm masking my anger with other feelings
- Practising assertive behaviors and coping strategies
- Listening to my and mind to learn how anger feels for me
- Responding to my anger in the present

I will know I am on my way to achieving these goals when:

- I seethe less, swear less and stand up for myself more
- I can express anger without feeling shame
- I start responding to anger in a way that is different from my parents'
- I can let go of grudges and past angers or resentments which are hurting me in present action
- I recognize my anger patterns and stop obsessive thinking before I escalate to rage
- I stop being terrified of my anger manifesting as violence
- I accept anger as a feeling and know that it is okay
- I hold less anger in my body
- I waste less time and energy plotting revenge for real or imagined slights
- I stop grinding my teeth at night and physically hitting myself

Other people will notice when:

- I say when I am angry without exploding
- I stop apologizing for being angry
- I curse less and use less violent language
- I can be gentle and kind instead of sarcastic, cynical and bitter
- I stop taking out past pain on present people
- I can calmly time out and care for myself if I am angry

I intend to hold myself accountable to these goals by:

- Seeing my counsellor regularly and reviewing them periodically
- Keeping in touch with members of the group
- Recognizing that I need to work on releasing past anger and hurts
- Trying to checkpoint catastrophic negative thoughts before the anger escalates
- Remembering that anger is a feeling like any other
- Remembering that anger is a messy feeling - it involves a lot of other things
- Working anger journals to check my progress
- Using healthier coping strategies (floating, breathing, time-outs)

I will celebrate my efforts and my success (as I define it for myself) by:

- Getting lots of hugs from my support group
- Visiting supportive friends
- Walking Margaret's dog
- Playing with my cats
- Enjoying lots of warm bubble baths
- Treating myself to afternoon tea
- Treating myself to a really nice dinner out and a movie
- Using my anger as a creative catalyst
- Caring for myself as best I can, as my FIRST priority
- Making space in my life for joy as well as anger
- Being gentler with myself and firmer with others
- Moving out of my current anger-laden space into new space